1 PERFORMANCE REPORT

1.1 Performance Overview

1.1.1 Welcome

Welcome to our annual report 2016/17. This has been the first year of implementing our Southwark Five Year Forward View (FYFV) and I am delighted to report real progress with our plans. The CCG has been inspired by the enthusiasm of local people, patients and clinicians who have engaged with us to look at radical new ways of planning and funding health services.

This year has been about robust performance, progress and partnerships. At a time of considerable pressure on the health service, we are proud to have continued to deliver quality services which have improved health outcomes for the people of Southwark.

None of this would be possible without the hard work of NHS staff and those who support them. I would like to give my personal thanks to all those on the frontline, both clinical and operational, who work tirelessly to care for local people, sometimes in very challenging circumstances. Their dedication is admired within and beyond the health service. I am grateful too for the support and contribution from the voluntary and community sector, and local people and carers who work alongside professionals to provide care for others.

In Southwark we are also proud to have been leading the way in transforming healthcare for the future. As the local population continues to grow, demand for healthcare grows alongside it. With careful planning and forecasting, we are striving to ensure our services can meet the needs of local people, and continue to offer high quality care for local residents, now and in the future.

Crucial to this is improving access to GPs and practice nurses. During 2016/17, nearly 30,000 people were given appointments through our Extended Primary Care Service (EPCS) that offers appointments from 8-8 every day of the week for people registered at Southwark GP practices. We know there’s still work to do to increase this number and ensure that more people are aware of the service – but we are making excellent progress. Funding allocated under the GP Forward View (GPFV) will enable us to continue to improve the EPCS and offer a greater scope of appointments.

Making primary care accessible online is vital if we are to make services easy for all to reach. So we have continued to promote GP Online services, which allow patients to book and cancel appointments, access their medical records and order repeat prescriptions online. We are also exploring new technology that will enable those patients who want to get advice and support without having to visit their surgery to do this online.

We hope that creating a range of different options for people to access the care they need, will also help GP practices by freeing up phone lines for emergency calls and making more appointments available for those patients who need or prefer to see their doctor or nurse face-to-face.

With NHS funding increasingly struggling to keep pace with growing demand on services, we have to make tough decisions about how best we use the money available to us. Ensuring that local people and clinicians are increasingly involved in planning will ensure that we do not lose sight of
what matters; that we continue to improve health outcomes for local people and that more money goes directly into patient care.

To this end, we have been investing in GP federations since 2014. Supporting practices to work together is essential for the future of strong and sustainable primary care. Our federations have been able to develop joint services and share learning, best practice and resources. These initiatives will make general practice more resilient and ensure that GPs and practice nurses are freed up to do what they do best – care for patients.

It is vital that we invest in our workforce if we are to continue to achieve the best possible health outcomes for our population. We have commissioned three new training programmes to help practice staff deal with day to day work pressures and improve the experience of patients; and also secured a ‘Darzi Fellow’ to support GP federations to test, design and develop a model for general practice-based pharmacists to work alongside GPs and nurses.

In developing these priorities we considered the resilience of every practice in Southwark and we are working closely with the federations to ensure that the progress we have made in 2016/17 continues throughout 2017/18.

Our emerging Local Care Networks (LCNs), a key part of the FYFV, have strengthened significantly this year, now drawing in patients to help shape the future of local health care services. During the year, LCN Boards have started to think about how they develop and manage health and care services for people who have three or more long term health conditions. We have listened to what these patients are telling us as we begin to work with them and the people who support them to consider improvements to their care.

At a more strategic level other partnerships have thrived too. The SLIC (Southwark and Lambeth Integrated Care) programme closed on March 31 2016 to make way for the Southwark and Lambeth Strategic Partnership, the next chapter in a long history of collaboration between the boroughs. The Strategic Partnership is using the lessons learned from SLIC to continue working towards improving care for local people by connecting up services and healthcare professionals to better support patients.

The year also saw us build a Partnership Commissioning Team with Southwark Council, bringing together commissioners across health and social care. The team is initially focusing on how we develop new ways of commissioning in line with our Five Year Forward View. They are initially looking at the opportunities around three key population groups: children and young people; people with significant mental health needs; and those people with multiple complex needs.

We ended the year by beginning a six month review, along with the five other CCGs in south east London, of our individual and collective commissioning arrangements - to ensure that they are fit for purpose going forward. This review is not driven by a financial requirement to cut management costs and has not been imposed on us by any other organisation, but we recognise that across south east London there are increasing challenges that require us to look at different ways of working collaboratively to address them. However we are clear that our primary purpose is to ensure our CCG has the capacity and capabilities to improve health outcomes and services for Southwark residents, and this will continue to require a very local focus.

Finally, we can be proud of the fact that we have maintained our financial position and met our financial duties. Going forward, the financial challenges will get much tougher and the changes that we have started to introduce through the FYFV and the south east London Sustainability and Transformation Plan (STP) will become ever more essential in helping us to maintain financial sustainability.
1.1.2 About us

NHS Southwark Clinical Commissioning Group is the statutory body responsible for planning and commissioning high quality health services for Southwark residents. All 41 GP practices in the borough are members of the CCG and guide the organisation through our Governing Body. In 2016/17 we were responsible for a budget of £418 million, which we used to plan, monitor and pay for hospital, community and mental health services for people living in the borough.

You can read our full audited accounts in the financial statements section of this report. The accounts have been prepared under a direction issued by NHS England under the National Health Service Act 2006 (as amended). Below is a breakdown of spending for the period from 1 April 2016 to March 2017.

Before the start of each financial year, the CCG agrees a set of corporate objectives to be delivered over the course of the coming year. Our objectives reflect both the national mandatory requirements of CCGs such as work to improve care quality; run a financial surplus; and operate effective systems of governance; and also the objectives we have determined as being particularly important to people in Southwark such as transforming care so that services are better for patients through the Southwark Five Year Forward View.

1.1.2.1 Our objectives:

Corporate objective 1: commissioning services we know are high quality, safe and effective
Corporate objective 2: delivering key standards, securing financial sustainability and running robust and effective governance
Corporate objective 3: delivering our programme of system transformation
Corporate objective 4: fully involving local people, member practices and partners in the work of our organisation

In this report, we highlight some of our achievements against these objectives.

As is required under statute, our annual report includes further detail about the structure and governance of the organisation as well as a comprehensive account of our financial performance and arrangements for financial management.

1.1.2.2 Financial position

In 2016/17, we had a budget of £417.96 million, received from NHS England and other NHS agencies. At the year end, the CCG had managed its cash flow and stayed within the cash target of having less than 1.25 per cent of the amount of cash drawn down in March remaining. We have also achieved a 2.44 per cent (£10.21 million) surplus on our overall budget for the year.

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1.1.2.3 Break down of spending and who we commission from

![Money spent chart]

![Services bought chart]

1.1.2.4 Going concern

The accounts in section 3 of this report have been prepared on the going concern basis. The CCG is a statutory organisation that receives government funding to plan and fund health services for the borough of Southwark. Point 1.1 in the notes to the accounts provides more detail about NHS Southwark CCG’s going concern status.

1.1.2.5 Our duties

Under the National Health Service Act 2006, CCGs have a number of duties and powers. You can find full details of these on the NHS England website at: [http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf)
The statutory duties of the CCG require us to arrange for the provision of hospital and other accommodation and medical and other services to meet the reasonable requirements of the people for whom we have responsibility. This includes people who are provided with primary medical services by a member of the CCG; or people who usually live in the London Borough of Southwark. Additionally the CCG is charged with arranging for the provision of ambulance services and emergency services for every person present within the London Borough of Southwark.

The CCG has a variety of powers to fulfil our statutory duties, including:
- Entering into contracts with providers of relevant services;
- Participating in corporate entities to provide relevant facilities and services;
- Delegating functions to other bodies;
- Pooling budgets (for example with Southwark Council);
- Provision of grants and loans.

In this annual report, we describe how we have fulfilled these duties to improve the quality of local services, reduce health inequalities, promote involvement of each patient in their own care, offer patient choice, support the integration of services, work together with the public and patients, and ensure that we have plans in place to deal with surges in demand for services and major incidents. We certify that the NHS Southwark CCG has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

### 1.1.2.6 Health and wellbeing of people in Southwark

Since 2010 life expectancy has continued to rise for people living in Southwark and over the last few years there has been a trend towards diminishing inequality in health outcomes between different socio-economic groups within the borough. Progress has been made on improving health outcomes in a wide variety of areas, including reduction in infant mortality; better, more comprehensive care for people at the end of their life; and improved outcomes for people living with HIV.

However, according to Southwark’s Joint Strategic Needs Assessment (JSNA), in Southwark and across the NHS there are a number of problems that we need to solve. The longer we wait to respond to these challenges, the more difficult these problems become. In essence, we know that health outcomes here in Southwark are not as good as they could be.

#### Key Health Issues

- Southwark people are more likely to die prematurely from cardiovascular disease than people living in similar parts of London.
- Chronic obstructive pulmonary disease (COPD) and lung cancer cause relatively high numbers of preventable early deaths and ill health in Southwark.
- There is significant variation in the management of patients with diabetes in Southwark and a high number of people are living with undiagnosed diabetes.
- Rates of preventable early deaths from liver disease and alcohol related hospital admissions are significantly higher in Southwark than they are in similar London boroughs.
- Southwark has a high prevalence and comparatively poor outcomes for people with low and medium-level mental ill-health. There is significant unmet need too.
- Childhood obesity levels in the borough are amongst the highest in England. Adult obesity is also higher than the London average.
- About three-quarters of the predicted numbers of patients with dementia are diagnosed (comparatively good in comparison to the London average). The effective management of diagnosed patients however remains highly variable.
- Admission rates and health related quality of life for older people is higher than in similar areas of London with rates of falls-related admissions particularly high.
Patients and members of the public consistently tell us that they often find it hard to get an appointment with their GP.

You can read the full Joint Strategic Needs Assessment for Southwark on Southwark Council's website.

1.1.2.7 Summary annual report

We will publish a summary annual report in August 2017. This will be available on the CCG website publications page: http://www.southwarkccg.nhs.uk/news-and-publications/publications/Pages/default.aspx
1.2 Performance analysis

1.2.1 Delivering Southwark’s Five Year Forward View, Sustainability and Transformation Plan and national commitments

1.2.1.1 Southwark Five Year Forward View

In 2016 the CCG started to design the plans needed to deliver our five-year strategic vision. The Southwark Five Year Forward View is a shared vision between the CCG and Southwark Council and is enabling us to work much closer and take a very different approach to commissioning and providing services in Southwark. You can read the full Southwark Five Year Forward View document and a summary document on the Publications page of the CCG’s website.

Reflecting the national NHS Forward View and south east London Sustainability and Transformation Plan, the Southwark Five Year Forward View is our attempt to lead the system locally and achieve some of the objectives everyone working in the NHS is striving towards: better outcomes; greater value; and sustainable service provision.

Our plan aims to:

1. **Emphasise populations rather than providers**
   - Arranging networks of services around geographically coherent local communities.

2. **Focus on total system value rather than individual contract prices**
   - Moving away from lots of separate contracts and towards population-based contracts that maximise quality outcomes (effectiveness and experience) for the available resources.

3. **Focus on the ‘how’ as well as the ‘what’**
   - Focusing on commissioning services that are characterised by the qualities of care below and taking into account people’s individual needs.

![Qualities of care](image.jpg)

- **Empowering**
- **Activating**
- **Enabling**
- **Holistic and Co-ordinated**
- **Proactive Preventative Outcomes Focused**

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Our plan aims to get maximise the value of health and care for Southwark people and ensure commissioned services exhibit positive attributes of care, we are addressing four root causes of complexity within the current system:

1. **The fragmented contracting arrangements** can make it difficult to move resources to where they are needed to deliver what really matters to people

2. **The fragmented arrangement of organisations and professions** can reinforce boundaries and can make it too difficult to work together and to work consistently

3. **The disempowerment of service users** and carers can create confusion and risks making people passive recipients of care

4. There is not yet a strong mechanism for different agencies in the local system to align strategies and work together purposefully to implement a transformation plan

In 2016/17 we made progress in all four of these areas.

We started to address the fragmented arrangements of commissioning and contracting by:

- **Establishing joint population-based commissioning development groups (CDGs) and a Joint Committee.**
- **Creating fully assured Better Care Fund plans**
- The Better Care Fund is a national policy initiative that requires local areas to agree plans for the integration and transformation of health and care related services. Under these arrangements Southwark Council and the CCG agree plans for the use of a £22m budget, covering a range of health and care related services that effectively support people at risk in the community, reduce hospital and care home admissions and help people to be discharged smoothly and safely from hospital.

Our submission for 2016/17 was submitted to NHS England in May 2016, and was rated as being ‘fully assured’, one of only four London boroughs to achieve such a rating at the initial review stage. Southwark’s plan is now used as a national exemplar which is testament to the hard work and dedication of teams from across the CCG and Council. The BCF has helped us deliver significant improvement across a number of areas including:

- Low levels of Delayed Transfers of Care (DTOCs), with Southwark one of the top 12 performers nationally, with delays less than a third of the national average.
- Improvements to re-ablement services, with a reduction in the number of patients re-admitted to hospital. Over 90% of patients remain at home 90 days after discharge.
- Care home admissions have been kept at low levels. Thanks to services such as re-ablement, Night Owls, and @home, more people are being able to be cared for at home, helping rebuild confidence and mobility and reducing need for long-term placements.

Work will continue to ensure that these achievements are built upon throughout 17/18 and provide a strong foundation for the development of our Partnership Commissioning Team.
- Recruiting an Associate Director to oversee the implementation of a Joint Partnership Commissioning Team for the CCG and Southwark Council.

- Establishing a shared system incentive (with alternative arrangements for general practice)

- Undertook a formal options appraisal and engagement to determine our decision to submit an application to take on delegated commissioning of primary medical services starting from 1 April 2017. This was approved by NHS England in February 2017.

We began to address the fragmented arrangement of organisations and professions by:

- Establishing two local care network (LCN) boards in Southwark, with consistent multi-agency representation, and funded LCN chairs.

Our Southwark Five Year Forward View describes how the CCG’s overall commissioning intention is to improve outcomes for local people by enabling the development of effective multi-agency Local Care Networks (LCNs). The CCG is continuing to support the development of our two LCNs (which mirror the geographies of our GP Federations), alongside other partners in the Lambeth and Southwark Strategic Partnership.

In 2016/17, LCNs have focused on the design of a pathway to better coordinate care for patients with three or more long-term conditions, which will be delivered to an identified group of patients in 2017/18. The CCG and LCN partners are also discussing other areas of work that will be improved by taking a joint approach.

Within the Strategic Partnership, we continue to have productive discussions about the capacity and capability needed to develop LCNs. This shift of LCNs from ‘coalitions of the
willing’ to more formal arrangements is in line with opportunities presented by NHS England’s Multispecialty Community Provider (MCP) Contracting Framework and our collective ambitions outlined in the Our Healthier South East London (OHSEL) – The Sustainability and Transformation Plan (STP). Formal Chairs have now been recruited to both the North and South LCNs, and we have also supported the recruitment of an LCN Programme Manager to support the delivery of this ambitious programme of work across both LCNs.

- **Putting into practice two “at scale” Extended Access Hubs (Extended Primary Care Service), developing GP federations, and orienting adult social care around neighbourhood and LCN geographies**

  The extended primary care service has continued to develop providing 29,105 additional appointments across both hubs (at December 2016). Patient experience continues to be high with over 90% of patients each month saying they would recommend the service to friends of family.

  These and other developments support local delivery of the General Practice Forward View, published by NHS England on 21 April 2016. This document describes how the NHS will earmark an extra £2.4 billion a year for general practice services by 2020/21, a 14% real terms increase. This investment will be supplemented by a £500 million national ‘turnaround’ package to support GP practices and additional funds from local clinical commissioning groups.

  The Plan acknowledges the existing pressure in General Practice, with rising workload matched by growing patient concern about convenient access. Set out within the Plan are steps to strengthen the primary care workforce, to drive improvements in workload, to modernise infrastructure and technology, and to redesign the way modern primary care is offered to patients.

  Many aspects of the new national approach were already part of our existing CCG work to develop Primary Care, working through our localities, with our Member Practices and with our local partners.

  For example, we have been investing in GP federations since 2014 and have developed locality resilience plans to support the resilience of general practice through federation business planning.

  The plans cover three areas:

  - Vulnerable / Sustainable Practice Programme
  - Merger support for practices who wish to consider this
  - Quality Improvement initiatives

  In developing these priorities we considered the resilience of every practice in Southwark (working with our GP Federations). NHS Southwark CCG is working closely with the two GP Federations to ensure activities delivered in 2016/17 continue through to 2017/18.

  A significant development in 2016 was the merger of four practices, the Aylesbury Partnership, Bermondsey and Lansdowne Medical Mission, Princess Street Group Practice and the Walworth Partnership serve a combined population of over 60,000. The aim of the merger is to give patients a better service, develop new ways of working while holding on to the good values of traditional general practice and to prepare for population growth in the area.
As well as the EPCS, initiatives to support more convenient access for patients include development of better IT infrastructure and the implementation of GP online, the Local Care Record and work to identify and implement a model and system which enables patients to access online consultations for urgent and regular care.

The **Local Care Record** joins up patient records between all GP practices in Lambeth and Southwark and Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts. It enables healthcare professionals to view a patient’s medications, previous treatments, test results and any other clinical information at the touch of button, helping improve the safety of care they provide to patients.

The Local Care Record was formally launched in February 2016. It has improved patient care by helping clinical teams understand and maintain consistency around advice given for long-term conditions, speeding up decision making in emergency departments, and reducing repetition of blood tests and brain scans.

In September 2016, the Local Care Record won the ‘Best use of IT to support integrated healthcare services’ category of the EHI (E-Health Insider) Awards. The EHI Awards are the UK’s only dedicated healthcare IT award scheme, showcasing excellence in using IT and digital technology to improve patient care and experience.

Recognising that not all patients are able to or wish to use online access methods, the CCG has invested funds through the Federation business plan allocations in two care navigation pilots. Our Federations have partnered with Age UK to employ six Safe and Independent Living (SAIL) navigators that are embedded within general practice and provide support to practices for those patients with more social orientated needs. The SAIL Navigators are active members of Community Multi-disciplinary Team (CMĐT) meetings, and work within practice teams to support patients.

In addition, the CCG is exploring a development programme for community leaders to enhance awareness and understanding of NHS services, and equip community leaders with signposting and navigation skills. This will enable the leaders to ensure patients are aware of the services they can access and when it is appropriate to access them (for example, increasing awareness of Extended Access and reducing unnecessary A&E attendances).

- **Agreeing our local Sustainability and Transformation Plan (STP).**
  See 1.2.1.3 Our Healthier South East London

We began to empower residents and service users by:

- **Holding public meetings about our GP contracts, involving local residents in the development of a new pathway of care for people with complex needs, and the incorporation of Healthwatch reports into our CDGs.**

- **Creating a three-way Voluntary and Community Services (VCS) strategy informed by a series of discussion events.**

- **Successfully bid to be a pilot site to embed patient activation measures (patients’ motivation to take more control of their health) in our local services.**

- **Requiring providers to include collaborative care planning and self-management in the pathways for people with chronic conditions.**
We established a local Strategic Partnership of commissioners, statutory providers and residents to ensure alignment of organisational strategies and to coordinate and enable the delivery of our shared transformation programme.

The CCG and the Council have agreed a Joint Strategic Framework for the wellbeing of Southwark’s Children and Young People. As a partnership, we have agreed an approach grounded in our Joint Strategic Needs Assessment for Children and Young People, with a shared focus on key priorities including mental health and wellbeing and improving outcomes for the most vulnerable children and young people.

Cross-borough working with Lambeth through the Children and Young People’s Health Partnership is delivering improvements through a broad programme of work that includes ‘Everyday Healthcare’ for children, to support primary care to provide the best possible service, as well as work to improve access to healthcare for teenagers. The programme also includes a work stream to help children with long term conditions, focused on asthma and epilepsy.

The CCG and the Council have been developing a joint mental health strategy; the parity of esteem agenda will continue to be addressed through new CCG governance arrangements, and the Southwark Crisis Care Concordat will be refreshed by re-establishing the governance group and redrafting the crisis care plan.
1.2.1.2 Developing a new healthcare centre for Dulwich and the surrounding area

The Dulwich Programme was set up in 2011 to consider what health services should be provided in the south of the borough, and what facilities should be available to support the delivery of those services. The programme covered Dulwich and the surrounding areas - including Nunhead, the southern parts of Camberwell and Peckham, and parts of Herne Hill. We also included people from nearby parts of Lewisham and Lambeth as some of them use the health services in Dulwich.

In 2012 we undertook a thorough engagement exercise where we talked to local people and clinicians providing services in the area and asked them what they thought. On the basis of that we developed some proposals and consulted local people about them.

In 2013 we ran a formal, public consultation and based on what local people told us, we are now developing a new centre to provide improved primary and community health services. Our goal is to improve community services and make them more accessible, joined up and convenient for patients, with a focus on long term conditions.

In 2014 we refined the list of services in accordance with the results of the consultation, and calculated how many patients we need the health centre to accommodate. That has helped us to determine how big it needs to be, and how big a site it needs to be built on.

We also looked objectively at all the possible locations for the health centre. This included refurbishments and new builds on the Dulwich Hospital site and also looking to see if there was anywhere else in the area the health centre could sensibly be located. The conclusion was that a new build represented best value for public money. This would be located on the south-east corner of the Dulwich Hospital site, offering good access to both East Dulwich Grove and the bus and train links on Grove Vale.

In early 2015 there was a review of how the building was to be funded, and the outcome was that it would be a ‘Land Retained Agreement’ under our LIFT arrangements. This means that the land remains in NHS ownership, and the building is funded through the NHS paying rent over a 25 year period. After that the building returns to the NHS.

From mid-2015 we started the design process, and ran a series of workshops and meetings where the design team talked to patients and clinicians about the way the building might be developed so that is best suits the services to be provided.

In spring and summer 2016, we held public engagement events where local people saw the initial proposals for the health centre and what it might look like from the outside. The feedback from these events as well as from on online survey widely promoted to residents in Dulwich and the surrounding area was used to inform the final design that was taken to the council’s planning committee in October.

The part of the site not needed for health purposes has been sold to the Education Funding Agency, and a secondary school will be built there. This is being done on a phased basis so that none of the existing services would be moved off the site until the new health centre is ready for occupation. Preparations for the construction of the school began in early 2017, with building in mid-2017 and the first phase open to students in September 2018. We expect the health centre to be completed in 2019.

The CCG and its partners are working very closely with the Charter School to make sure that the site developments work well together.
The health centre and the school schemes were granted planning permission (subject to a number of planning conditions) in October 2016.

In the summer of 2016 the CCG submitted the ‘Stage 1’ business case to NHS London for approval, and we are pleased to confirm that this has been awarded. We are now completing the final stages of the design and financial arrangements in advance of the submission of the ‘Stage 2’ business case in May 2017.

Managing the programme
This work is managed by the Dulwich Programme Board. It has representation from relevant local NHS organisations, Healthwatch and additional patient representatives. It meets monthly, and once approved, the minutes of each meeting are available on our website. We also produce summary minutes which are incorporated into the Chief Officer’s Report to the Governing Body. These are also accessible on the website.

Full details about this project are available at: [http://www.southwarkccg.nhs.uk/our-plans/improving-services-in-dulwich-and-the-surrounding-areas/Pages/default.aspx](http://www.southwarkccg.nhs.uk/our-plans/improving-services-in-dulwich-and-the-surrounding-areas/Pages/default.aspx)
1.2.1.3 Our Healthier South East London

Our Southwark Five Year Forward View reflects the work of the whole of the NHS to transform health services and sustain them for future generations. Our neighbouring CCGs are all working to achieve similar changes. We address issues locally, in Southwark, where this is the best place to bring about improvements. Where there is more interaction between services over a wider area we work together with our neighbouring CCGs, local authorities and trusts through Our Healthier South East London (OHSEL), the Sustainability and Transformation Plan (STP) for south east London.

In December 2015, NHS organisations in 44 areas of England were asked to work together to produce a five-year plan (covering up to March 2021) to implement the NHS Five Year Forward View. These plans are called Sustainability and Transformation Plans (STPs).

Our STP is called Our Healthier South East London. It has evolved from a commissioner-led strategy – established in 2013 - into a partnership between local commissioners and providers, working with local authorities, patients and the public.

The STP is not a blueprint for the next five years: it is a series of plans for different clinical areas that are at different stages of development.

The STP (full version and summary) was published on 4 November 2016 and was one of the first in the country to be made public. The plan aims to address a number of challenges, including:

- a growing and aging population living with long term conditions like diabetes, high blood pressure and mental illness
- quality of care and outcomes of treatment differs depending on when and where people access services
- patient experience differs and some people find it difficult to get an appointment or feel they do not have enough information about their condition
- NHS funding increases in line with inflation but the costs of providing care are rising much faster – which, at the moment, could mean an overspend for south east London of around £1bn by 2021 if we were to do nothing. Our plan is designed to help us avoid spending more than we receive, while making sure services are high quality, more joined up and available closer to home.

What does the plan mean for local people?

Better community based care including: extra £7.5 million a year to ensure that people in south east London can book a GP at a time that suits them – including more evening and weekend slots.

No closures of any A&E and maternity departments – we want to make sure they all meet high standards of care in the future.

Better maternity care – dedicated midwives supporting mothers throughout pregnancy, better advice and choice on birth options.

Developing world-class orthopaedic services – fewer cancelled operations, shorter waiting times and more procedures carried out. Detailed work is underway to refine proposals to develop elective orthopaedic centres, which could mean consolidating planned adult procedures onto two or three sites. More material is being developed to allow the public to consider the pros and cons of both options. A public consultation may then take place in 2017.

Faster cancer diagnosis – new £160 million purpose built cancer centres at Guy’s Hospital and £30 million centre at Queen Mary’s Sidcup, launch of dedicated oncology support phone line, dedicated clinical nurse specialists for all patients.

All the different parts of local health and care services working together to use available money and resources in the best way possible - helping us avoid a £1bn overspend by 2021.

Fully integrated mental health services – improving the link between physical and mental health and mental health support and liaison team in A&Es 24/7; we’re working towards no out-of-area placements for non-specialist care by 2021.

See section 1.2.4 Patient and Public Involvement to find out how local people have been involved.
1.2.1.4 Healthy London Partnership – London CCGs working together to support the delivery of better health in London

NHS Southwark CCG, along with every other London CCG and NHS England (London), has made a commitment through Healthy London Partnership to unite and amplify the work of our partners to support the transformation of health and care in London. Our partners include the Greater London Authority, Public Health England, London councils and Health Education England and through Healthy London Partnership we are working to deliver changes that are best done ‘once for London’.

Collectively we believe it is possible to achieve a healthier, more liveable global city by 2020, by delivering on the ambitions set out in Better Health for London: Next Steps and the national NHS Five Year Forward View.

Some of the key achievements of Healthy London Partnership are included in the 2015/16 highlights report on our website here.

Highlights this year include the development of the London-wide standards for people experiencing a mental health crisis endorsed by all London mental health trusts, London Ambulance Service, London Councils and the Met Police. During 2016-17 we facilitated a year-long engagement with Londoners on childhood obesity, called the Great Weight Debate, which reached over half a million Londoners on social media, saw 3,900 people fill in our survey, nearly 2,000 people attend roadshows during October half term and culminated in 60 teenagers working through the issues at a Hackathon in January 2017 at City Hall. London’s young people also helped us design and launch a mobile health website and app called NHS Go that gives them targeted health information plus health advice and signposts to services – approx. 30,000 people are now using NHS Go. Watch their launch video.

Healthy London Partnership on behalf of London CCGs has also led on the collaboration that saw all 32 CCGs, all 33 borough councils, the Mayor of London, NHS England and Public Health England sign the London Health and Care Collaborative Agreement. Together with the London Devolution Agreement, this paves the way for central government and national bodies to devolve powers and funding to the London system to enable local, sub-regional and London-wide transformation.

This year Healthy London Partnership has been in a unique position to support the developing sustainability and transformation plans. Sustainability and transformation plans are sub-regional place-based plans across commissioners, providers and local authorities within five defined footprints in London. Plans will set out how London’s health and care system will improve over the next five years and achieve Better Health for London’s 10 aspirations.

Read more about our work online at www.healthylondon.org

Taking forward devolution in health and care for London

London faces significant population, health, organisational and financial challenges, which must be addressed if we are to support Londoners to be as healthy as they can be and for services to be sustainable. London Partners, including London CCGs, have committed to work more closely together to support those who live and work in London to lead healthier, independent lives, prevent ill-health, and to make the best use of health and care assets. London health and care leaders have worked closely together at local, sub-regional and regional level over a number of years to develop a clear vision for better health and care, built on the views of Londoners, and central government and national bodies backed this commitment through the 2015 London Health Devolution Agreement.

Throughout 2016, local, multi-borough and sub-regional (STP) areas in London have worked hard to plan rapid improvements to health and care within existing powers. Five London devolution ‘pilots’
have also explored how more local powers, resources and decision-making could accelerate the improvements that Londoners want to see. Our devolution work has underscored the importance of working at different levels in London under the three themes of prevention, integration and estates. We are clear that transformation must be locally led and that many services can only be delivered at the borough or smaller locality level, whereas others are more appropriately aggregated across boroughs or London-wide. The forthcoming London Health and Care Devolution Memorandum of Understanding (MoU) will express commitments by national bodies to enable these improvements to go further and faster, based on the different ambition and appetite of local areas. We have also been working to commence delivery of more collaborative health and care governance and delivery capability at London-level working within the London Health Board arrangements. This aims to complement and support local areas in their transformation ambitions. As an example the London Estates board has started to meet in shadow form, looking at what projects need help at a London level to progress more speedily and the use of NHS buildings. This work will help to deliver the modern buildings which London's health service needs, use them as intensively as possible and potentially deliver the land for much needed new housing.
1.2.2 Assuring delivery of performance and constitutional standards

1.2.2.1 NHS Constitution standards and national performance indicators in 2016-17

The following section sets out how the CCG performed against national NHS Constitution Standards and mandatory key performance indicators (KPIs) in 2016/17. A summary of the target is described together with year-to-date performance and a short description of the performance position.

**A&E 4 hour performance (95% target):** Percentage of A&E attendances where the patient spent four hours or less in A&E from arrival to transfer, admission or discharge.

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<tr>
<td>KCH</td>
<td>83.5</td>
<td>85.1</td>
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<td>82.0</td>
<td>81.3</td>
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<td>75.5</td>
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<tr>
<td>GSTT</td>
<td>91.9</td>
<td>89.4</td>
<td>89.8</td>
<td>90.8</td>
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<td>89.2</td>
<td>86.7</td>
<td>84.2</td>
<td>88.9</td>
<td>87.9</td>
<td>89.5</td>
<td>87.0</td>
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In common with many health systems across England, local hospitals have been challenged in delivering target standards for A&E waiting times during the year. Issues include patients being more ill, estates issues materially affecting both A&E departments and hospital bed bases and vacancy rates for staffing at both local providers. Performance is in line with the experience of many trusts across the country.

Over the last few months, the CCG has undertaken significant work with health and care partner organisations to ensure that patients can be transferred from hospital more efficiently and that both hospitals were able to make full use of community and social care discharge pathways such as '@home' and supported discharge. Our Continuing Healthcare Team has worked closely with local providers and helped to reduce the number of patients that were Delayed Transfers of Care (DTOCs) or Medically Fit for Discharge (MFFD), achieving a 58% reduction since December 2016 at Denmark Hill.

Work is also underway to explore opportunities to expand initiatives that enable assessments to be undertaken in patients’ homes or in a suitable step down facility speeding up transfer from hospitals. Evidence from elsewhere has indicated that these initiatives help promote patients’ independence and can lead to better outcomes. We are collaborating with NHS Lambeth CCG on our local approach, as well as working with colleagues across south east London to ensure there is a system-wide approach.

It should be noted that significant estates work is being undertaken at both trusts. For GSTT, the rebuilding of the A&E department 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 A&E during the period. As a result, the A&E department is operating in suboptimal conditions whilst essential works are completed. Whilst the quality of care and safety of patients has been maintained, this has had an impact on operational performance and waiting times. We anticipate that whilst all efforts will be made to strengthen the emergency pathway at GSTT, it is likely that performance will be slightly below the national standard until all estates works are completed in early 2018.
In relation to Denmark Hill, capacity constraints have been cited as a key driver to underperformance against the four hour target. Twenty three additional beds are due to open at the Denmark Hill in spring 17/18 and additional beds have also opened at Orpington Hospital, which over time, will facilitate the moves of some elective work from both the PRUH (Princess Royal University Hospital) and Denmark Hill sites. However, it is likely that the full benefits of this additional capacity will not be felt until midway through next year as a number of site moves need to take place over the coming months. In addition, a re-specified 24/7 Urgent Care Centre (UCC) is due to open at Denmark Hill in July 2017. The UCC will provide additional space and dedicated staffing to significantly improve waiting times for patients with minor conditions. Alongside this, King’s College Hospital has launched the ‘Here and Now’ programme. This one year programme has a number of key work streams including: Emergency Department, acute pathway (including ambulatory care), frailty, surgery and patient flow; each with a clear plan to redesign pathways and processes to achieve performance and quality improvements.

London Ambulance Service (LAS) Response Times:

8 minutes (75% target) - May be life threatening. Emergency response within 8 minutes

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<tr>
<td>Cat A - 8 minutes (75% target) - LAS</td>
<td>65.1</td>
<td>65.6</td>
<td>65.8</td>
<td>64.1</td>
<td>68.3</td>
<td>64.7</td>
<td>67.6</td>
<td>67.5</td>
<td>64.1</td>
<td>62.4</td>
<td>67.8</td>
<td>73.5</td>
</tr>
<tr>
<td>Cat A - 8 minutes (75% target) - Southwark</td>
<td>73.0</td>
<td>73.9</td>
<td>75.2</td>
<td>7376</td>
<td>75.5</td>
<td>70.8</td>
<td>75.2</td>
<td>75.7</td>
<td>72.7</td>
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LAS experienced severe activity pressures, and in common with national services performance has not met targets. Recognising the recovery position that the service was in, 2016/17 trajectories were agreed for LAS that deviated from the national standard. LAS broadly met trajectories during Q1 and Q2, but missed targets in Q3. This coincided with a period where they saw some of their busiest ever days.

A key issue identified has been recruitment and retention of paramedic staff. Staffing and recruitment plans continue to progress, with increases in substantive hours worked and a drop in overtime being used. Crew capacity is now higher than plan.

Delays in handing the patient over at hospitals continue to represent an operational challenge. King’s College Hospital has now implemented a new RAT model following discussions with LAS to reduce delays, noting that handing over delays have since reduced.

Note: Performance within Southwark itself has been better than the London average but the CCG target relates to service performance across London as a whole.
Referral to Treatment (RTT) waiting times (92% target - incomplete pathways): The percentage of patients waiting for treatment who have waited less than 18 weeks.

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<tr>
<td>SCCG</td>
<td>84.7</td>
<td>84.7</td>
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<td>KCH</td>
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<td>80.8</td>
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<td>76.9</td>
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<tr>
<td>GSTT</td>
<td>92.1</td>
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<td>92.1</td>
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<td>89.9</td>
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Southwark CCG breached the incomplete RTT pathways target throughout 2016/17. This represents a fall in performance from 2015/16. The drop in performance is attributed to challenges at both KCH and GSTT, particularly given an increase in referrals of around 14%. In addition, the competing demands of urgent care and elective care can result in elective activity getting cancelled or temporarily suspended, resulting in longer delays for treatment and patients being treated out of date or priority order.

To look at the challenges and some potential solutions, a Planned Care Programme Board has been set up across Lambeth, Southwark and Bromley, with representation from both GSTT and KCH and all local commissioners.

Providers and commissioners have agreed that we need a shared work programme and to be targeted in our approach. We can only make progress if all parts of the system work together towards common goals.

Five planned care specialities have been selected by the group that would be the focus for the next year. The specialties are; ophthalmology, dermatology, gynaecology, ear nose and throat (ENT) and neurology.

These specialties have been selected as they have seen particular growth in referral levels, thus working to better manage demand is likely to have a significant impact. With each of the five specialties, we will need to look collectively at how we work, and how we can best support each other, and thus improve the timeliness of care for patients. It is recognised that each speciality will have their own challenges and opportunities, but in broad terms our areas of focus will be:

- **Primary Care** – Ensuring a referral advice and guidance service is available for each specialty. Rather than immediately referring a patient, GPs should be able to seek direct and immediate access to a specialist opinion. This will help better support GPs in decision making, strengthen relationships between primary and secondary care, and ensure that onward referrals go to the right place, first time. To help support this further, we are also working to establish a primary care led referral review process which will help optimise the referral process across all specialties.

- **Community** – Many specialties have a community alternative in place, but these are often inconsistently used. We need to make the best use of these services to reduce pressure on acute services and enable patients to be seen closer to home. We are also keen on establishing new services and pathways where appropriate.
• **Acute** – We would like our acute providers to be actively involved in the advice and guidance services, in redirecting referrals where these can be managed in the community and in reviewing internal pathways and follow-up policies.

**Referral to Treatment (RTT) 52 week waits:** The number of Referral to Treatment (RTT) incomplete pathways greater than 52 weeks (target zero).

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<td>KCH</td>
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<td>196</td>
<td>137</td>
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<td>156</td>
<td>129</td>
<td>158</td>
<td>183</td>
<td>199</td>
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<tr>
<td>GSTT</td>
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Southwark currently has 55 patients waiting over 52 weeks for treatment. Significant increases in long waiters have been seen across both trusts when compared to equivalent months last year. This reflects the growing pressures on the waiting list in certain specialities. Few have been Southwark patients as they have tended to be transfers of complex patients from out of area hospitals.

Recovery plans are in place for both GSTT and KCH and are being implemented. Actions include:

- Internal demand and capacity exercises and actions to improve internal productivity and efficiency, including additional clinics and theatre sessions.
- KCH has been working with the independent sector to outsource some neurosurgery, general surgery and gynaecology work.
- KCH has been receiving external support on RTT; actions are being taken forward through the RTT improvement group.
- KCH and GSTT are working with Southwark, Lambeth and Bromley CCGs participating in recently established referral management groups focusing on five key specialty areas. (neurology, ENT, gynaecology, dermatology, ophthalmology).

**Cancer waiting times – all standards:**

a. **Two week waits**: Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer (target 93%)

b. **31 day waits**: Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from ‘date of decision to treat’) (target 96%)

c. **62 day waits**: Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer. (Target 85%)

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<tr>
<td>2 weeks</td>
<td>93.4</td>
<td>90.1</td>
<td>91.6</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>
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<tr>
<td>31 days</td>
<td>97.1</td>
<td>100.0</td>
<td>97.6</td>
<td>98.6</td>
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<td>100</td>
<td>92.6</td>
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<td>97.1</td>
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<tr>
<td>62 days</td>
<td>85.7</td>
<td>83.3</td>
<td>82.1</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>
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<td>80.5</td>
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The delivery of the 62 day cancer standard remains challenging for south east London providers, particularly as delivery of the overall 62 day cancer treatment standard is closely linked to reducing late referrals to GSTT from other trusts. GSTT internal performance continues to be close to the national target. Achievement of this target is approached on system basis - improved timeliness of inter-hospital processes and transfers (ITTs) is the key component of south east London recovery plans.
Significant work is taking place to support care pathway redesign and adherence to timed pathways across south east London providers.

The south east London 62 Day Cancer Review Group has agreed an improvement plan with a recovery trajectory including actions to address the delivery of timed pathways through enhanced diagnostics capacity, focus on the first seven days after referral and system wide oversight of patients transferring between providers. Providers are also prioritising reviews in those tumour groups where delivery of timed pathways is most challenging, including lung, urology and lower GI.

The improvement plan, which has been developed by both south east London commissioners and providers, has been reviewed by NHS England and the London Transforming Cancer Services Team.

**Diagnostic waits:** The percentage of patients waiting 6 weeks or more for a diagnostic test. (Target 1% or less)

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<tr>
<td>SCCG</td>
<td>2.9</td>
<td>5.7</td>
<td>5.7</td>
<td>4.5</td>
<td>1.0</td>
<td>0.9</td>
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<td>1.0</td>
<td>0.96</td>
<td>0.87</td>
<td>1.1</td>
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Southwark’s performance has improved through the year and the target was achieve in quarter four. This has been driven by improved performance across both trusts.

**Improving Access to Psychological Therapies (IAPT):**

a. **Contacts:** the number of people entering treatment. The target of 524 set for Southwark is based on 15% of the estimated prevalence of people who have depression and/or anxiety disorders in Southwark.

b. **Recovery:** The percentage of people who have completed treatment (having attended at least two treatment) and are assessed as moving to recovery (target 50%).

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<tr>
<td>First Treatments (Target 524)</td>
<td>405</td>
<td>410</td>
<td>645</td>
<td>385</td>
<td>425</td>
<td>770</td>
<td>440</td>
<td>415</td>
<td>385</td>
<td>730</td>
<td></td>
<td></td>
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<tr>
<td>Recovery (Target 50%)</td>
<td>36</td>
<td>38</td>
<td>34</td>
<td>37</td>
<td>39</td>
<td>38</td>
<td>43</td>
<td>40</td>
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IAPT services have not delivered targeted levels of recovery during 2016/17. The re-commissioned service commenced in April 2016. A detailed recovery plan has been agreed between the CCG and trust in order to achieve the 50% target and short-term investment has been made to tackle some of the barriers to achieving and sustaining access and achieving recovery rate. Delivery against the plan is being monitored by commissioners on a monthly basis at the Integrated Governance and Performance Committee.

**Dementia:** Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence - target 67%

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<tr>
<td>Actual % Diagnosed</td>
<td>75.4</td>
<td>76.0</td>
<td>76.9</td>
<td>77.8</td>
<td>78.9</td>
<td>79.2</td>
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<td>79.0</td>
<td>78.9</td>
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The CCG has successfully worked with GP practices to ensure good diagnosis and recording of dementia on registers in line with the target requirements.
Incidence of healthcare-associated infection – MRSA: target zero

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<td>SCCG</td>
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<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
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Incidence of healthcare-associated infection – C.Difficile: (target 45 or less for full year, 3.75 per month.)

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<tr>
<td>SCCG</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>3</td>
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Targets for the year have been marginally exceeded for MRSA and met exactly for CDiff.

Infection control issues (including MRSA and CDiff) are discussed at the monthly Clinical Quality Review meetings at KCH and GSTT. KCH and GSTT undertake a Root Cause Analysis (RCA) on all MRSA cases and all CDI cases attributed in their organisation.

**Friends and Family Test:**
The Friends and Family Test measures whether people receiving NHS treatment would recommend the place where they received care to their friends and family. There is not a specific numerical target but performance is expected to improve over time. The performance relating to A&E and inpatients is shown in the table below.

**A&E – % of patients recommending care**

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**Inpatients – % of patients recommending care**

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Performance is good for inpatients but the CCG would expect to see improvements in ratings A&E as waiting times improve as a result of initiatives in urgent care.

**Better Care Fund performance:**
The Better Care Fund (BCF) is a pooled budget for improving the performance of community health and social care services through an integrated service delivery approach. The performance indicators set under the national framework to measure the success of the BCF are set out below.

1) Delayed transfers of care – target is a reduction in bed days lost on 2014/15
Southwark had relatively low rates of delayed discharge in 2015/16. The BCF target required a further improvement on this position which has not been achieved as there has been an increase in delayed transfers of care. Delays relating to care home admissions and patient/family choice are a feature of the growth.

2) Care Home admissions - target is a reduction in new permanent admissions

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The 2016/17 target for reducing new permanent care home admissions for older people has been achieved, with 128 admissions compared to the target of 155. This reflects well on the effectiveness of community support services to help people live at home.

3) Effectiveness of re-ablement services
This metric relates to the proportion of people who are still living at home 91 days after discharge from hospital with the support of a re-ablement or similar rehabilitation service, without having been re-admitted. It is an annual figure relating to those discharged during October to December and will not be available until after the year end. The quarter 1 figure was 91.1% against a target of 90.5%.

4) People feeling supported by services to manage their long term conditions – GP survey
The Better Care Fund target was to increase the proportion reporting positively from 58% to 62%, bringing Southwark into the top quartile for London. Last published data (July 16) shows an improvement to 59.7% (from the January figure of 57.2%) and is above the London average of 57.9%. However this remains below the stretch target of 62%

5) Local measure on patient experience of integrated care (new)
A local question was added to the adult social care user survey targeted at people receiving health and social care services asking "do all the people treating and caring for you work well together to give you the best possible care and support?" In the 2016 survey 81% said yes, an improvement on the 2015 when the figure was 78%.

1.2.2.2 CCG assurance annual assessment 2016/17

NHS England conducts an annual performance assessment of CCGs. NHS England will publish the annual ratings for CCGs for 2016/17 by July 2017. The assessment will be available at the following site: www.nhs.uk/service-search/Performance/Search

The assessment will include a Quality of Leadership indicator, as published on MyNHS under the section on ‘Review of economy, efficiency and effectiveness of use of resources’. We have been advised that the year-end position for this indicator will now not be published until after the publication of CCG annual reports. The latest available results on MyNHS relate to Quarter 2 of 2016/17. The year end results for the Quality of leadership Indicator will be available from July 2017 at: www.nhs.uk/service-search/scorecard/results/1175

The methodology for the calculation of the CCG ratings is still being finalised by NHS England, and without this it is not possible to predict what the CCG’s annual assessment will be.
1.2.2.3 Right Care – Commissioning for Value

Right Care - Commissioning for Value is collaboration between NHS Right Care, NHS England and Public Health England. The programme is about identifying priority programmes that offer the best opportunities to improve healthcare for our population – improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

The CCG received the Right Care Commissioning for Value insight packs in January 2016 from NHS England, which have subsequently been refreshed in February 2017. The national Right Care programme includes the provision of CCG level Commissioning for Value benchmarking data packs that highlight significant variation and potential opportunities for improving value for money and outcomes. For Southwark the data highlights that the disease pathway areas with the greatest opportunities for improvement are as set out in the table below. The left hand column identifies the top areas where spend can be reduced and outcomes improved, the middle column indicates where there are best opportunities for improving outcomes and the right hand column identifies the best opportunities for reducing spend, chiefly by reducing non-elective activity.

The CCG joined the Right Care programme as a ‘wave 2’ organisation. Since February 2017 we worked to analyse our Commissioning for Value information packs and identify opportunities to enhance the value of the services we commission and to enable better outcomes for our residents. Our Right Care programmes of care, intervention areas and QIPP opportunities will be developed in 2017-18 in a way that aligns with the Southwark Forward View. They will also align with the transformation work planned as part of the STP in south east London. In identifying the Right Care programmes of care we will take forward in Southwark, we will look at those areas that satisfy three principles:

- Is the CCG the responsible commissioner for the key service within the pathway?
- Do the programmes of care area correlate with the objectives and approach to transformation set out in the CCG’s Five Year Forward View?
• Do the programmes of care area suggest there is significant unwarranted variation locally and potential for CCGs to address this for the benefit of residents?

From this we will propose QIPP opportunities and interventions that we will then begin to implement. Commissioners will be examining outcomes-based approaches that incentivise prevention, early detection and prompt planned treatment across the whole system that would help deliver these opportunities. The outcomes of this work will be received by the CCG’s Commissioning Strategy and Integrated Governance and Performance Committees.

Further details are available at:


1.2.2.4 National CCG 360 survey results

NHS England commissioned Ipsos-Mori to undertake a stakeholder survey on behalf of all CCGs to provide feedback on their working relationships with a range of stakeholders. The survey is run on an annual basis and was previously run in 2016, 2015 and 2014 and prior to that as part of the authorisation process in 2012. There was no survey in 2013. The purpose of the survey is:

1. To provide CCGs with useful information to help with on-going organisational development to help develop strong relationships with a range of stakeholders.
2. To feed into assurance conversations between CCGs and NHS England and provide evidence to assess whether stakeholder relationships continue to be central to effective commissioning and improved quality and outcomes.

NHS Southwark Clinical Commissioning Group (CCG) had the highest overall response rate in London for the fourth consecutive year and the fifth highest nationally. The CCG’s overall response rate in 2016 was 88% and 86% (38) for member practices (there were 44 member practices in 2016).

Overall the results for Southwark CCG are positive with scores consistently higher than the national, regional and cluster average in most areas.

Improved Scores
The CCG has improved score in the following areas compared to 2016:

• Feeling engaged by the CCG (95% compared to 93%)
• Satisfaction with the way that the CCG has engaged (86% compared to 82%)
• Extent that the CCG has contributed to wider discussions (81% compared to 63%)
• Understanding reasons for the CCG’s decisions when commissioning (76% compared to 70%)
• Agreement that the CCG’s plans will deliver continuous improvement in quality (78% compared to 68%)
• Feeling that the CCG is a local system leader (83% compared to 80%)
• Leadership of CCG has necessary blend of skills and experience (84% compared to 78%)
• Clear and visible leadership of the CCG (93% compared to 88%)
• Confidence in the CCG leadership to deliver its plans and priorities (79% compared to 72%)
• The leadership of the CCG is delivering continued quality improvements (76% compared to 70%)
• Confidence in the CCG leadership to deliver improved outcomes for patients (74% compared to 68%)
• Feeling able to raise any concerns about quality of local service with the CCG (90% compared to 85%)
• Knowledge about CCG’s plans and priorities (97% compared to 87%)
• Felling that comments taken on board when comments been given on plans and priorities (57% compared to 52%)
• Agreement that improving patient outcome is a core focus for the CCG (95% compared to 90%)

Lower Scores
The CCG has a few areas where it has scored lower than in the previous year, these are:

• Rating of working relationship with the CCG (86% compared to 87%)
• Confidence in the CCG to act on feedback it receives about the quality of services (67% compared to 72%)

We use this feedback to help us to understand areas where we need to improve engagement with member practices and stakeholders and develop our plans accordingly.
1.2.3 Improving quality and safety

It is the CCG’s mission to put quality at the heart of everything we do and ensure we meet our statutory duties for the quality of services we commission.

1.2.3.1 CQC inspections:

During 2016/17 most GP practices in the borough had a CQC inspection to assess whether the practice is safe, effective, caring, and well led, and that patients have a good experience. The CCG offered support to practices and using findings to prompt a thematic review, has produced a Learning Resource document. The review identified good practice as well as areas for development and this, along with themes and learning from visits to GP practices, is being shared to support quality improvements.

Of the practices who have received their CQC inspection reports 67% (25 surgeries) have been rated as “Good” in all domains (Safe, Effective, Caring, Responsive, Well Led).

The CQC took urgent enforcement action to cancel the registration of one practice in July 2016. The CQC report, published in September 2016, rated the practice as inadequate overall. An alternative provider, Quay Health Solutions, has been care-taking patients on the list at the closed practice to ensure continuity and safe care.

Two practices which were previously rated Inadequate and placed in special measures have improved considerably since their original rating and have subsequently achieved a rating of ‘Good’ following re-inspection. A further practice which remains rated as ‘Inadequate’ has shown progress resulting in an upward rating to ‘Requires Improvement’ in two domains.

The CCG Primary Care and Quality Team work closely with all practices to offer support and guidance.

You can read CQC inspection reports on the CQC website: http://www.cqc.org.uk/

1.2.3.2 Putting quality at the heart of the CCG

In 2016/17 we undertook to raise the profile of quality within the organisation and ensure it remains at the forefront of our minds. To support this we ran a number of workshops for our Governing Body, heads of service and all staff. We also ran a successful event with Lambeth CCG and Lambeth Healthwatch and Southwark Healthwatch for over 120 patients, carers and health care staff, focusing on improving patients’ experiences upon leaving hospital. These have been important milestones in revising our strategy, and resulted in personal pledges, a CCG-wide quality plan and recommendations to the Lambeth and Southwark Strategic Partnership Board.

Building upon this engagement we have also refreshed our approach to the monthly Quality and Safety Committee, which has wide attendance from across the Governing Body and heads of service and is chaired by the Governing Body Clinical Lead for Quality.

The CCG had good processes in place for quality assurance, but we felt more could be done on quality improvement and disseminating learning as the CCG has the ability to connect different parts of the health economy and enable learning to go beyond the discrete areas of a service, a hospital or a GP practice. To address this, during 2016/17 the CCG introduced a quarterly programme for the Quality and Safety Committee rotating our monthly focus on assurance, system-wide learning and quality improvement.

Some of the achievements the CCG has made during the year include:
• **Monthly meetings** between senior CCG representatives with the Medical Director and senior team of each provider at the Clinical Quality Review Groups (CQRG). These meetings with KCH, GSTT, LAS and SLaM review the quality of care delivered and hold providers to account for the quality element of their contracts. Topics covered during 2016/17 include critical care, medicines’ safety, workforce, duty of candour, nutrition, mortality, fleet and logistics, infection control, clinical IT strategy, maternity, children and young people.

• We ran a programme of clinical quality visits using a framework as part of the CCG’s quality assurance; during the year visits by CCG teams including the Director of Quality and Chief Nurse, GP Clinical Leads, and lay members have been made to KCH Clinical Decision Making Unit, SLaM hospital in-patient wards and Centralised Place of Safety, GSTT Evelina Children’s Hospital and the Multi-Agency Safeguarding Hub (MASH). The Evelina visit was led by Lambeth CCG; two Southwark CCG Governing Body clinicians participated, to continue our drive for joined-up working and shared learning across the health economy.

Further visits across all providers will take place during 2017/18 and cover all aspects of the hospital including supporting admin systems. The visits have been helpful in understanding patient care and the CCG was assured by each visit with no areas of concerns raised.

The CCG gathers feedback about quality issues via its **Quality Alerts** system. These are raised mostly by GPs who become aware of negative issues, often from patients’ experiences. Examples include delays receiving an appointment, hospital letters being sent to the wrong GP, or missed community visits.

The CCG Quality team reviews all alerts received, liaises with the provider affected, and updates the reporter with action taken. All providers are asked to investigate quality alerts, either individually or as themes, and update the CCG and reporter with findings.

The CCG also encourages providers to report good service and in summer 2016 the CCG first received commendations via the quality alert route. Summer 2016 also saw the first alerts received about issues within general practice which the CCG have encouraged to enable system learning. The Quality Team has worked with these practices to develop a system which will assure our providers that there is a robust mechanism in place to improve practice where incidents occur. No patient harm resulted in any of the alerts.

The CCG revised its Quality Alert process and now gives improved feedback to each submitter indicating what will happen next.

Over 260 Quality Alerts were received during 2016/17 including 8 commendations for good service and 7 raised by secondary care about issues in primary care.

The CCG has been made aware of important quality issues via quality alerts being raised and this knowledge has enabled the organisation to act. Examples of issues raised and actions taken include:

• **Patients are requesting urgent appointments for Fit Note certificates which the hospital should be issuing:** CCGs raised this with Trust Directors at the Clinical Quality Review Group (CQRG) meetings for both GSTT and KCH. The two trusts set up a working group to manage safe introduction and effective cascade. A process is being piloted and training on issuing Fit Notes is being incorporated into the junior doctors’ teaching programme. Target roll-out date will be decided following review of the pilot.

• **Discharge summaries were poor, delayed or contained inaccurate or missing information:**
Improvements have been made to the layout and content of discharge notification in the KCH’s new Electronic Patient Record system, including clearer sections for recommendations for GPs and responsibility to arrange further tests and follow ups. New sections have been added to state reasons drugs have been stopped or changed.

- **@At Home patient summaries are not produced in the same way as in-hospital discharges:**
  The service will add all @home patients to EPR and complete discharge summaries through this route as is done for in-hospital stays.

- **There are problems contacting the Urology department by telephone:**
  A rota system has been put in place to manage the phones. A dedicated staff member will be recruited to deal with calls/queries.

In July 2016 the CCG worked with Lambeth CCG and Lambeth and Southwark Healthwatch groups to design and run an event entitled ‘Going Home’. With more than 130 attendees from hospitals, local authorities, PPGs, third sector and commissioners, the aim of the workshop was to gain a better understanding of patients’ experiences when leaving hospital. This proved to be a really stimulating and energising event with excellent feedback. We presented a report to the Lambeth and Southwark Strategic Partnership Board recommending next steps.

The Medicines Optimisation Team submitted work to the London Procurement Partnership (LPP) about a case study of implementing best practice to reduce inappropriate antibiotic prescribing and were awarded second place from numerous entries from across primary and secondary care. The case study demonstrated that auditing GP practices’ antibiotic prescribing was successful in reducing inappropriate broad spectrum prescribing.

The CCG continued to track all Serious Incidents at provider trusts affecting Southwark residents to ensure lessons are learned and changes are implemented as fast as possible. The CCG Quality Team has worked with providers to improve processes and this has led for example to the introduction of a 48hr scrutiny of Never Events by the Medical Director.

The CCG has overseen thematic analysis undertaken by providers for areas of concern. In 2016/17 these were retained objects, misplaced naso-gastric tubes (NGTs) and falls, and resulted in changes including:

- an algorithm for NGT placement, avoiding overnight NGT feeds where possible, radiology reporting NGT x-ray within two hours
- improved storage, labelling and verbal checks to mitigate risk of the wrong device being used, improved use of WHO Safer Surgery Checklist and LocSSIPs (Local Safety Standards for Invasive Procedures)
- falls assessments, non-slip socks and soft floors, dignity and continence project

In 2016/17 the CCG appointed an Infection Control Nurse to support primary care and the community. This is a joint post with Lambeth CCG; Lambeth Public Health leads the operational IPC service on behalf of Lambeth and Southwark CCGs. Health Care Acquired Infections (HCAI) are monitored closely by the CCG as increased cases, especially due to C.diff lapses in care, can occur with hospitals under capacity pressure.

The CCG ran a panel to review 20% of C.diff cases reported, looking at root causes, lessons learned and whether a lapse in care occurred. By encouraging hospitals and GP practices to let us know when they become aware of issues which are below par, we liaise and support to investigate and enable changes.
The CCG provided the **Governing Body with a regular quality report** during 2016/17 with contributions from each area of the organisation – and from Southwark Healthwatch – to update with pertinent issues about patient safety, patient experience, and clinical effectiveness.

### 1.2.3.3 Complaints

CCGs are responsible for managing any complaints about local healthcare services they commission directly. Providers are responsible for managing complaints they receive about their own services, and the CCG monitors those themes and systems. The CCG has oversight of these systems at its regular provider meetings and challenges partners to ensure they act upon lessons learned. Information about complaints is included in the quarterly quality report to the CCG Governing Body.

NHS Southwark CCG purchases a service from NELCSU to manage both complaints and PALS (Patients Advice and Liaison Service) on our behalf. Feedback is welcomed, both positive and negative, so that improvements can be made based on the concerns of patients and the public. The CCG regularly analyses the number of complaints and PALS queries to identify any patterns, themes and trends which both informs current service provision as well as ensuring that fairness and transparency is exercised. In some cases the CSU will receive complaints which relate to other services, these are redirected appropriately and are included in the figures below.

The table below shows the total numbers of Complaints and PALS queries received by the CCG in 2015-2016 and in 2016-17 for Quarters 1, 2 and 3.

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<td>16</td>
<td>100%</td>
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*Q 1, 2 and 3

### 1.2.3.4 Safeguarding adults and children

Keeping adults and children safe is a key priority for us and an integral part of all our planning, commissioning, contracting and monitoring arrangements. As a commissioning organisation, the CCG is required to ensure that all health providers from which it commissions services have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect vulnerable adults from abuse or the risk of abuse.

Gaining assurance is a key priority for the CCG’s safeguarding team, which works alongside providers to ensure compliance with Section 11 of the Children’s Act of 2004 and Section 42 of the Care Act 2014.

NHS Southwark CCG is a core member of the Southwark Safeguarding Children’s Board and the Southwark Safeguarding Adults Board of which the CCG Director of Quality and Chief Nurse is the Vice Chair. The CCG therefore plays a key role in working with partners to set and shape the safeguarding agenda in Southwark.

The CCG works closely with colleagues at Southwark Council to raise the profile of children and adults at risk of harm and the risks of abuse they may face and we put measures in place to ensure that they live in safety and receive early help should they need it. We also ensure that there is a robust response to any incident of abuse of a child or adult at risk.

In 2016/17 NHS Southwark CCG supported Southwark’s two GP federations to embed systems to allow consistent quality and safety reporting and ensure lessons are learned. The CCG
Safeguarding team worked across adults and children agendas, including domestic abuse, female genital mutilation (FGM) and Prevent.

The appointment of a Named GP for Adults Safeguarding to the CCG Safeguarding team adds to our existing structure; Adult Safeguarding Lead Nurse, Designated Nurse and Doctor for Safeguarding Children, Named GP for Safeguarding Children, Designated Nurse and Doctor for Looked After Children. This dedicated resource provides support for the safeguarding of both adults and children across all member GP practices.

The CCG also continues to promote learning events in primary care such as annual Protected Learning Time (PLT) focusing on safeguarding themes. The CCG encourages the participation and cascading of learning from serious case reviews (SCR), safeguarding adult reviews (SAR), concise reviews (CR) and domestic homicide reviews (DHR). The CCG is represented on the Southwark Channel Panels and works with Southwark Council to develop and deliver on the Prevent agenda.

As a responsible commissioner, NHS Southwark CCG is acutely aware that there are times when individuals might not be able to make important health and social care decisions in their lives; the CCG is committed to ensuring that the services that are commissioned demonstrably comply with the provisions of the Mental Capacity Act 2005. As evidence of commitment, the CCG worked with neighbouring CCGs and service providers to organise an awareness raising event which attracted high level of attendance and engagement across the local health economy.

Safeguarding Compliance including Prevent is monitored bi-monthly at the CCG Safeguarding Executive Committee. Assurance is also given via the Safeguarding Children and Adult Boards.


### 1.2.3.5 Continuing Care

As part of the overall assurance of the CCG, NHS England investigated the CCG’s continuing health care systems and processes. This required the completion of an assessment template which consisted of four key areas:

- Assessment and Decision Making - lawful, high quality and timely
- Fast Track
- Care and Support Planning
- Previously un-assessed periods of care

These four areas were divided into 13 standards and 28 key lines of enquiry. The assurance process also included an assurance meeting with NHS England to examine the CCG’s return in more depth. The CCG was rated ‘green’ on all 28 key lines of enquiry and rated ‘Good’ overall with ‘Outstanding’ assurance for fast track processes. The CCG was particularly commended on its timely agreement of palliative care fast tracks, work with the wider health economy on supporting people at the end of their lives, implementation of personal health budgets and joint work around end of life care. The CCG has concluded work on the 74 previously unassessed period of care appeals received following the Ombudsman’s announcement in this area. This work was concluded in advance of the Ombudsman’s deadline of 30 September 2016.

This is an excellent result for the CCG and pays testament to the dedicated and high professional work of our continuing care team.
1.2.3.6 Mental health and parity of esteem

Talking therapy (IAPT) services in Southwark continued to see an increased number of people with anxiety and depression accessing the service for treatment and support.

In April 2016 we started a new contract with SLaM as the lead provider. This provided the opportunity to re-state our intention to continue to improve access to these services; to reduce variation in quality and access across the borough; to improve outcomes for patients accessing these services; increase the range and number of locations from which talking therapy services are provided; and extend opening times to include week-day evenings and Saturdays. It allowed us to expand access to this service for people with long term conditions like asthma, heart failure and diabetes and help them cope with the psychological effects of their physical health needs.

The service continues to improve the lives of more people with common mental health problems, such as anxiety and depression and contribute to the CCG’s objective of a parity of esteem for people with mental and physical health conditions.

Adult mental health

The CCG is working closely with SLaM to improve adult mental health services through a major investment in an adult mental health transformation programme. This includes a number of interlocking initiatives that will deliver improved outcomes for people with long-term mental health problems by providing support at home or in the community; reducing reliance on acute inpatient treatment, and delivering person-centred care that has been co-designed with experts by experience. The new initiatives include:

Early intervention and treatment for people suffering from psychotic illnesses – early detection and intervention are known to improve outcomes, reduce the likelihood of relapse, and prevent chronic illness development. In 2016 the CCG increased its investment in these services and developed a new service model which actively seeks vulnerable young people who are at risk of developing psychosis and delivers intensive support to them.

The CCG plan was to reduce waiting times for service access and to improve the quality of services for sufferers and their families/carers.

Crisis Line – we have further developed this 24/7 telephone service, staffed by professionally qualified mental health practitioners. It provides support, advice and guidance to anyone of any age experiencing mental health problems across Southwark and also provides a service for carers and other healthcare professionals. The service aims to improve the quality of patients’ and carers’ experience during times of crisis and reduce pressure on emergency acute services.

Opening of a central Place of Safety (PoS)

Section 136 of the Mental Health Act can be used to take someone to a “place of safety” to carry out a mental health assessment. The police can use this power to take someone to a place of safety from a public place. The PoS suite is open 24 hours per day, seven days per week and avoids people in mental health distress being taken into custody in police cells.

Acute peer support – the CCG is committed to increasing peer support and has commissioned training for experts by experience.

Assessment Team – These teams (in the north and south of the borough) act as the single point of access for referrals into secondary mental health services, and ensure patients are effectively assessed and directed to the appropriate service, receiving the required support and treatment promptly. This also improves relations between mental health services and GPs by offering specialist advice on managing patients not requiring secondary care.
Medication support
The CCG piloted a service providing support for people at risk of relapse due to poor compliance with medication. The service has demonstrated positive outcomes with people whose previous chaotic behaviours had seen multiple admissions to hospital.

Enhanced Home Treatment Team (HTT)
The CCG has invested in the HTT in order to have a 24/7 service which acts as gatekeeper to inpatient beds and offers a safe alternative to admission to people who can be managed in their own homes or in the community.

Focus on Recovery
The CCG has begun work on reconfiguring the recovery pathway for people with complex needs (including a review of supported accommodation) with the intention of caring for more people in the least restrictive environment and their own homes.

Older adults mental health services

Dementia
Dementia services in Southwark are performing above the diagnosis target and there has been a steady improvement in waiting times for the Southwark and Lambeth Memory Service. Additional resources are improving outcomes for dementia sufferers through the appointment of a dementia nurse specialist leading to a reduction in variation in services and increasing knowledge of post-diagnostic support; reduced waiting times for MRI scans; additional nurse assessors recruited; and the extension of the community navigation pilot.

The CCG and local authority have developed a joint outcomes framework which will provide recommendations for a fully integrated and streamlined dementia care pathway for Southwark.

Functional mental health services for older adults
The CCG has started to look at models of care for this group of vulnerable patients, with the aim of providing support to help them to remain well in their own homes. This will include providing support for their physical health needs.

Learning disability
During 2016 services for people with learning disability were enhanced by investment in two new services:

- A new multi-disciplinary assessment and liaison team providing assessment and treatment for people with Autism/Asperger’s syndrome has been brought on stream. It provides support for more people with these learning disabilities and allows them to remain independent or at home for longer periods of time.
- The CCG and local authority have jointly funded an Enhanced Intervention Service team for people with complex mental health and learning disabilities to prevent crisis, maintain independence and facilitate moving people returning to Southwark from out of borough placements. This means that people are supported for longer in the community, the number of people entering institutional care is reduced, and people have been supported to leave long term residential placements to return to community living options.

Children and young people mental health and wellbeing
The CCG invested over £500k in transforming mental health services for children and young people. We agreed and implemented a range of initiatives during 2016 including:
• Development of an evidence-based eating disorder service for children and young people, releasing capacity for self-harm and crisis services

• Enhanced adult talking therapies (IAPT) service to include over 16s

• Rolling out trauma focused work across the child and family adolescent service, providing support and treatment for Post-Traumatic Stress Disorder (PTSD), self-harm, sexual assault and exploitation and Female Genital Mutilation

• Increasing capacity at the Southwark Youth Offending Service to better respond to demand for children and adolescent mental health service (CAMHS) clinical practitioners

• Therapeutic assessment training for CAMHS teams and other frontline staff working with children and young people including paediatric liaison staff in King’s Emergency Department and adolescent teams

• Refreshed CAMHS needs assessment

• Developed plans to engage further with children and young people, families, parents/carers and engaged with local stakeholders

• Improved strategic commissioning partnership and governance arrangements: The CCG in partnership with Southwark Council has developed a Joint Children and Young Peoples’ Health and Care Strategic Framework, which embeds the emotional wellbeing and mental health of children and young people in practice. It sets out the way in which comprehensive and integrated CAMHS will be commissioned to improve outcomes.
1.2.4 Patient and Public Involvement

The CCG was assured as outstanding by NHS England for its engagement work for the second year running and we have continued to develop our approach to engagement to ensure that the voice of local people is at the heart of what we do. You can read the assurance letter on our website here: http://www.southwarkccg.nhs.uk/news-and-publications/meeting-papers/governing-body-committees/Pages/default.aspx under the section headed Engagement and Patient Experience Committee meeting papers, meeting held on 9/03/17.

Our approach builds on the engagement toolkit which we have developed and incorporates co-design methodologies such as the use of personas and journey (pathway and process) mapping. Our approach follows six principles developed by the national People and Communities Board, in conjunction with the new models of care ‘vanguards’ sites, to give practical support to services as they deliver the ‘new relationship with people and communities’ set out in the Five Year Forward View. These ‘six principles’ set out the basis of good, person-centred, community-focused health and care, requiring that:

- Care and support is person-centred: personalised, coordinated and empowering
- Services are created in partnership with citizens and communities
- Focus is on equality and narrowing inequalities
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers.

Both our approach and our toolkit are available on our website under our Get Involved section at:

http://www.southwarkccg.nhs.uk/get-involved/Our-approach-to-engagement/Pages/default.aspx

Areas of engagement work that the CCG undertook in 2016/17 using our approach and methodologies include:

Engaging children and young people (CYP)
The CCG and Southwark Council have worked together to develop priorities for health, education and social services as part of a joint strategic framework for children and young people. The CCG used a number of different ways to engage with children and young people including a graffiti wall at International Young People’s Day; working with the Youth Council to develop a survey which members could use with their peers; running a focus group with participants of Stand Up Southwark, a group for vulnerable young people who have previously been in care; running a My Voice Counts event with Healthwatch Southwark for young people; working with the London Bubble Theatre to bring personas alive in a short play and through a spoken word artist to enable exploration of mental health, sexual health and substance misuse issues and identifying solutions; working with the National Citizen’s Service programme - the Challenge - to design and develop a campaign so they could talk to young people about health issues.
The CCG’s Engagement and Commissioning teams were finalists in two categories in the Patient Experience Network National Awards (PENNA) on Tuesday 21 March 2017. They were runners-up in the Commissioning for Patient Experience award for their work in Championing the Voice of Children and Young People, as well as being finalists in the Championing the Public category. Although they were not outright winners, taking second place was a fantastic achievement and brought national recognition to the CCG’s commitment to innovative and successful engagement with local people.

**Engaging people with three or more long term conditions in developing and improving care coordination**
The Southwark Local Care Networks (LCNs) asked the CCG to support them in engaging local people to inform the development of care coordination of people with three or more long term conditions. Our engagement team worked with Healthwatch and engagement leads from across the sovereign organisations of the LCNs. We particularly wanted to identify and bring in people who live with three or more long terms health conditions and their family and carers, recognising that this is a cohort who are quite frail and who might not usually be involved in having a say about health or care services.

People were identified through GP lists and the GP federations wrote to around 2,000 patients in October 2016, inviting them to be involved in this project. There were responses from 120 people and, working with Healthwatch and Revealing Reality, we visited 16 people to listen to their in-depth stories. We filmed some people’s stories about living with long term health conditions and they are available on our YouTube channel.

https://www.youtube.com/channel/UCWZ__8sTULEFc-qQUK7SGyQ
Twenty-two local people living with multiple long term conditions joined us for a workshop in January 2017 to tell us what was important to them, and what they felt needed to be put in place so that everyone involved in their care and support (including family members) knew what was important to the person and how best to support them. Health, care, voluntary and community sector colleagues later joined the conversations about what was needed to enable everyone involved in someone’s care to know what their goals were and how everyone could work together to help them achieve these.

“My thanks for what felt a very well thought out, considerate and comfortable patient engagement event. I hope the outcome will make a meaningful contribution to improving peoples' lives.”
A copy of the full report is available on the CCG website – http://www.southwarkccg.nhs.uk/get-involved/Shaping-services/developing-care-coordination-for-people-with-long-term-conditions
**Southwark patient participation group network (SPPGN)**

The CCG continues to support engagement structures in Southwark and in May 2016 established the Southwark PPG Network to support the engagement, involvement and participation of patients in general practice. The SPPGN is a vehicle to share good practice, explore solutions to common problems and bring together patients and practice staff across north and south localities. The SPPGN is driven by the SPPGN steering group, which includes active patients from across Southwark.

Discussions at the network have included developing digital champions to support take-up of GP Online. This has resulted in joint working with Age UK Lewisham and Southwark to train up local digital champions to support other patients in GP practices to register and use GP Online. We have also started exploring links between voluntary sector and community groups and settlements, time banks, tenants and residents associations and local GP practices to look at how we can facilitate more active communities. There is more information on the CCG website about the Southwark PPGN at:


**The Our Healthier South East London Programme**

The models of care developed through Our Healthier South East London (OHSEL, also see 1.2.1.3.) are the result of several years of partnership working between clinicians, commissioners, council social care leads and local hospitals and have been informed by extensive engagement with local communities, patients and the public. See chapter “Patient and public involvement” for more information.

Engagement activity includes a series of events and programme of local engagement in each borough; publication of an ‘issues’ paper and ‘emerging thinking’ paper setting out the challenges we face and ideas to tackle them; 2-3 patient and public voices and Healthwatch representatives on each of our clinical workstreams. We have also carried out equalities analysis and created a dedicated Equalities Steering Group to ensure our work takes account of equalities issues.

Our approach has been informed and endorsed by The Consultation Institute, who advise on best practice engagement at national level. The engagement programme was also shortlisted for a national award by the Association of Healthcare Communications and Marketing (AHCM).

During 2017-18, we aim to extend the reach of our conversations, inviting more local people and interest groups to find out about our developing plans and contribute their views. A six-month programme of ‘civic engagement’ – a dialogue with the people of south east London –was launched in March 2017. This is creating more opportunities for local people to hear about the plans direct from NHS leaders and tell us what they think.

All of our engagement activity and information on how we use feedback is routinely published on our website. You can find out how to get involved by visiting [www.ourhealthiersel.nhs.uk](http://www.ourhealthiersel.nhs.uk)

**Clinical engagement**

We have a strong history of clinical engagement and have a number of structures in place to support membership engagement in the work of the CCG. There are eight clinical leads including a practice nurse lead, who sits on the CCG’s governing body. The CCG also has nine clinical associates who lead in specific areas of work such as safeguarding, domestic violence, mental health and medicines optimisation.

The CCG organises ten locality meetings per year in the north and south of Southwark. These are chaired by clinical leads and are a forum for GP and nurse leads from all practices in Southwark to engage in the work of the CCG at an early stage before decisions are made. The focus of
discussions is to inform the CCG’s commissioning intentions and this has been an agenda item at every locality meeting. In addition the Council of Members, chaired by a local GP and made up of a GP representative from all practices in Southwark, meets four times a year and is responsible for signing off CCG plans and budget.

The CCG also organises learning and development events for primary care and other clinicians which take place ten times a year and regularly involves 100 – 150 clinicians. The focus is on clinical aspects of care. Topics this year have included care co-ordination, safeguarding, HIV and sexual health.

We have continued to develop the content of the members’ and staff zone – a password protected extranet which is regularly accessed by practices in Southwark. The CCG sends out a GP e-bulletin 51 weeks a year which is also aimed at other practice staff. We continue to develop our GP smart phone app and this was instrumental in our Change the Face of HIV campaign aimed at GPs to raise awareness of the signs and symptoms of HIV and to empower GPs to include HIV testing as part of their differential diagnoses when consulting with patients.
1.2.5 Reducing health inequality

1.2.5.1 The work of the Health and Wellbeing Board

The Health and Wellbeing Board is made up of the key partners from the health and care system who work together to improve the health and wellbeing of our local population and to reduce health inequalities. Membership includes NHS Southwark CCG, Southwark Council, Healthwatch Southwark, Community Action Southwark, King’s Health Partners and the Metropolitan Police.

The role of the health and wellbeing board is to prepare and publish a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the JSNA in relation to the local authority’s area. The CCG has made a significant contribution to the development of Southwark’s JHWS. The strategy can be accessed [here](#).

The Health & Wellbeing Board met three times in 2016-17. Over the course of the year the board reviewed and agreed a number of local strategies including Southwark Healthy Weight Strategy; Lambeth, Southwark and Lewisham Sexual Health Strategy; Voluntary and Community Sector Strategy; and action plan into the Health Impact of Air Quality in Southwark.

The Health & Wellbeing Board received updates on: the South East London Sustainability & Transformation Plan; the performance of preventative / public-health related services; the annual reports of Southwark’s safeguarding boards; progress with the Dulwich Health Centre development; and also on the delegation of primary care commissioning from NHS England to the CCG.

The Board approved and monitored the Better Care Fund 2016-17 and endorsed the CCG’s Operating Plan. It also received updates on progress in delivering the joint Southwark Five Year Forward View strategy for local service transformation.

Further details of the Southwark Health & Wellbeing Board can be accessed at [here](#).

The Annual Report of the Director of Public Health details the significant public health challenges and inequalities seen in the borough of Southwark and outlines the strategies and interventions in place to address these. Many of these are in partnership with NHS Southwark CCG.

1.2.5.2 Update on equalities and Equality Delivery System

CCGs have a duty to ensure that commissioning decisions safeguard vulnerable people, do not put people’s lives at risk, or expose them to inhumane or degrading treatment (Human Rights Act 1998). At the same time, the Equality Act 2010, which incorporates the public sector equality duty (PSED), requires that CCGs, when commissioning services, do not unlawfully discriminate and must pay due regard (general duty) to the needs of people from the nine protected groups.

Also as part of the PSED, CCGs have specific duties to set four-year local equality objectives and report progress on them by 31 January each year. The CCG has made steady and demonstrable progress on its four-year equality objectives, which were chosen as part of the authorisation process in 2012, and reflect the key local equality priorities pertinent at that time.

**Equality Objective 1 – Engagement and patient experience**
The CCG continues to develop its approach in this area to reach out to engage with those with lived experience. We have been assured as outstanding in this area for the second year running.

**Equality Objective 2 – Learning disability**
The CCG has focused on promoting equality of access, and protecting human rights for people with learning disabilities. To this end, the Winterbourne Review recommendations have been embedded through the local Transforming Care programme. The vision for the TCP programme was developed with people with lived experience and commissioners from CCGs and councils.

**Equality Objective 3 – Mental health**
During 2016 the CCG has been working with Southwark Council to develop out Mental Health and Wellbeing Strategy and are developing a new model of accommodation for those with mental health needs in Southwark. Both areas of work have engaged with stakeholders and service users.

**Equality Objective 4 – Provider contracts**
During 2016, equality has been a main agenda item at the CQRG for each of the CCG’s main providers, King’s College Hospital NHS Foundation Trust (KCH) and Guy’s and St Thomas’ NHS Foundation Trust (GSTT) and SLAM. CQRG sought assurance against equalities contractual requirements.

**Equality Objective 5 – Care Homes in Southwark**
In 2015, the CCG took a multidisciplinary approach (MDT) to improving support of residents of care homes with nursing in Southwark. In 2017 the CCG undertook an evaluation of the enhanced primary care service and MDT due to be reported in May 2017. However, it has been agreed to extend the current provider, recognizing the quality of the service and continuity for residents.

The CCG is also consolidating its approach in this area by using the Equality Delivery System (EDS2), which is equality, human rights and health inequalities reporting framework for the NHS. EDS2 measures progress against four goals and 18 outcomes related to securing equalities. Moving forward the CCG will be using the deep dive approach developed by the South East Commissioning Support Unit.

Full details of the CCG’s work on equality, human rights and health inequalities, including the EDS2 summary report, current (2017) and previous equality objectives’ reports can be found by following the link: [http://www.southwarkccg.nhs.uk/about-us/equality-and-diversity/Pages/default.aspx](http://www.southwarkccg.nhs.uk/about-us/equality-and-diversity/Pages/default.aspx)

**National Diabetes Prevention Programme**
Southwark was one of the first places in the country to roll out this new scheme to help people avoid developing Type 2 diabetes. The programme helps people at high risk of developing Type 2 diabetes to adapt their lifestyles to help avoid them developing the condition. Those referred get tailored, personalised help including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes; all of which together have been proven to reduce the risk of developing the disease. In 2016/17, the scheme’s first year of operating, over 750 people took part. We anticipate enrolling a further 1,200 people onto the scheme during 2017-18.

**Walking Away from Diabetes**
Walking Away from Diabetes is an evidence-based programme for people who are at risk of developing Type 2 Diabetes. It is a one-off, self-management course which lasts for 3.5 hours and offers local people the opportunity to explore their personal risk and to identify the changes they need to make to remain healthy. The programme focuses on increasing physical activity and reducing saturated fat in the diet. Each programme is delivered by two healthcare professionals who have been trained as Walking Away from Diabetes educators.

The course is group-based and runs with up to a maximum of 20 people who can be accompanied by a partner, family member or friend. Throughout 2016-17 performance has been significantly ahead of 2015-16 outcomes with 1,650 referrals received, and higher conversion rates from referral to attendance. This has triggered greater interest in the longer Diabetes Prevention programme.
Developing care and support services for HIV patients
Beginning late 2016, we have been piloting a new approach to HIV testing in Southwark, in order to tackle the rate of late HIV diagnosis. Two out of five people newly diagnosed are diagnosed at a late stage, which means treatment may not be as effective and they may have inadvertently spread the virus to others before they were diagnosed.

We have raised awareness of the signs and symptoms and empowered GPs to include HIV testing as part of their differential diagnoses when consulting with patients. GPs have positively welcomed this approach, believing that crucial opportunities to diagnose HIV in primary care were being missed, and that they as GPs have a real opportunity to help reduce the rate of late diagnosed HIV, improve health outcomes, and help in tackling this important public health issue. The CCG aims to recruit more practices to adopt the approach in 2017-18.

Responding to changes in the way people live with HIV, we worked with our sexual health commissioning team, based at Lambeth Council, to consult on proposals to change how people living with HIV access advice and counselling services. The proposals were informed by the Lambeth Southwark and Lewisham joint sexual health strategy published in 2012. This review found that we needed to change the service model because:

- Most people living with HIV are now able to work and have a normal life expectancy. Treatment has transformed HIV from a fatal disease into a long term condition.
- A very small proportion of people living with HIV access existing services.
- People living with HIV are using mainstream services.

Following consultation in May and June 2016, Lambeth Council, in conjunction with Southwark and Lewisham CCGs, decided to end contracts for:

- Counselling provided by the Terrence Higgins Trust
- Advice and Advocacy provided by the Terrence Higgins Trust
- First Point (assessment/signposting service) provided by Metro

A decision was also taken that the following services which were also consulted on would continue:

- Peer support and mentoring provided by Metro, with expanded capacity
- Children and Families services for families affected by HIV provided by Metro/Positive Parenting

A steering group, made up of service users, clinicians and key stakeholder organisations, has overseen the transition, ensuring that people living with HIV feel confident in accessing mainstream services. Staff affected by the changes received training on the new service model and the needs of people living with HIV.
1.2.6 Sustainable development

Sustainability has become increasingly important as the impact of peoples’ lifestyles and business choices are changing the world in which we live. As a local employer and organisation whose activities impact the local economy, environment and community, we acknowledge our responsibility to our patients, local communities and the environment to ensure our actions consider issues of sustainability and work hard to minimise our footprint. We recognise sustainability goes beyond carbon emissions and environmental sustainability and have incorporated financial and social sustainability into our Procurement policy.

Statement of commitment
NHS Southwark CCG is committed to commissioning services in a way that supports the NHS sustainable development agenda and contributes to environmental improvements, regeneration and reducing health inequalities. In our commissioning processes, this means designing services with sustainability in mind. Practically this means the CCG should make sure we do the following: plan services which are efficient and effective; procure services which provide highest quality at best value and which have the least impact on the environment, offer positive sustainable employment and deliver value for money.

Sustainability in commissioning
The CCG focuses on two key ways to support sustainability. The first is to act to secure sustainability through our procurement and contracting processes and in our work with commissioned providers.

As our procurement policy (section 22.2) states: “The development of Southwark as a vibrant and sustainable local health economy lies at the heart of our vision. This requires a sustainable mix of large and small businesses that can deliver local services, innovate and provide local prosperity for the ultimate benefit of the patient”

An example of commissioning from community providers would be the contract awarded this year to eight Southwark high street optometrists to provide minor eye diagnosis and treatment services for the people of Southwark.

Sustainability within our organisation
NHS Southwark CCG shares office accommodation with Southwark Council which was designed to the highest environmental standards including a biomass boiler and rainwater harvesting. The CCG participates in Southwark Council’s Green Buildings programme. The project works to reduce environmental impact and costs by improving efficiency in a number of areas: energy, water, waste and recycling, use of paper and transport.

Andrew Bland
Accountable Officer
26 May 2017
2 ACCOUNTABILITY REPORT

2.1 Corporate Governance Report

2.1.1 Members Report

NHS Southwark CCG has a strong history of clinical involvement in commissioning. We are a membership organisation made up of 41 GP practices and bound by an agreed constitution.

The 41 member practices work together in two localities: north Southwark and south Southwark. GPs meet on a monthly basis in both localities to discuss local health services in focusing on quality and effectiveness. The issues raised inform clinical leads who chair or attend various CCG meetings and feed in the view of the wider membership to committees such as the Commissioning Strategy Committee, a committee of the Governing Body, where CCG’s plans and proposals are discussed in details before being agreed at the Governing Body meetings held in public.

Representatives from all 41 practices constitute the Council of Members; meetings are held regularly throughout the year. This is the forum where clinicians from member practices can engage directly with and hold to account the Governing Body. The Council of Members met five times during the year. The Council of Members receives regular updates on the CCG financial position and contributes to the development of the priority areas of work for the CCG to take forward. You can find more information about our governance structure in the annual governance statement.

The CCG produces a weekly e-bulletin for practice staff to keep them informed of plans and developments and how they give their views as well as highlighting training and development opportunities. This is complemented by the members and staff zone of the public website.

In addition, the CCG also organised training and development events for clinicians from general practice over the year to support improvement in patient care. The events are usually run by hospital doctors or specialist GPs. Feedback is positive and the CCG is developing these to include more time for clinical group discussions which are particularly useful for participants.

2.1.1.1 Member profiles

See Annual Governance Statement

2.1.1.2 Member practices

NHS Southwark CCG is made up of 41 practice contracts over 42 sites; three sites with multiple practices. The largest practice Nexus covers the north of the borough and has 58,000 registered patients. The average Southwark practice size is 8,000 registered patients. There are two GP federations: Quay Health Solutions (QHS) in north Southwark with 21 practices and Improving Health Limited (IHL) in south Southwark with 20 member practices. Southwark practices are as below:

<table>
<thead>
<tr>
<th>North Southwark</th>
<th>South Southwark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackfriars Medical Practice</td>
<td>3-Zero-6 Medical Centre</td>
</tr>
<tr>
<td>Borough Medical Centre (Dr Misra)</td>
<td>Acorn  and Gaumont Surgery</td>
</tr>
<tr>
<td>Borough Medical Centre (Dr Sharma)</td>
<td>Camberwell Green Practice</td>
</tr>
</tbody>
</table>
2.1.1.3 Composition of Governing Body

Chair and Chief Officer
The CCG Chair is Dr Jonty Heaversedge.
Andrew Bland is the Chief Officer.
CCG directors
The directors of the CCG are as follows:
- Malcolm Hines, Chief Financial Officer
- Gwen Kennedy, Director of Quality and Safety (on secondment to NHS England)
- Kate Moriarty-Baker, Interim Director for Quality and Nursing
- Caroline Gilmartin, Director of Integrated Commissioning
- Mark Kewley, Director of Transformation

The CCG’s Governing Body is appointed with the main function of ensuring that the organisation has made appropriate arrangements for ensuring that it complies with its obligations under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and that generally accepted principles of good governance as are relevant to it.

Details about the members of the CCG’s Governing Body are available on the website: http://www.southwarkccg.nhs.uk/about-us/who-we-are/meet-our-governing-body/Pages/default.aspx

Changes to Governing Body
Dr. Ruth Wallis retired in 2016 and was replaced in February 2017 by Prof Kevin Fenton as the Director of Public Health for Lambeth and Southwark.

Professor John Moxham of King’s Health Partnership stepped down from the post in February and was replaced by Dr Ian Abbs.

Governing Body Appointments
In September 2016, the CCG’s Council of Members approved an increase in number of lay members from 3 to 4. This was primarily to support the increasing role of lay members in supporting primary care commissioning as well as other duties of the CCG.

In addition, two of the three existing lay member contracts came to an end. Thus, three lay member posts were advertised late November and interviews were held at the end of January 2017.

Total no. of applications received = 37
No. of applicants interviewed = 9
No. of lay members selected = 3

Newly appointed lay member: Andrew Nebel (to take office from 1 April 17)
Re-appointed members: Dr Richard Gibbs and Robert Park

There are no directors as ‘members’ on the CCG Audit Committee. The Chief Financial Officer and Chief Officer are in attendance only.

See also page 57 (AGS)

2.1.1.4 Committee(s), including Audit Committee
See 2.1.1.4 (AGS)
2.1.1.5 Register of Interests

The CCG reviewed its Conflict of Interest Policy to align it with NHS England guidance released in June 2016. There will be a further review in 2017 to incorporate guidance released in February 2017.¹

NHS Southwark CCG’s Register of Interests and is made publicly available on the CCG’s website at http://www.southwarkccg.nhs.uk/about/Governance/Pages/ConflictofInterest.aspx

The register is maintained by CCG Governance team and is constructed in line with national guidance and the CCG’s Conflicts of Interest Policy which can be found at http://www.southwarkccg.nhs.uk/news-and-publications/publications/policies-strategies-registers/Pages/default.aspx.

The Register of Interests contains details of all members of the CCG’s formal committees and the Governing Body itself. The interests of those individuals that are in attendance only will be captured in the minutes of the meeting concerned unless those in attendance are employees of the CCG or the South East Commissioning Support Unit (the arrangements for those individuals are addressed by their contract of employment and their Job description) who are not members of the committee in question.

2.1.1.6 Personal data related incidents

There were no personal data related incidents that were reported to the Information Commissioner’s Office during the year.

2.1.1.7 Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members’ Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG’s auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG’s auditor is aware of it.

Modern Slavery Act

NHS Southwark CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

¹ All attendees at CCG meetings are asked to indicate any change to the available register of interests and any interests relating to the agenda of the meeting.
2.1.2 Statement of Accountable Officer’s responsibilities

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

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section 14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG’s auditors are aware of that information.
that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Andrew Bland
Accountable Officer
26 May 2017
2.1.3 Governance Statement

2.1.3.1 Introduction and context

NHS Southwark Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group’s statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG’s general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 / is subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 as follows:

- NHS Southwark Clinical Commissioning Group has been authorized to commission health services for its population [https://www.england.nhs.uk/ccg-details/](https://www.england.nhs.uk/ccg-details/)
- In 2016-17, the clinical commissioning group’s licence continued being approved without conditions.

NHS Southwark Clinical Commissioning Group is a membership organisation made up of 41 Southwark GP practices, as on 31 March 2017. We are responsible for commissioning healthcare services for the people of Southwark. Our Constitution sets out the way we operate.

As a member organisation we work through the Council of Members and our Governing Body to ensure health services are commissioned effectively and meet the needs of local people. We do this in line with our agreed mission, vision and values. The CCG is made up of two localities, North Southwark and South Southwark, together comprising all of our 41 member practices.

Working collaboratively with others has been a key foundation of the CCG’s approach over the past year. As members of the Health and Wellbeing Board for Southwark we work closely with colleagues in the local authority, NHS England, King’s Health Partners and Healthwatch Southwark to ensure that our combined efforts have the greatest impact and to oversee the delivery of the Health and Wellbeing Strategy for Southwark.

We work together with other CCGs, across south-east London in particular, on areas where our local strategies find common ground, and are currently developing a joint strategy for south east London’s NHS, in collaboration with NHS England.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.
2.1.3.2 Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

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

Governance Framework of the CCG

NHS Southwark CCG is a membership organisation and its member practices are accountable for exercising statutory functions. The CCG has delegated authority to the following, to act on behalf of its member practices in order to discharge its functions and responsibilities:

- a) Council of Members;
- b) Governing Body;
- c) CCG employees;
- d) Committees and sub-committees of the Governing Body;
- e) Member Practices in their Localities.

The Governance structure of NHS Southwark Clinical Commissioning Group is comprised of the Council of Members, Governing Body and its committees and sub-committees as detailed in the following diagram. The structure was revised following a governance review in February 2016, implemented from April 2016.

Figure 1 – Governance Structure of NHS Southwark CCG
**Council of Members**
The Council of Members is the body made up of elected representatives of practices that constitute the CCG. The Council of Members has delegated most governance related duties to the CCG Governing Body whilst retaining key responsibilities such as signing off CCG plans, Annual Accounts and Annual Report and approving changes to the CCG Constitution. More details are available in the CCG’s Scheme of Delegation. The Council of Members holds the Governing Body accountable for ensuring the CCG carries out its obligations as set out in the NHS Act 2006 (as inserted by section 26 of the 2012 Act).

Dr. Richard Proctor (Chair) and Alison Pisani (Deputy Chair) of the Council of Members served in these posts until December 2016 and October 2016 respectively. These posts are currently being recruited to.

There were four meetings during the year to approve changes to CCG constitution, forward plan and commissioning intentions 17/18 and received updates on CCG's financial position, King’s College Hospital CQC inspection, PMS review, and signed off the commissioning plan and budgets. Representatives of the Council of Members also attended the year end Audit Committee meetings for signing off the draft and final Annual Accounts and Annual Report. In December 2016, the Council of Members approved the CCG’s Operating Plan and Budget Framework for 17/18.

**The Governing Body**
The Governing Body for NHS Southwark CCG ensures that the CCG has appropriate arrangements for complying with its obligations under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and such generally accepted principles of good governance as are relevant to it. The Governing Body does this through its main function which is to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance. The CCG Constitution serves as the terms of reference for the discharge of functions by the Governing Body.

Papers and details for public governing body meetings are published on the CCG’s website in advance of the meetings, link here: http://www.southwarkccg.nhs.uk/news-and-publications/meeting-papers/governing-body/Pages/default.aspx. There were six public meetings during the year.

**Composition of the Governing Body**
The Governing Body for NHS Southwark CCG has strong clinical leadership and comprises:

- Eight GP Representatives of Member Practices - one of whom is the Chair of the Governing Body – **all voting**; Chair does not have a casting vote,
- Four lay members - one of whom is the Deputy Chair of the Governing Body – **all voting**,
- two registered nurses - one from community care and one nurse from a Member Practice – **both voting**,
- one secondary care specialist doctor - **voting**,
- Chief Officer - **voting**,
- Chief Financial Officer - **voting**,
- Director of Public Health/ deputy - **voting**,
- Local Health Watch representative - **voting**,
- Local Authority representative – **non-voting**,
- LMC representative – **non-voting**,
- CCG Director of Integrated Commissioning – **non-voting**,
- CCG Director of Quality and Safety – **non-voting**,
- CCG Director of Transformation and Performance – **non-voting**,
- Secondary Care Doctor from local NHS trust (co-opted member) – **non-voting**

The responsibilities and scope of work of the Governing Body is detailed in the CCG’s Constitution.
Committees of the Governing Body
The Governing Body has appointed the following committees, all of whom have delegated authority to form sub-committees to assist them in the discharge of their duties. A new internal governance structure came into effect in April 2016, with commissioning development groups for Adults, Children and Serious Mental Illnesses. These groups were designed to take a holistic view of physical and mental health for adults and children. Highlights of the work carried out by the different committees are as follows:

Audit Committee: The CCG Audit Committee membership is made up of three lay members and two clinical leads. The Chief Financial Officer is an attendee. The committee met five times during the year including two end-of-year meetings in April and May to sign off draft and final accounts and Annual Report. These extra meetings were attended by representatives of the CCG Council of Members.

All meetings were well-attended by lay members and Clinical Leads. The committee is chaired by the lay member leading on governance. Some of the significant issues that the committee considered and reviewed were internal audit reviews and assurances, external audit reviews, risks to the CCG and CCG Board Assurance Framework, risk management arrangements in the CCG, and appointment of auditors counter fraud service providers.

The Audit Committee completed a self-assessment of its effectiveness in September 2016. The Audit committee’s overall self-assessment found itself to be satisfactory and the committee’s functioning complied with best practice.

Remuneration Committee: The Remuneration Committee met four times during the year including to review pension automatic enrolment, CCG and Medicines Optimisation team re-structures, contract extension to registered nurse member etc. The Committee membership is three lay members and two clinical leads, the committee is chaired by one of the lay members.

Integrated Governance and Performance Committee: The Committee provides oversight of the activities of the CCG and providers, particularly in respect of: finance, QIPP, performance, governance and risk management, quality, and safety. It is also responsible for assuring the effective functioning of the following areas for both the activities of the CCG and of its main contracted providers: safeguarding – adults and children; information governance; equality delivery system; emergency planning and business continuity.

This committee met every month of the year 2016/17. It was quorate in 11 of 12 months. The one month where this was not met, no decisions were made by the committee. Regular agenda items include: finance report, risk reporting and board assurance framework, and the improvement and assessment framework assurance report (incorporating the integrated performance report). The agenda also focuses on quality, safety and performance issues such as referral to treatment time (RTT) and A&E performance, quality premium, approval of CCG policies including the policies related to dealing with conflict of interests, whistleblowing policy, business continuity plan for the CCG, and delegation of primary care commissioning.

The committee is informed by its sub-committees: Information Governance Steering Group, Safeguarding Executive, Medicines Management Committee and the Quality and Safety Sub Committee.

Commissioning Strategy Committee: The Commissioning Strategy Committee met every month of the financial year 2016/17. Every meeting held met quorum requirements and had good attendance from clinical and non-clinical Governing Body members. The committee scrutinised, debated and recommended CCG commissioning plans, strategies and proposals to the Governing Body. The
committee was also regularly attended by the finance, performance and quality leads within the CCG. The committee is supported by:

**Joint Commissioning Strategy Committee** – this committee was established with the local authority, co-chaired by the Chair of the CCG and Southwark Council’s Strategic Director for Children’s and Adults’ Services. There was senior representation from the CCG and local authority, as well as attendance by Southwark Health Watch. The committee met once every quarter from its inaugural meeting in October 2016 and was quorate.

The Committee oversaw the three Commissioning Development Groups for children and young people; adults; and serious mental illness and provided a strategic steer on the joint work of these groups as they deliver the CCG’s shared strategy with Southwark Council, the *Southwark Five Year Forward View for Health and Social Care*.

**Conflict of Interest Panel (CoI):** Commissioning and procurement decisions that cannot be taken by any of the committees of the Governing Body due to conflicts of interest issues are referred to the Conflict of Interest Panel. The panel’s recommendations are considered and approved by the Governing Body. The panel can also be asked to audit the process by which a Governing Body committee reaches a recommendation and to give assurance that it has not been influenced by a conflicted interest. This panel is chaired by the CCG’s lay member for governance. It includes the Director of Public Health, Chief Officer/Chief Financial Officer, Secondary Care Consultant and Registered Nurse on the Governing Body for increased clinical input. During the year, some of decisions that the CoI panel reviewed were as follows: CCG’s funding for support of practice group mergers, funding for co-design of primary care, membership incentive payment scheme, KCH urgent care centre service specification, direct funding of practices for LCN development.

**Engagement and Patient Experience Committee:** The Engagement and Patient Experience Committee provided oversight of the development of patient engagement structures to the Governing Body. The committee has representation from Locality Patient Participation Groups that enable the patient voice to be fed in to the CCG’s commissioning activities. The committee is chaired by the lay member for engagement and has representation from Healthwatch Southwark, Community Action Southwark and Forum for Equality and Human Rights in Southwark. The Engagement Programme Board and Equalities and Human Rights Steering Group inform the activities of the Committee. Every meeting held during the year was quorate and was well attended by locality leads and patient participation group representatives. During the year, the committee received regular updates from the PPG networks and oversaw CCG’s engagement structures, Local Care Network engagement, Extended Primary Care Access Service Evaluation, developing community hubs at practices and participation facilitators, feedback on engagement event on shaping the future of GP practices.

**Primary Care Joint Commissioning Committee:** Set up under joint commissioning arrangements with NHS England, this committee is responsible for discharging the CCG’s responsibilities for primary care commissioning. All six CCGs in South east London meet with NHS England at the same time. This committee met in public seven times during 2016-17. The agenda for the committee in this period was a blend of issues pertaining to general practice in Southwark and other south east London CCGs, and a consideration of regional issues where Southwark CCG or other south east London CCGs are affected. Some of the key areas of focus in 2016/17 were: reviewing primary care quality, performance and finance reports and identifying solutions to issues raised therein, aligning commissioning intentions, planning and delivery of a nationally mandated Personal Medical Services (PMS) review to be completed midway through 2017-18, overview of the planning and approvals process for bids for Estates, Transformation and Technology (ETTF) funding in 2016-17 and the subsequent three years, overview of national assurance timescales set as part of the General Practice Forward View (GPFV) programme, reviewing the governance of co-commissioning arrangements as established via the operating model with NHS England in 2015-16, and in line with the emerging planning and application process toward formally taking on the status of full delegation.
of commissioning or primary care services, approving contractual actions pertaining to respective
boroughs, implementation of the CCG’s Primary and Community Care strategy and its emergent
commissioning intentions for integration, outcomes based commissioning and new models of care
and development of commissioning intentions for 2017/18 and the five year planning period to
2020/21. Every meeting held in the year was quorate.

South East London Committee in Common for Strategic Decision Making: This committee in
common met two times in 2016-17. The committee in common takes forward the work of the
commissioning strategy programme for South East London. The committee’s remit is to 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 Southeast London
programme or subsequent programmes, as agreed by the CCGs, which involves public consultation.

All of the committees set out above are accountable to the Governing Body. The terms of reference
of all committees were reviewed following internal structure changes to reporting in to them. The
Governing Body has approved and keeps under review the terms of reference for the committees,
which includes information on the membership of the committees.

Other Joint Committees

1. South East London Area Prescribing Committee: The South East London Area Prescribing
Committee, established in 2013, hosted by Lambeth CCG, meets quarterly and is a partnership
committee which discusses and makes recommendations on medicines issues. It has
representation from acute trusts, mental health, CCGs and community health services in the south
east London region. The committee discusses strategic prescribing issues across the patch.

2. Lambeth, Southwark and Lewisham (LSL) Infection Control Committee: LSL Infection Control
Committee met quarterly to ensure LSL CCGs fulfilled the criteria set out in the Health and Social
Care Act 2008 and other relevant infection control standards. This committee reports to the
Integrated Governance and Performance Committees in Lambeth and Southwark CCGs. It is
currently chaired by the Team Lead, South London Health Protection Team, Public Health England,
as an interim measure while awaiting the appointment of the Director of Public Health,
Lambeth. The committee includes membership from all three acute trusts located in LSL,
corresponding community and CCG infection control leads, representatives from medicines
management teams, Public Health England South London Health Protection team and Lambeth and
Southwark public health teams. The committee also invites representatives from the Care Homes
Support Team, Brixton Prison and NHS England (London region). The committee reports in to the
Integrated Governance Committees of the respective CCGs.

3. Health and Wellbeing Board: Established and hosted by the local authority, the Health and
Wellbeing Board brings together the NHS (CCG), public health, adult social care and children’s
services, including elected representatives and Southwark Healthwatch, to plan how best to meet
the needs of their local population and tackle local inequalities in health (see section 1.2.5.1
The work of the Health and Wellbeing Board).

4. Office of London CCGs: In addition to the joint committees above, the CCG has representation in
the ‘Office of London CCGs’ which is a partnership of the 32 Clinical Commissioning Groups (CCGs)
in London. It brings together CCG Clinical Leads, Chief Officers, and Chief Financial Officers for
regular business meetings to drive forward programmes of work. Each CCG is a statutory NHS body
with its own governance arrangements and as such decisions made by the partnership are
recommendations to individual CCG Boards.
## Attendance record for Governing Body meetings

**Figure 2 – Attendance record for GB meetings**

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Title</th>
<th>GB attendance 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dr Jonty Heaversedge</td>
<td>Chair and GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>2</td>
<td>Mr Andrew Bland</td>
<td>Chief Officer</td>
<td>6/6</td>
</tr>
<tr>
<td>3</td>
<td>Mr Malcolm Hines</td>
<td>Chief Financial Officer and Deputy Chief Officer</td>
<td>6/6</td>
</tr>
<tr>
<td>4</td>
<td>Ms Gwen Kennedy (on secondment) Or Kate Moriarty-Baker</td>
<td>Director of Quality and Safety</td>
<td>6/6</td>
</tr>
<tr>
<td></td>
<td>(Interim Director of Quality and Chief Nurse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mr Mark Kewley</td>
<td>Director of Transformation and Performance</td>
<td>6/6</td>
</tr>
<tr>
<td>6</td>
<td>Ms Caroline Gilmartin</td>
<td>Director of Integrated Commissioning</td>
<td>6/6</td>
</tr>
<tr>
<td>7</td>
<td>Dr Nancy Kuchemann</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>8</td>
<td>Dr Jacques Mizan</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>9</td>
<td>Dr Noel Baxter</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>10</td>
<td>Dr Yvonneke Roe</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>11</td>
<td>Dr Emily Gibbs</td>
<td>GP Clinical Lead</td>
<td>5/6</td>
</tr>
<tr>
<td>12</td>
<td>Dr Robert Davidson</td>
<td>GP Clinical Lead</td>
<td>4/6</td>
</tr>
<tr>
<td>13</td>
<td>Prof Ami David</td>
<td>Registered Nurse</td>
<td>5/6</td>
</tr>
<tr>
<td>14</td>
<td>Ms Linda Drake</td>
<td>Practice Nurse</td>
<td>4/6</td>
</tr>
<tr>
<td>15</td>
<td>Dr Richard Gibbs</td>
<td>Vice-Chair and lay member</td>
<td>6/6</td>
</tr>
<tr>
<td>16</td>
<td>Mr Robert Park</td>
<td>Lay member</td>
<td>5/6</td>
</tr>
<tr>
<td>17</td>
<td>Ms Joy Ellery</td>
<td>Lay member</td>
<td>6/6</td>
</tr>
<tr>
<td>18</td>
<td>Dr Michael Khan</td>
<td>Secondary Care Consultant</td>
<td>5/6</td>
</tr>
<tr>
<td>19</td>
<td>Dr. Ruth Wallis (until October 16) or Richard Pinder or</td>
<td>Director of Public Health for Lambeth and Southwark</td>
<td>5/6</td>
</tr>
<tr>
<td></td>
<td>Jin Lim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Mr David Cooper or Deputy</td>
<td>Healthwatch Southwark Representative</td>
<td>4/6</td>
</tr>
<tr>
<td>21</td>
<td>Prof John Moxham or Deputy</td>
<td>Clinical Lead for Kings Health Partners</td>
<td>6/6</td>
</tr>
</tbody>
</table>
An online self-assessment survey was conducted by the CCG’s Governing Body members during February 2017 to individually assess how effective they considered the Governing Body had been over the past year. All 17 members responded achieving a response rate of 100%.

Questions sought respondents' views about the effectiveness of the Governing Body, clarity about individuals’ roles, challenge provided by the Governing Body, role in ensuring effective financial control, planning and value for money as well as suggested areas of improvement.

Areas of note:
- 88% respondents were ‘very clear’ about their role as the GB member, while the remaining were ‘somewhat clear’. This has risen from last year when it was 69%
- 76% of respondents agree that the Governing Body works as an effective team, up from 63% in 2016 (q10)
- 100% of members are satisfied with the CCG’s conflict of interests arrangements (q1)
- 82% agreed that the GB understands its role and is clear on what responsibilities are reserved to itself and what can be delegated to its officers, up from 63% last year
- 87% respondents think the committees they sit on perform useful functions

Overall, the results of the 2017 Board Effectiveness survey indicate a positive picture of an effective Governing Body that works as a team and recognises its areas of strength and challenge, having seen a number of improvements since the CCG was established in 2013.

The findings will be fed into the CCG’s Organisational Development plan with a view to prioritising areas which saw a weaker or medium response and reducing development focus on any areas already working well. The CCG will include continuing to build team working and a culture of challenge via workshops, master classes, Governing Body seminars and personal development.

**Governing Body development**

Developmental sessions for Governing Body members have been carried out both collectively and individually during 2016/17.

A range of workshops and seminars were arranged for the Governing Body in 2016-17, these included Sustainability and Transformation Plan (STP) updates, continuing care, moving to delegated primary care commissioning, a quality workshop, a workshop on exploring the CCG’s approach to at-scale working in general practice, London primary care organisational development updates, lessons learned from audits on other London CCGs, and estates opportunities in Southwark.

Additionally, each member of the Governing Body had an appraisal and personal development plan and undertook a 360 Leadership assessment to help them to do their job better.
2.1.3.3 UK Corporate Governance Code

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

For the financial year ended 31 March 2017, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.

The CCG Governing Body and its committees and sub-committees adopted and practiced the Nolan principles as stated in the CCG Constitution and terms of reference. These are:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

As a part of the NHS, the CCG Governing Body affirms its commitment to the rights and values set out in the NHS Constitution and the seven key principles that guide the Governing Body in all its actions.

The NHS provides a comprehensive service available to all:

- Access to NHS Services is based on clinical need, not an individual’s ability to pay;
- The NHS aspires to the highest standards of excellence and professionalism on the provision of high-quality care that is safe, effective and focussed on the patient experience;
- NHS services must reflect the needs and preferences of patients, their families and carers;
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;
- The NHS is committed to providing best value for taxpayer’s money and the most cost-effective, fair and sustainable use of finite resources;
- The NHS is accountable to the public, communities and patients that it serves.

2.1.3.4 Discharge of Statutory Functions

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

In light of the Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. The CCG Constitution and Conflicts of Interest Policy have been reviewed and updated to take account of the functions to be delegated and jointly commissioned with by NHS England. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of
the clinical commissioning group’s statutory duties. In conclusion, no significant internal control
issues have been identified.

2.1.3.5 Risk management arrangements and effectiveness

The CCG recognises that every activity it undertakes or commissions others to undertake on its
behalf brings with it some element of risk that has the potential to threaten or prevent the
achievement of its objectives. It has responded to this by:

- encouraging a culture where risk management is viewed as integral to daily activity
- ensuring structures, policies and processes are in place to support the assessment and
  management of risks
- assuring the Governing Body, the public and patients that the CCG manages risk effectively.

These aims have been achieved through the development and implementation of an Integrated Risk
Management Framework which enables:

- a clear view of the risks affecting each area of its activity
- clarity on how those risks are being managed,
- assessment of the likelihood of a risk occurring and its potential impact.

NHS Southwark CCG’s approach to risk management and board assurance is in accordance with
legislation, national and local guidance. It seeks to embed recognised and developed best practice
through a process of on-going review and improvement and underpins the production of the Annual
Governance Statement.

The Integrated Risk Management Framework for the CCG has been established to ensure that the
principles, processes and procedures for best practice in risk management are consistent across the
organisation and fit for purpose. The framework was put in place at the time of CCG authorisation
and last reviewed in March 2017. It lays down risk management duties and responsibilities for staff
at different levels in the organisation as well as Governing Body members including clinical leads. It
presents a framework for CCG policies designed for proactive and reactive risk management to the
CCG’s objectives.

The CCG systematically identifies, at all levels, those risks that could affect these objectives and
takes every reasonable step to control risk. This includes a process to monitor, and if necessary
improve, how risks are being managed and demonstrate how this is occurring.

The CCG leadership team employs effective techniques for risk management, supported by good
information systems, discusses and shares risk information amongst themselves and trains and
supports all their staff to an appropriate level of expertise. Southwark CCG also requires that the
organisations and people it commissions to provide health services operate demonstrably effective
risk management systems.

NHS Southwark CCG is committed to the application and embedding of best practice principles
across all services and actively communicating these principles with NHS stakeholders in an effort
to share best practice risk management activities.

Risk appetite

The Good Governance Institute has worked with Southwark CCG to determine its risk appetite. NHS
Southwark CCG has adopted a ‘mature’ risk appetite which means that it will have no appetite for
fraud and a zero tolerance for regulatory breaches but will take considered risks where the long term
benefits outweigh any short term losses.

The CCG risk appetite, the amount of risk it is prepared to accept before it takes action, is as
follows:
- Low and Moderate risks - represent low levels of threat and action is limited to contingency planning rather than active risk management action. They are regularly reviewed and reassessed at directorate risk meetings to ensure actions are in place to contain risks.
- High risks - represent medium levels of threat which may have a short-term adverse impact and have defined actions. They are regularly reviewed and reassessed at senior management meeting and monitored by relevant committees.
- Extreme risks - represent higher levels of threat which may have a major or long term adverse impact on CCG strategic goals.

Such risks have individual action plans and are proactively managed. They are regularly reviewed and reassessed, and are reported to the Governing Body, Audit Committee and relevant lead committee on a monthly basis. In the review and monitoring process there is particular focus on the controls that have been applied to each risk and the extent of the assurances that the actions are proving effective.

**Identification and evaluation of risk**

The risks to which the CCG is exposed are identified by:

- internal methods – such as audits, evaluating CCG’s commissioning plans, QIPP plans, Project Initiation Documents, patient satisfaction surveys, whistle-blowing, complaints and monitoring the quality of commissioned services
- external methods - such as service auditor reports for commissioning support services, CQC inspections, media, national reports, new legislation, reports from assessments/inspections by external bodies, reviews of partnership working
- liaison with practices through Council of members, practice visits, locality meetings, GP Forum meetings, patient engagement forums, practice feedback and practice meetings.
- NHS Southwark CCG has adopted the Australia/New Zealand (AS/NZS 4360/1999) standard as shown below which it applies to all risk assessment and management including corporate, financial, clinical, operational and reputational risks.

**Figure 3 – Risk Management Process**
Risk scoring and grading

The CCG has adopted a 5x5 matrix for scoring risks, consistent with the NPSA guidelines (January 2008). The risks scored for likelihood and impact are graded as below:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Extreme Risk</td>
<td>15-25</td>
</tr>
<tr>
<td>Amber</td>
<td>High Risk</td>
<td>8-12</td>
</tr>
<tr>
<td>Yellow</td>
<td>Moderate Risk</td>
<td>4-6</td>
</tr>
<tr>
<td>Green</td>
<td>Low Risk</td>
<td>1-3</td>
</tr>
</tbody>
</table>

Extreme risks are those that attract the highest scores, are graded ‘red’ and therefore warrant immediate attention by relevant personnel.

Risk reporting and management structure

The CCG has systems to ensure the identification, analysis, scoring and recording of risks and the consequences of their potential impact. Risk registers are maintained at each level in the organisation and the CCG ensures that risks are managed at each level and in each directorate. The Board Assurance Framework is reviewed regularly by the each individual director, the Integrated Governance and Performance Committee and the CCG Governing Body.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the CCG and as professionals working to professional codes of conduct. The Governing Body promotes reporting of incidents, risks and hazards. This is supported by a range of policies which are in place for the CCG.

The CCG’s risk management reporting structure in the following diagram illustrates how risk escalation and management in the CCG is carried out through Board Assurance Framework and Risk Registers.
Board Assurance Framework and Risk Registers
The Board Assurance Framework (BAF) is formed of strategic CCG risks against corporate objectives.

The Directorate Risk Registers comprise of operational risks to directorate and team objectives.

Red risks from the Directorate Risk Registers that are perceived to be directly affecting the organisation’s objectives are escalated to the BAF greater visibility and requirement of assurance.

In addition, various teams within each of the directorates maintain their own risk registers, risks from which are escalated to the directorate risk registers and above.

Committees reviewing BAF and Risk Registers
The Audit Committee, Integrated Governance and Performance Committee and Senior Management Team support the Governing Body in the effective management of risk within the CCG through providing scrutiny and discussion of risks on the CCG BAF and Risk Registers.

The Integrated Governance and Performance Committee receives a monthly risk highlight report providing the committee members with a snapshot of movement of risks and the rationale behind it. The IGP provide in depth scrutiny and debate on risk articulation, aggregation, mitigation and grading.

The Audit Committee provides additional assurance to the Governing Body through:
- assessing the CCG’s work in monitoring risks;
- assessment of relevant internal and external audit work on systems of control;
- assuring the effectiveness of external and internal audit and counter fraud services;
- ensuring that the scope of internal audit provides adequate coverage and review of fundamental systems;
- commenting on the nature and scope of the annual internal and external audit plan and regular progress reports; and
- reviewing the annual financial statements before submission to the Governing Body, focusing particularly on: changes in, and compliance with, accounting policies and practices, major judgmental areas; and significant adjustments resulting from the audit.

The BAF and heat map are also presented to Governing Body meetings held in public for discussion and approval.

Prevention of risk
Prevention is viewed as a key element of risk management and is embedded within the operation of the CCG through:

Policies
A number of policies are in place to support risk management within the CCG. These are Information Governance, Counter Fraud, Conflict of Interest policies, Whistleblowing policy, Children and Adult Safeguarding policies, Incident Reporting policy to name a few. These policies are reviewed regularly and are available on the staff intranet. Equality Impact assessments are considered for all new policies and policy revisions.

Training
CCG staff completed the following mandatory training during the year:
- Information Governance training toolkit (including a directorate face-to-face training as well as privacy impact assessment training)
- Health and safety awareness
- Fire safety
- Equality and diversity
- Safeguarding awareness
- Manual handling
- Prevent awareness
- In addition, the CCG Governing Body participated in numerous training and development activities throughout the year.

**Equality Impact Assessments**
The CCG completes Equality Impact Assessments for all policies and redesign of services. Equality and Diversity service and support is provided on incident reporting and management.

**Stakeholder involvement**
The CCG has a Communications and Engagement strategy to counter risks involved in redesigning and commissioning of services affecting the patients and residents of Southwark.

The Annual Governance Statement will be presented to the Audit Committee (including the CCG’s internal and external auditors), the Integrated Governance and Performance Committee and the CCG Governing Body before being signed off by the Accountable Officer.

**Counter Fraud and Security Management**
The provider of counter fraud and security management service to the CCG is TIAA Ltd. which provides independent and professional accredited counter fraud specialist service to the CCG. The CCG follows NHS Standards for Commissioners published by NHS Protect in implementing appropriate measures to counter fraud, bribery and corruption. The CCG has completed the Self Review Tool (SRT) and workplan to build on the processes implemented during the previous year fiscal year which are designed to mitigate against the risk of crime at Southwark CCG.

The Local Counter Fraud Specialist Manager (LCFSM) and Local Security Management Specialist (LSMS) has continued to raise awareness of fraud, bribery and corruption risks at Southwark CCG through the delivery of a series of workshops to CCG staff and external stakeholders. In addition, the LCFSM has used other media forms to engage with staff and stakeholders, such as newsletters; intelligence briefings and information posters. The CCG has undertaken all health and safety risk assessments where applicable and is compliant with legislation. The CCG is compliant with emergency preparedness and civil contingency requirements and able to meet its obligations as a Category 2 responder.

Counter fraud specialists also carry out any investigations on counter fraud referrals. CCG staff were given training in counter fraud at a staff meeting session and were alerted to mechanisms of reporting through staff bulletin.

**Emergency Planning and Business Continuity**
During the year, the CCG submitted its Emergency Planning, Response and Resilience assurance to NHS England. The CCG reviewed its business continuity plan and completed a table-top exercise for testing its plans. The results of exercise were incorporated in to the CCG’s business continuity plans. The CCG is regularly represented at the South London patch EPRR meetings and assurance meetings conducted by NHS England. The Chief Financial Officer is the Accountable Emergency Officer for the CCG.

**Conflicts of Interest**
The CCG takes conflict of interest management very seriously in view of its role as a membership organisation and has put in place numerous controls to manage the risks involved in the course of its commissioning duties. In addition to reviewing its policies, it has put in place a CoI panel and are guided by the CoI Guardian, who is also the chair of the panel.
Prevent Awareness
The CCG has a Prevent programme lead who is also the Head of Safeguarding Adults and Children. All CCG staff are required to complete the Prevent training as part of annual mandatory training.

Capacity to Handle Risk
As the Accountable Officer I have overall responsibility for risk management and discharge this by:
• continually promoting risk management and demonstrating leadership, involvement and support
• ensuring an appropriate committee structure is in place and ensuring each receives regular risk reports
• ensuring that the Governing Body, Directors and Senior Managers are appointed with managerial responsibility for risk management.

All Risk Owners have been trained in the risk management process and this has been supplemented with written guidance in the Risk Management Framework. In addition, on a regular basis, the Governance and Assurance Manager assists Risk Owners to review the controls and assurances in respect of each risk, and by this means good practice is shared between CCG staff. The Governing Body is responsible for the performance management of risk and systems of clinical, financial and organisational control. It oversees the overall system of risk management and assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and is supported in that function by its committees:

The Audit Committee, in line with the NHS Audit Committee Handbook, ensures the CCG has an effective process in place with regards to risk management and monitors the quality of the Assurance Framework, referring significant issues to the Governing Body.

• The Integrated Governance and Performance Committee has overarching responsibility for monitoring quality, corporate, performance, financial, information governance and health & safety risks. The committee also continuously assesses financial and non-financial risks relating to the QIPP plans and ensure the CCG has in place measures and mitigation to manage risk.
• The Governing Body monitors, in detail, risks to achieving individual corporate objectives including action plans with a particular focus on risks rated amber and red risks. After every meeting, each Committee reports its findings on risk management, in this way the CCG is assured that risk is effectively controlled and that its Governance Statement is valid.

2.1.3.6 Risk Assessment
Management of the CCG’s Risk Profile
The Governing Body regularly received a summary of the risk profile for the organisation through risk reports and heat maps, capturing the CCG’s key strategic risks, aligned to its seven corporate objectives. Developing the risk registers has been an evolving and iterative process with demonstrable evidence of improvement in identifying effective controls and independent sources of assurance, together with triangulation of the most critical and highly rated risks. Oversight of this has been provided by the Governing Body, Audit Committee, Integrated Governance and Performance Committee, Information Governance Steering Group and Senior Management Team, with increasing confidence in the arrangements and assurance that the output reflects a true picture of the risk profile of the CCG.

The CCG does not have any risks to compliance with its licence. It operates an effective governance framework which clearly identifies reporting lines and responsibilities between Governing Body, its committees and the Senior Management Team (SMT), with overall rigour in overseeing the CCG’s performance across all its functions and statutory duties. These arrangements have also been subject to an annual review of effectiveness to ensure continuous improvement and refinement of the governance framework.

The total number of risks on the BAF at the end of March 2017 is 34 and rated as below:
10 rated Extreme/ Red
14 rated High/ Amber
10 rated Moderate/ Yellow
0 rated Low/ Green

Extreme risks:

- Acute providers do not meet contractually agreed trajectories for performance targets for **Referral to Treatment**.
- Acute providers do not meet contractually agreed trajectories for performance targets for **A&E 4 hour waiting times by March 2017**.
- Non-delivery of 62-day cancer targets
- **CQC inspection outcome report** for some north Southwark practices affecting quality of care
- Risk to the **sustainability of general practices in north and south Southwark** due to financial, workload, workforce and infrastructure pressures
- Risk that the quality of outcomes for Southwark patients is the lowest in South East London
- Risk that the provider does not deliver achievement of IAPT 50% recovery rate in year as well as by end March 2017.
- 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 expenditure reductions.
- Risk that **reduction in Council funding impacts on Children and Young People’s services** incl. mental health services e.g. Early Help Service, Parental Mental Health and Functional Family Therapy team
- Risk that **public health grant reductions** 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.

These risks have been presented to and discussed at various committees and Governing Body as detailed before.
In year risks during 2016-17

1. Financial position of the Local Health Economy
The CCG has achieved a good financial position for the financial year 2016/17. This positive performance is forecast to continue for the rest of the year and the CCG is set to achieve all of its statutory financial performance duties. This includes achieving Quality, Innovation, Productivity and Prevention savings (QIPP) of £6.4m net.

However, planning for 2017/18 and onward has highlighted that it will be extremely challenging to maintain this performance in future years. Local NHS providers have had a very difficult time in 2016/17 with regard to their financial positions and this is reflected in the CCG’s plans for 2017/18, as we respond to the increased demand to fund cost pressures and activity growth across the system. In addition to these increased cost pressures, the CCG is likely to need to find QIPP savings of circa £12.4m for 2017/18.

King’s College Hospital NHS Foundation Trust continues to face very significant financial difficulties. The CCG will continue to support it with its financial recovery plans in 2017/18, with a view to ensuring that the initiatives planned and started in 2016/17 are all realised in a sustainable way, and contribute to the challenge of financial recovery.

2. Achievement of targets for A&E and Referral to Treatment (RTT)
NHS performance in a number of important areas continued to be below the required standards in 2016/17; A&E, referral-to-treatment (RTT), and cancer waiting times in particular. As the commissioner of these services for Southwark residents, we are responsible for ensuring that all of the providers we commission deliver services in line with national waiting time standards.

Meeting national performance requirements has been, and still remains, a huge challenge for both King’s College Hospital NHS Foundation Trust and Guy’s and St Thomas’ NHS Foundation Trust. This year CCG clinical leads and commissioners have worked with system partners (NHS England, Monitor, and other CCGs) and with local acute trusts to develop and implement clear actions plans to improve performance in all of these areas.

It is worth noting that our performance in all of these areas is significantly better than it is for many patients in other areas of London and England. It has been achieved in Southwark because providers and commissioners have worked together to ensure these standards are consistently met.

3. Improved Access for Psychological Therapy (IAPT) services
The new contract for IAPT began on 1 April 2016; it was awarded to South London and Maudsley NHS Foundation Trust as the lead provider, the major risk in this area being the mobilisation of the contract to ensure quality services to the users. IAPT service received a further 350k non-recurrent funding to deal with waiting times issues and to take forward further re-alignment of the service to deal with complex needs.

4. Council budget cuts for Adult Social Care, Children’s and Public Health Services
In February 2017, the Joint Commissioning Strategy Committee had detailed discussion of proposed council savings. Further follow on work to look at understanding impact and possible mitigation is under way.

Risks identified for 2017-18
Apart from financial risks facing the CCG itself and services commissioned by the CCG for its population, additional risks that have been identified by the CCG are as follows:

1. Developing local care networks
Over the last 12 months, Local Care Networks have come together to work on a range of issues and new ways of working. Moving forward, the CCG will need to put the right incentives into provider
contracts to support the delivery of key priorities for out-of-hospital care. In 2017/18, this will be through a shared system-wide incentive focused on delivering coordinated care and improved outcomes for patients with three or more long term conditions, including mental illness. This incentive will be shared across primary, community, acute and mental health contracts; with delivery coordinated through Local Care Networks.

2. Commissioning Support
There is a national requirement for some elements of commissioning support services to be market tested in 2017. In 2016-17, the six CCGs in south east London worked together to agree their requirements for a tendering process, after considering which services should be procured through this route, and which services will be retained on a local basis. Risks of destabilisation and loss of continuity due to change in provider as SECSU merges with NELCSU will be managed by the CCG through undertaking appropriate risk assessments.

3. Delivery of the Sustainability Transformation Plan
Future risks for the CCG will be focused around delivery of the Five Year Forward View and the sector Sustainability and Transformation Plan.

4. Delegated Primary Care Commissioning and Contract Negotiation
The CCG has been approved to take on delegated commissioning of primary care from 1 April 2017. The SEL Joint Commissioning Committee will be replaced by the local Primary Care Commissioning Committee. Risks related to primary care commissioning i.e. financial, governance, reputational and engagement with member practices on contract negotiations to be implemented by October 2017 will be continually assessed and presented to the committees, Council of Members and CCG Governing Body for information.

5. Approval of Dulwich Programme Business Case
Additional requirements from NHS England in order to approve the Stage 1 business case for Dulwich has meant some delay in concluding the scheme design process.

2.1.4 Other sources of assurance

2.1.4.1 Internal Control Framework
A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The CCG has put in place a suite of policies, processes and reporting procedures to ensure adequate oversight of the CCG’s control environment by governing body members. The CCG has put in place various committees and sub-committees to support its internal control framework. The CCG’s risk management framework and Board Assurance Framework are the main mechanisms used by the CCG for providing assurance to the Governing Body that an effective system of internal control is adopted and embedded. The framework considers risks in relation to each of its corporate objectives, the control measures in place to manage the risk, positive assurance that the control measures are working and any gaps that may be outstanding in relation to both control measures and assurance provided. SMART actions are then devised by risk owners to address gaps which are monitored by the Integrated Governance and Performance Committee and the Audit Committee.
The framework also links explicitly to the CCG’s directorate risk registers and project specific risk registers to ensure risks affecting the delivery of objectives are managed effectively. Red risks on directorate risk registers (and their mitigation) are highlighted to the assurance committees and Governing Body in a regular manner.

2.1.4.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG’s internal auditors have conducted an annual internal audit of conflicts of interest management. The audit received an assurance of “Significant Assurance with minor improvement opportunities” with 1 medium priority and 2 low priority recommendations regarding aligning policy and templates with NHS England guidance. These recommendations have been accepted by the CCG and will be implemented early in the new financial year.

2.1.4.3 Data Quality

The data provided to the membership body and governing body is generated from a variety of sources and is reported internally and externally through monthly reports and a summary of the year end performance data is included in this report. The CCG has robust processes and governance arrangements in place to ensure that the quality of data used by the membership body and Governing Body is accurate and fit for purpose. All data that is forwarded to the Governing Body has been discussed, and analysed at a minuted committee meeting prior to being submitted for discussion or noting or for a formal decision at the Governing Body. Governing Body papers are made publicly available through the CCG website.

The quality of the data used by the Membership Body and Governing Body is of an acceptable standard and improvements will continue to be made in 2017/18.

2.1.4.4 Information Governance

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

The annual Information Governance Toolkit internal audit was conducted in February 2017. The CCG is aspiring for Level 3 (100%) compliance for which received an assurance of “significant assurance with minor improvement opportunities”.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance Quick Reference Guide to ensure staff are aware of their information governance roles and responsibilities.
We have assigned the roles of Senior Information Risk Owner and Caldicott Guardian who attend all Information Governance Steering Group meetings.

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

### 2.1.4.5 Business Critical Models

NHS England recognises the importance of quality assurance across the full range of its analytical work. In partnership with analysts in the Department of Health we have developed an approach that is fully consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government models. The framework includes a programme of mandatory workshops for NHS England analysts, which highlights the importance of quality assurance across the full range of analytical work.

The Macpherson Report on the review of quality assurance (QA) of Government Analytical Models set out the components of best practice in QA making eight key recommendations. For 2016/17, Southwark CCG has worked with other CCGs and NHS providers in South East London, through the Sustainability and Transformation Plan (STP), to develop the business and financial modelling for the five year strategic plan. The modelling is led through South East London PMO and reports back to the South East London Finance Leads Group. The group includes Directors of Finance and Chief Finance Officers from all organisations within the STP. The group is chaired by our Chief Finance Officer who acts as the Senior Responsible Officer for the development of the model. The output of the financial modelling is reviewed by a varied number of stakeholders from different disciplines, both internal and external, and underpins the modelling of the impacts of service changes over the next five years.

Locally in Southwark CCG, we have developed a number of business and financial models which underpin the local financial planning, QIPP delivery, procurement and service transformation. The identified senior responsible officer is the Chief Finance Officer, who ensures that there are effective processes underpinning the modelling, including appropriate guidance, documentation and training, as well as sharing best practice. This includes ensuring that appropriate assurance processes are in place to ensure the robustness of any modelling.

### 2.1.4.6 Third party assurances

The CCG uses the services of South East Commissioning Support Unit and North East London Commissioning Support Unit for provision of various services like ICT, Communications, Financial Accounting, Complaints and PALs, Procurement etc. The CCG Audit Committee received mid-year and end of year Service Auditor Reports conducted by an independent auditor, which provided assurance to the CCG on the effectiveness of services and arrangements.

### 2.1.4.7 Control issues

No significant control issues were identified on the CCG’s month 9 governance return.

### 2.1.4.8 Review of economy, efficiency and effectiveness of the use of resources

The CCG Integrated Governance and Performance Committee: is a prime committee of the CCG’s Governing Body. It is accountable for overseeing a robust organisation-wide system of financial management. On a monthly basis, the Committee, chaired by a lay member, receives the CCG Finance Report which includes description of central management costs, and in-year financial performance monitoring. The report also contains information on contracts and QIPP which include
elements of efficiency control. The committee also reviews the CCG’s Budgetary Framework and financial plan. The committee provides scrutiny to ensure budgets are set and managed in an appropriate and timely manner. It ensures that the Governing Body is fully aware of any financial risks which may materialise throughout the year. It works alongside the Audit Committee to ensure financial probity in the organisation.

Audit Committee: Every year, the internal audit plan for the CCG includes an audit on financial management. Results of the audit and any recommendations are presented to the Audit Committee. Recommendations are tracked for completion by the internal auditors and presented in their progress report to the Audit Committee. The external audit function audits the CCG on Value for Money.

Governing Body: is presented with the latest finance report at every meeting. The Council of Members also receives a finance and performance update at every meeting.

The Quality of Leadership indicator on the CCG Improvement Assessment Framework was rated green throughout the year.

Delegation of functions

The CCG has not delegated any of its functions either internally or externally.

Counter fraud arrangements

NHS Southwark CCG engaged TIAA Ltd to provide independent and professional accredited counter fraud specialist service to the CCG. The Counter Fraud Progress Report to the CCG is based on NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption which was developed to support NHS Commissioners in implementing appropriate measures to counter fraud, bribery and corruption.

To assure the CCG on compliance with the NHS Standards for Commissioners, TIAA deploys a work plan designed to meet the four objectives of the guidance:

• Strategic governance
• Inform and involve
• Prevent and deter
• Hold to account

The focus of the work during 2016/17 has been to build on the processes implemented during the previous year fiscal year which are designed to mitigate against the risk of crime at Southwark CCG. The Audit Committee with its three lay member and two clinical members representation provide proactive supports and direction to the Counter fraud workplan to ensure it accurately reflects the CCG’s remit of work and fraud risks.

TIAA’s Local Counter Fraud Specialist Manager (LCFSM) has continued to raise awareness of fraud, bribery and corruption risks at Southwark CCG through the delivery of a series of workshops to CCG staff and external stakeholders. In addition, the LCFSM has used other media forms to engage with staff and stakeholders, such as newsletters; intelligence briefings and information posters.

Counter fraud specialist also carries out any investigations on counter fraud referrals. CCG staff were given training in counter fraud at a staff meeting session and were alerted to mechanisms of reporting through staff bulletin.

The CCG’s Chief Financial Officer is the Executive board member with the responsibility to proactively tackle fraud, bribery and corruption.
2.1.4.9 Head of Internal Audit Opinion

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

Our overall opinion for the period 1 April 2016 to 31 March 2017 is that:

‘Significant assurance with minor improvements’ can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.

During the year, Internal Audit issued the following audit reports:

<table>
<thead>
<tr>
<th>Area of Audit</th>
<th>Level of Assurance Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance and Risk Management</td>
<td>Significant Assurance (maximum level of assurance given by the auditor)</td>
</tr>
<tr>
<td>Financial Management</td>
<td>Significant Assurance with minor improvement opportunities</td>
</tr>
<tr>
<td>Sustainability and Transformation Planning</td>
<td>Significant Assurance with minor improvement opportunities</td>
</tr>
<tr>
<td>Conflicts of Interest</td>
<td>Significant Assurance with minor improvement opportunities</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>Significant Assurance with minor improvement opportunities</td>
</tr>
<tr>
<td>Information Governance</td>
<td>Significant Assurance (maximum level of assurance given by the auditor)</td>
</tr>
</tbody>
</table>

The full Head of Internal Audit Opinion is at 2.1.4.12.

2.1.4.10 Review of the effectiveness of governance, risk management and internal control

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Governing Body
- The Audit Committee
- Integrated Governance and Performance Committee
- Internal audit

All of the above assure me that sound systems are in operation to ensure effectiveness of governance, risk management and internal control. There are plans in place to address any weaknesses and to ensure continuous improvements are taken forward.
2.1.4.11 Conclusion

No significant internal control issues have been identified.

Andrew Bland
Accountable Officer
26 May 2017
2.1.4.12  Head of Internal Audit Opinion 2016/17

Basis of opinion for the period 1 April 2016 to 31 March 2017

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards (PSIAS). As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

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

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

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with PSIAS, based upon and limited to the work performed, on the overall adequacy and effectiveness of the CCG’s risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

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

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

A further component will be the assurances provided on the operation of the systems of internal control the service organisations which provide financial services on behalf of the CCG during 2016-17 as follows:

• NHS South East Commissioning Support Unit (Deloitte);
• NHS Shared Business Service (Grant Thornton); and
• IBM: NHS Electronic Staff Records (PwC).
Assurance on the operation of these systems is provided by ISAE3402 Service Auditor Reports issued by the internal auditors of these organisations.

Opinion

Our opinion is set out as follows:
Basis for the opinion;
Overall opinion; and
Commentary.

Basis for the opinion

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning aspects of the risk and assurance framework and supporting processes; and
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

Overall opinion

Our overall opinion for the period 1 April 2016 to 31 March 2017 is that: ‘Significant assurance with minor improvements’ can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1 April 2016 to 31 March 2017 inclusive, and is based on the six audits that we completed in this period and the ISAE3402 reports received from Deloitte, Grant Thornton and PwC as outlined on the previous page.

The design and operation of the Assurance Framework and associated processes

The CCG’s Board Assurance Framework does reflect the CCG’s key objectives and risks and is regularly reviewed by the Governing Body. The Executive reviews the Board Assurance Framework on a monthly basis and the Audit Committee provides reviews whether the CCG’s risk management procedures are operating effectively.

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

We issued no partial assurance reports or no assurance opinions in respect of our 2016/17 assignments. We raised no high risk recommendations in the period.

KPMG LLP
Chartered Accountants
London
March 2017
2.2 Remuneration and Staff Report

2.2.1 Remuneration Report

2.2.1.1 Remuneration Committee
The Remuneration Committee comprises of five members – three lay members and two clinical leads. The Chair of the committee is our lay member, Richard Gibbs. A full list of members, their roles is as below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Gibbs</td>
<td>Lay member, Chair</td>
<td>April 2013</td>
</tr>
<tr>
<td>Robert Park</td>
<td>Lay member</td>
<td>April 2013</td>
</tr>
<tr>
<td>Joy Ellery</td>
<td>Lay member</td>
<td>November 2015</td>
</tr>
<tr>
<td>Dr. Robert Davidson</td>
<td>Clinical Lead Governing Body</td>
<td>January 2016</td>
</tr>
<tr>
<td>Dr. Nancy Kuchemann</td>
<td>Clinical Lead Governing Body</td>
<td>January 2016</td>
</tr>
</tbody>
</table>

In addition, the following provided services and/or advice to the committee which was material to the committee’s deliberations.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malcolm Hines</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Andrew Bland</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>Caroline Gilmartin</td>
<td>Director of Integrated Commissioning</td>
</tr>
<tr>
<td>Dr. Jonty Heaversedge</td>
<td>CCG Chair</td>
</tr>
<tr>
<td>Mark Easton</td>
<td>Programme Director, Our Healthier South London Programme</td>
</tr>
</tbody>
</table>

Also see Committees of the Governing Body – Remuneration Committee Page 57.

2.2.1.1.2 Policy on the remuneration of senior managers
The Committee’s deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures. There are no arrangements in place for additional payments or allowances to staff, at any level, outside of national regulations.

Remuneration of Very Senior Managers
The CCG’s policy concerning senior managers’ contracts is that they are of permanent duration, with a notice period of up to three months. Termination payments are calculated on the basis of national regulations, and Treasury advice.

Lay members roles were advertised in late November 2016 and of 37 applications received. Three lay members were successfully selected, their term runs from April 2017 to March 2020.

The nurse member position has been extended by Lambeth and Southwark to October 2019.

GP Clinical Leads are subject to a two year fixed term, which for four leads, plus the Practice Nurse Lead, ends in June 2017.

There are no other employment liabilities for the CCG, for any of the above.
### 2.2.1.1.1 Senior manager remuneration (including salary and pension entitlements)

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2016/17</th>
<th>(a) Salary (bands of £5,000)</th>
<th>(b) Expense payments (taxable) to nearest £100</th>
<th>(c) Performance pay and bonuses (bands of £5,000)</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000)</th>
<th>(e) All pension-related benefits (bands of £2,500)</th>
<th>(f) TOTAL (a to e) (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jonty Heaversedge</td>
<td>95-100 (95-100)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>95-100 (95-100)</td>
</tr>
<tr>
<td>Mr Andrew Bland</td>
<td>120-125 (120-125)</td>
<td>27.5-30 (20-22.5)</td>
<td>150-155 (140-145)</td>
<td></td>
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<tr>
<td>Mr Malcolm Hines</td>
<td>110-115 (110-115)</td>
<td>0-2.5 (0-2.5)</td>
<td>110-115 (110-115)</td>
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<td></td>
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<tr>
<td>Ms Gwen Kennedy</td>
<td>105-110 (100-105)</td>
<td>60-62.5 (5-7.5)</td>
<td>165-170 (105-110)</td>
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<tr>
<td>Ms Kate Moriarty-Baker</td>
<td>95-100 (N/A)</td>
<td>57.5-60 (N/A)</td>
<td>150-155 (N/A)</td>
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<tr>
<td>Mr Mark Kewley</td>
<td>100-105 (65-70)</td>
<td>35-37.5 (37.5-40)</td>
<td>135-140 (105-110)</td>
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<tr>
<td>Ms Caroline Gilmartin</td>
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<td>160-165 (55-60)</td>
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<td>Dr Nancy Kuchemann</td>
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<tr>
<td>Dr Jacques Mizan</td>
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<td>35-40 (35-40)</td>
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<tr>
<td>Dr Noel Baxter</td>
<td>50-55 (70-75)</td>
<td>215-217.5 (NIL)</td>
<td>265-270 (70-75)</td>
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<td>Dr Yvonneke Roe</td>
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<td>35-40 (35-40)</td>
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<tr>
<td>Dr Emily Gibbs</td>
<td>35-40 (30-35)</td>
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<tr>
<td>Dr Robert Davidson</td>
<td>70-75 (55-60)</td>
<td>70-75 (55-60)</td>
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<tr>
<td>Prof Ami David</td>
<td>20-25 (5-10)</td>
<td>20-25 (5-10)</td>
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<tr>
<td>Ms Linda Drake</td>
<td>45-50 (35-40)</td>
<td>0-2.5 (12.5-15)</td>
<td>45-50 (50-55)</td>
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<td></td>
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<tr>
<td>Mr Robert Park</td>
<td>5-10 (5-10)</td>
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<tr>
<td>Ms Joy Ellery</td>
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<tr>
<td>Dr Michael Khan</td>
<td>15-20 (0-5)</td>
<td>15-20 (0-5)</td>
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<tr>
<td>Dr Ruth Wallis (until October 2016)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
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</tr>
<tr>
<td>Name and Title</td>
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<td></td>
</tr>
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<td>-------------------------------------------------------------------------------</td>
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<tr>
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<td>(a) Salary (bands of £5,000)</td>
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<td>(b) Expense payments (taxable) to nearest £100</td>
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<td>(c) Performance pay and bonuses (bands of £5,000)</td>
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<td>(d) Long term performance pay and bonuses (bands of £5,000)</td>
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<td></td>
<td>(e) All pension-related benefits (bands of £2,500)</td>
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<td></td>
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<tr>
<td></td>
<td>(f) TOTAL (a to e) (bands of £5,000)</td>
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<tr>
<td>Prof Kevin Fenton (from Feb 2017)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
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<tr>
<td>Mr David Cooper (until Dec 2016)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
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<td>Mr Stephen Whittle (from Jan 2017)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
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<tr>
<td>Prof John Moxham (until Feb 2017)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
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<td></td>
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<tr>
<td>Mr Jay Stickland</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Dr Jane Cliffe</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Ian Abbs (from Feb 2017)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Figures in brackets in the above table are prior year comparators.

No taxable benefits were paid in 2016/17.

For GP clinical leads, the sums shown are just those pertaining to their GB role, not their own practice income as a GP partner or salaried GP. Some GPs were paid through the payroll system, whilst for some others their remuneration was paid direct to their practice, to meet the additional costs incurred by the practice.
### Pension benefits as at 31 March 2017

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>(a) Real increase in pension at pension age (bands of £2,500)</th>
<th>(b) Real increase in pension lump sum at pension age (bands of £2,500)</th>
<th>(c) Total accrued pension at pension age at 31 March 2017 (bands of £5,000)</th>
<th>(d) Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)</th>
<th>(e) Cash Equivalent Transfer Value at 1 April 2016</th>
<th>(f) Real Increase in Cash Equivalent Transfer Value</th>
<th>(g) Cash Equivalent Transfer Value at 31 March 2017</th>
<th>(h) Employers Contribution to partnership pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Andrew Bland, Chief Officer</td>
<td>0.0-2.5</td>
<td>0.0-2.5</td>
<td>25-30</td>
<td>65-70</td>
<td>306</td>
<td>24</td>
<td>282</td>
<td></td>
</tr>
<tr>
<td>Ms Gwen Kennedy, Director of Quality &amp; Safety</td>
<td>2.5-5.0</td>
<td>7.5-10</td>
<td>35-40</td>
<td>115-120</td>
<td>764</td>
<td>95</td>
<td>858</td>
<td></td>
</tr>
<tr>
<td>Ms Kate Moriarty-Baker, Interim Director of Quality &amp; Safety</td>
<td>2.5-5.0</td>
<td>7.5-10</td>
<td>20-25</td>
<td>65-70</td>
<td>375</td>
<td>58</td>
<td>434</td>
<td></td>
</tr>
<tr>
<td>Ms Caroline Gilmartin, Director of Integrated Commissioning</td>
<td>2.5-5.0</td>
<td>7.5-10</td>
<td>25-30</td>
<td>75-80</td>
<td>484</td>
<td>85</td>
<td>569</td>
<td></td>
</tr>
<tr>
<td>Mr Mark Kewley, Director of Transformation and Performance</td>
<td>2.5-5.0</td>
<td>0.0-2.5</td>
<td>5.0-10</td>
<td>0.0-5.0</td>
<td>45</td>
<td>18</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Dr Noel Baxter, Clinical Lead Governing Body</td>
<td>7.5-10</td>
<td>25-27.5</td>
<td>15-20</td>
<td>40-45</td>
<td>101</td>
<td>158</td>
<td>259</td>
<td></td>
</tr>
<tr>
<td>Ms Linda Drake, Practice Nurse, Clinical Lead Governing Body</td>
<td>0.0-2.5</td>
<td>0.0-2.5</td>
<td>15-20</td>
<td>45-50</td>
<td>0</td>
<td>0</td>
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<td></td>
</tr>
</tbody>
</table>
2.2.1.2 Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (or other allowable beneficiary’s) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

2.2.1.3 Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation on early retirement or for loss of office

There has been no compensation on early retirement or for loss of office in 2016-17.

Payments to past members

There have been no payments in respect of past senior managers in 2016-17.

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid member in their organisation and the median remuneration of the organisation’s workforce. The banded remuneration of the highest paid member in NHS Southwark CCG in the financial year 2016/17 was £122,500 (2015/16: £122,500). This was 3.19 times (2015/16: 3.83) the median remuneration of the workforce, which was £38,360 (2015/16: £31,947).

In 2016/17, no (2015-16, two) employees received remuneration in excess of the highest-paid member. Remuneration ranged from £1,423 to £123,072 (2015/2016: £1,790 to £162,240).

2.2.2 Staff Report

2.2.2.1 Number of senior managers

<table>
<thead>
<tr>
<th>Clinical Lead</th>
<th>GB</th>
<th>VSM</th>
<th>Director</th>
<th>Employee</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>3 3 5 3 2 0 3 5 21 54 99</td>
<td></td>
<td></td>
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</tbody>
</table>
2.2.2.2 Staff numbers and costs

<table>
<thead>
<tr>
<th>Employee Category</th>
<th>FTE</th>
<th>Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time</td>
<td>74.00</td>
<td>74</td>
</tr>
<tr>
<td>Part Time</td>
<td>10.76</td>
<td>25</td>
</tr>
<tr>
<td>Grand Total</td>
<td>84.76</td>
<td>99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>FTE</th>
<th>Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>57.21</td>
<td>65</td>
</tr>
<tr>
<td>Male</td>
<td>27.55</td>
<td>34</td>
</tr>
<tr>
<td>Grand Total</td>
<td>84.76</td>
<td>99</td>
</tr>
</tbody>
</table>

**Employee benefits**

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Total £'000</td>
<td>Permanent Employees £'000</td>
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<tr>
<td>Employee Benefits</td>
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<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
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<td>3,756</td>
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<tr>
<td>Social security costs</td>
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<td>442</td>
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<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>451</td>
<td>451</td>
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<tr>
<td>Gross employee benefits expenditure</td>
<td>7,148</td>
<td>4,649</td>
</tr>
<tr>
<td>Less recoveries in respect of employee benefits (note 4.1.2)</td>
<td>0</td>
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</tr>
<tr>
<td>Total - Net admin employee benefits including capitalised costs</td>
<td>7,148</td>
<td>4,649</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>(116)</td>
<td>0</td>
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<tr>
<td>Net employee benefits excluding capitalised costs</td>
<td>7,032</td>
<td>4,649</td>
</tr>
</tbody>
</table>
Employee Benefits

Salaries and wages: £4,466, £2,869, £1,597
Social security costs: £318, £318, £0
Employer Contributions to NHS Pension scheme: £363, £363, £0

Gross employee benefits expenditure: £5,147, £3,550, £1,597

Less recoveries in respect of employee benefits (note 4.1.2): £0, £0, £0

Total - Net admin employee benefits including capitalised costs: £5,147, £3,550, £1,597

Less: Employee costs capitalised: £0, £0, £0

Net employee benefits excluding capitalised costs: £5,147, £3,550, £1,597

2.2.2.3 Staff composition

<table>
<thead>
<tr>
<th>Gender</th>
<th>Band</th>
<th>Headcount</th>
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<tbody>
<tr>
<td>Female</td>
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<td>1</td>
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<td>Band 9</td>
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<td>Local Grade</td>
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<tr>
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<tr>
<td>Grand Total</td>
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<td>84.76</td>
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2.2.2.4 Sickness absence data

January 2016 – December 2016

<table>
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<th>Figures Converted by DH to Best Estimates of Required Data Items</th>
<th>Statistics Published by NHS Digital from ESR Data Warehouse</th>
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<tr>
<td>Average FTE 2016</td>
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<tr>
<td>Adjusted FTE days lost to Cabinet Office definitions</td>
<td>Average Sick Days per FTE</td>
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<tr>
<td>67</td>
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<td>FTE-Days Available</td>
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<tr>
<td></td>
<td>24,397</td>
</tr>
<tr>
<td></td>
<td>FTE-Days recorded Sickness Absence</td>
</tr>
<tr>
<td></td>
<td>500</td>
</tr>
</tbody>
</table>

ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.

Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

There may be inconsistencies between these data and the statutory basis for accounts, in terms of the organisation against which staff are reported for a particular month.

2.2.2.5 Staff policies

Disabled employees are protected under the “protected characteristics” of the Equality Act 2010, one of which is disability. The CCG ensures that the requirements and reasonable adjustments necessary for employees with disabilities are taken into account during their employment and that people with disabilities are not discriminated against on the grounds of their disability at any stage of the recruitment process or in their employment with the CCG.

The CCG’s Sickness Absence Policy confirms that, where an employee becomes disabled as a result of sickness, the CCG will make any necessary reasonable adjustments, as required and in accordance with the Equality Act, to enable the employee to return to work. The types of adjustments may include adjustments to work base, working hours, redeploying the employee to another suitable position, or providing any necessary equipment to assist the employee to perform their role.

Disabled staff are protected under the terms of the Disability Discrimination Act. The Sickness Absence policy confirms that if an employee is disabled or becomes disabled, the CCG is legally required under the Equality Act 2010 to make reasonable adjustments to enable the employee to continue working – for example, providing an ergonomic chair or a power-assisted piece of equipment. CCGs must make sure the individual is not disadvantaged because of their disability.

The following policies were in place during the year:

- Suspension policy, procedure and rules
- Stress, mental health and wellbeing policy
- Whistleblowing policy
- Organisational Change policy
- Individual Grievance Policy and Process
- Sickness Absence policy
- Bullying and Harassment policy
- Re-banding policy
- Shared Parental Leave Policy
- Annual and special leave policy
- Maternity, Paternity and Adoption leave policy
- Capability policy
- Disciplinary policy
- Flexible Working policy
- Training and Development policy
- Health and Safety policy
- Incident reporting policy for staff and visitors
- Security policy
- Violence and aggression policy
- Gifts and hospitality policy
- Anti-Fraud, Bribery and Corruption Policy
- Conflict of interest policy
- Policy in relation to terms and conditions for members of the Governing Body

2.2.2.6 Expenditure on consultancy and contingent labour

The CCG has spent a total of £3,448,659.83 on consultancy. £691,129.22 relates to core CCG business with the remainder (£2,757,530.61) being attributable to spend relating to the Healthy London Partnership Transforming Primary Care programme for which NHS Southwark CCG is the host, and also the CCG's share of costs incurred as a part of Our Healthier South East London Programme.

The CCG has spent a total of £2,498,833.57 on contingent labour (non-permanent staff) costs. 67% of this relates to core CCG business, with the remainder being mainly attributable to spend relating to the Healthy London Partnership Transforming Primary Care programme for which NHS Southwark CCG is the host, and also the CCG's share of costs incurred as a part of Our Healthier South East London Programme.

The Healthy London Partnership Transforming Primary Care programme is a pan-London programme which was established to transform London’s experience of primary care. The programme aims to support patients to consistently receive a high quality of care, no matter who they are or where they live in London and to support the sustainability of primary care.
2.2.2.7 Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months
For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of existing engagements as of 31 March 2017</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>for less than one year at the time of reporting</td>
<td>3</td>
</tr>
<tr>
<td>for between one and two years at the time of reporting</td>
<td>6</td>
</tr>
<tr>
<td>for between 2 and 3 years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>for between 3 and 4 years at the time of reporting</td>
<td>1</td>
</tr>
<tr>
<td>for 4 or more years at the time of reporting</td>
<td>0</td>
</tr>
</tbody>
</table>

NHS Southwark CCG annually requests assurance to be given that the individual is paying the right amount of tax.

Table 2: New off-payroll engagements
For all new off-payroll engagements between 01 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements which include contractual clauses giving NHS Southwark CCG the right to request assurance in relation to income tax and National Insurance obligations</td>
<td>4</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
<td>4</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>assurance has been received</td>
<td>3</td>
</tr>
<tr>
<td>assurance has not been received</td>
<td>1</td>
</tr>
<tr>
<td>engagements terminated as a result of assurance not being received.</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3: Off-payroll engagements / senior official engagements
For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2016 and 31 March 2017.

<table>
<thead>
<tr>
<th>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.</td>
<td>19</td>
</tr>
</tbody>
</table>
2.2.3 Parliamentary Accountability and Audit Report

NHS Southwark CCG is not required to produce a Parliamentary Accountability and Audit Report.

Andrew Bland
Accountable Officer
26 May 2017
## 3 ANNUAL ACCOUNTS

### 3.1 The Primary Statements

#### 3.1.1 Statement of comprehensive net expenditure for the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>Note</th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income from sale of goods and services</strong></td>
<td>3</td>
<td>(10,493)</td>
<td>(13,159)</td>
</tr>
<tr>
<td><strong>Other operating income</strong></td>
<td>3</td>
<td>(3,153)</td>
<td>(1,599)</td>
</tr>
<tr>
<td><strong>Total operating income</strong></td>
<td></td>
<td>(13,646)</td>
<td>(14,758)</td>
</tr>
<tr>
<td><strong>Staff costs</strong></td>
<td>4</td>
<td>7,032</td>
<td>5,147</td>
</tr>
<tr>
<td><strong>Purchase of goods and services</strong></td>
<td>5</td>
<td>414,296</td>
<td>402,585</td>
</tr>
<tr>
<td><strong>Depreciation and impairment charges</strong></td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Provision expense</strong></td>
<td>5</td>
<td>(232)</td>
<td>(174)</td>
</tr>
<tr>
<td><strong>Other Operating Expenditure</strong></td>
<td>5</td>
<td>300</td>
<td>148</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td></td>
<td>421,396</td>
<td>407,706</td>
</tr>
</tbody>
</table>

**Comprehensive Expenditure for the year ended 31 March 2017**

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>407,750</td>
<td>392,948</td>
</tr>
</tbody>
</table>

The notes on pages 96 to 123 form part of this statement.
3.1.2 Statement of financial position as at 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>7</td>
<td>345</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td></td>
<td>345</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>8</td>
<td>14,284</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>9</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td>14,323</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>14,668</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>10</td>
<td>(34,650)</td>
</tr>
<tr>
<td>Provisions</td>
<td>11</td>
<td>(25)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td>(34,675)</td>
</tr>
<tr>
<td><strong>Non-Current Assets plus/less Net Current Assets/Liabilities</strong></td>
<td></td>
<td>(20,007)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td></td>
<td>(20,007)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers’ Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td>(20,007)</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity:</strong></td>
<td></td>
<td>(20,007)</td>
</tr>
</tbody>
</table>

The notes on pages 96 to 123 form part of this statement.

The financial statements on pages 92 to 95 were approved by the Governing Body on 26 May 2017 and signed on its behalf by:

Accountable Officer
Andrew Bland
26 May 2017

Chief Finance Officer
Malcolm Hines
26 May 2017
3.1.3 Statement of changes in taxpayers’ equity for the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>General fund £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in taxpayers’ equity for 2016-17</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 01 April 2016</td>
<td>(20,083)</td>
<td>(20,083)</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 31 March 2017</td>
<td>(20,083)</td>
<td>(20,083)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2016-17</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(407,750)</td>
<td>(407,750)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(407,750)</td>
<td>(407,750)</td>
</tr>
<tr>
<td>Net funding</td>
<td>407,826</td>
<td>407,826</td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>(20,007)</td>
<td>(20,007)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>General fund £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in taxpayers’ equity for 2015-16</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 01 April 2015</td>
<td>(22,758)</td>
<td>(22,758)</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 31 March 2016</td>
<td>(22,758)</td>
<td>(22,758)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2015-16</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(392,948)</td>
<td>(392,948)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(392,948)</td>
<td>(392,948)</td>
</tr>
<tr>
<td>Net funding</td>
<td>395,624</td>
<td>395,624</td>
</tr>
<tr>
<td>Balance at 31 March 2016</td>
<td>(20,083)</td>
<td>(20,083)</td>
</tr>
</tbody>
</table>

The notes on pages 96 to 123 form part of this statement.
### 3.1.4 Statement of cash flows for the year ended 31 March 2016

<table>
<thead>
<tr>
<th>Note</th>
<th>2016-17 £’000</th>
<th>2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(407,750)</td>
<td>(392,948)</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>8</td>
<td>(6,518)</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>10</td>
<td>6,905</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>11</td>
<td>(232)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td>(407,595)</td>
<td>(395,543)</td>
</tr>
<tr>
<td><strong>Cash Flows from Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Payments) for property, plant and equipment</td>
<td>(300)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Investing Activities</strong></td>
<td>(300)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) before Financing</strong></td>
<td>(407,895)</td>
<td>(395,543)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Funding Received</td>
<td>407,826</td>
<td>395,624</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td>407,826</td>
<td>395,624</td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td>9</td>
<td>(69)</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td>108</td>
<td>27</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td>39</td>
<td>108</td>
</tr>
</tbody>
</table>

The notes on pages 96 to 123 form part of this statement.
3.1.5 Notes to the accounts

1 Accounting Policies
NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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

During the year the Governing Body has considered and approved a number of documents that assume that services will be provided on an on-going basis:

- Our Healthier South East London Strategy
- Sustainability and Transformation Plan (STP)
- Five year financial plan
- Southwark’s Five Year Forward View of health and social care (NHS Southwark CCG and Southwark Council)
- Better Care Fund 2017/18
- Future arrangements for the delegated commissioning of primary care services

The CCG has agreed service contracts for 2017/18 and has a cash plan for 2017/18 based on the CCG’s notified Maximum Cash Drawdown.

1.2 Accounting Convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.
1.3 Movement of Assets within the Department of Health Group

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

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a “jointly controlled operation”, the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group’s share of the income from the pooled budget activities.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.5.1 Critical Judgements in Applying Accounting Policies

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

- NHS Southwark CCG exercised critical judgement in respect of prescribing accruals.
1.5.2 Key Sources of Estimation Uncertainty
The following are the key estimations that management has made in the process of applying the clinical commissioning group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements:
- NHS Southwark CCG had no material key sources of estimation uncertainty during 2016-17.

1.6 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.7 Employee Benefits
1.7.1 Short-term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.
1.8 **Other Expenses**
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

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

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**
Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **Valuation**
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

1.9.3 **Subsequent Expenditure**
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.
1.10. **Depreciation, Amortisation & Impairments**
Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group’s cash management.

1.12 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rate as follows:
- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)

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

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

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

1.15 **Continuing healthcare risk pooling**
In 2014-15 a risk pool scheme was introduced by NHS England for continuing
healthcare claims, for claim periods prior to 31 March 2013. Under the scheme
clinical commissioning group contribute annually to a pooled fund, which is used to
settle the claims.

1.16 **Contingencies**
A contingent liability is a possible obligation that arises from past events and whose
existence will be confirmed only by the occurrence or non-occurrence of one or
more uncertain future events not wholly within the control of the clinical
commissioning group, or a present obligation that is not recognised because it is not
probable that a payment will be required to settle the obligation or the amount of the
obligation cannot be measured sufficiently reliably. A contingent liability is disclosed
unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose
existence will be confirmed by the occurrence or non-occurrence of one or more
uncertain future events not wholly within the control of the clinical commissioning
group. A contingent asset is disclosed where an inflow of economic benefits is
probable.
Where the time value of money is material, contingencies are disclosed at their
present value.

1.17 **Financial Assets**
Financial assets are recognised when the clinical commissioning group becomes
party to the financial instrument contract or, in the case of trade receivables, when
the goods or services have been delivered. Financial assets are derecognised when
the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
Loans and receivables.
The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.17.1 Loans & Receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

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

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

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

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

1.19 Value Added Tax
Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.
1.20. **Foreign Currencies**

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

1.21 **Losses & Special Payments**

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

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

1.22 **Joint Operations**

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.23 **Accounting standards that have been issued but have not yet been adopted**

The Government Group Accounting Manual 2016-17 does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.
### 2 Other operating revenue

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Total</th>
<th>2016-17 Admin</th>
<th>2016-17 Programme</th>
<th>2015-16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>0 £'000</td>
<td>0 £'000</td>
<td>0 £'000</td>
<td>17 £'000</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>10,493 £'000</td>
<td>0 £'000</td>
<td>10,493 £'000</td>
<td>13,159 £'000</td>
</tr>
<tr>
<td>Other revenue</td>
<td>3,153 £'000</td>
<td>73 £'000</td>
<td>3,080 £'000</td>
<td>1,599 £'000</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>13,646 £'000</strong></td>
<td><strong>73 £'000</strong></td>
<td><strong>13,573 £'000</strong></td>
<td><strong>14,758 £'000</strong></td>
</tr>
</tbody>
</table>

Other Operating Revenue includes income from lead commissioner arrangements with the London Borough of Southwark and income from other CCGs where NHS Southwark CCG acted as the host organisation for South East London CCGs.

### 3 Revenue

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Total</th>
<th>2016-17 Admin</th>
<th>2016-17 Programme</th>
<th>2015-16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from sale of goods and services</td>
<td>10,493 £'000</td>
<td>0 £'000</td>
<td>10,493 £'000</td>
<td>13,159 £'000</td>
</tr>
<tr>
<td>Other operating income</td>
<td>3,153 £'000</td>
<td>73 £'000</td>
<td>3,080 £'000</td>
<td>1,599 £'000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13,646 £'000</strong></td>
<td><strong>73 £'000</strong></td>
<td><strong>13,573 £'000</strong></td>
<td><strong>14,758 £'000</strong></td>
</tr>
</tbody>
</table>
4. Employee benefits and staff numbers

4.1 Employee benefits 2016-17

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>Total</th>
<th>Admin</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent Employees</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>6,255</td>
<td>3,756</td>
<td>2,499</td>
<td>3,138</td>
</tr>
<tr>
<td>Social security costs</td>
<td>442</td>
<td>442</td>
<td>0</td>
<td>272</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>451</td>
<td>451</td>
<td>0</td>
<td>261</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>7,148</strong></td>
<td><strong>4,649</strong></td>
<td><strong>2,499</strong></td>
<td><strong>3,671</strong></td>
</tr>
<tr>
<td>Total - Net admin employee benefits including capitalised costs</td>
<td><strong>7,148</strong></td>
<td><strong>4,649</strong></td>
<td><strong>2,499</strong></td>
<td><strong>3,671</strong></td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>(116)</td>
<td>0</td>
<td>(116)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>7,032</strong></td>
<td><strong>4,649</strong></td>
<td><strong>2,383</strong></td>
<td><strong>3,671</strong></td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>Total</td>
<td>Permanent Employees</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------</td>
<td>---------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>4,466</td>
<td>2,869</td>
<td>1,597</td>
<td>2,752</td>
</tr>
<tr>
<td>Social security costs</td>
<td>318</td>
<td>318</td>
<td>0</td>
<td>251</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>363</td>
<td>363</td>
<td>0</td>
<td>267</td>
</tr>
<tr>
<td><strong>Total employee benefits expenditure</strong></td>
<td>5,147</td>
<td>3,550</td>
<td>1,597</td>
<td>3,270</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>5,147</td>
<td>3,550</td>
<td>1,597</td>
<td>3,270</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>5,147</td>
<td>3,550</td>
<td>1,597</td>
<td>3,270</td>
</tr>
</tbody>
</table>
4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanently employed</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td>69</td>
</tr>
<tr>
<td>Of the above:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of whole time equivalent people engaged on capital projects</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

In terms of value, 95% of Permanently employed staff are employed on core CCG business, with 67% of the "Other" category being employed on the same. The remainder (5% of permanently employed staff and 33% of other staff) are employed in services for which NHS Southwark CCG is the host for either south east London, or pan-London projects and programmes.

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanently employed</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>55</td>
</tr>
<tr>
<td>Of the above:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of whole time equivalent people engaged on capital projects</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>308</td>
<td>240</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>67</td>
<td>63</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
4.4 Pension costs

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

Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

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

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

4.4.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account its recent demographic experience), and to recommend the contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2016-17, employers’ contributions of £450,866 were payable to the NHS Pensions Scheme (2015-16: £397,901) at the rate of 14.3% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.
### 5 Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>6,052</td>
<td>2,635</td>
<td>3,417</td>
<td>4,168</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>1,096</td>
<td>1,096</td>
<td>0</td>
<td>979</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>7,148</td>
<td>3,731</td>
<td>3,417</td>
<td>5,147</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>5,096</td>
<td>1,928</td>
<td>3,168</td>
<td>4,290</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>297,738</td>
<td>0</td>
<td>297,738</td>
<td>290,344</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>24,852</td>
<td>0</td>
<td>24,852</td>
<td>21,451</td>
</tr>
<tr>
<td>Services from other WGA bodies</td>
<td>(42)</td>
<td>0</td>
<td>(42)</td>
<td>61</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>44,261</td>
<td>0</td>
<td>44,261</td>
<td>43,735</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>136</td>
<td>136</td>
<td>0</td>
<td>99</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>69</td>
<td>34</td>
<td>35</td>
<td>917</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>3,448</td>
<td>17</td>
<td>3,431</td>
<td>520</td>
</tr>
<tr>
<td>Establishment</td>
<td>285</td>
<td>152</td>
<td>133</td>
<td>908</td>
</tr>
<tr>
<td>Transport</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Premises</td>
<td>3,533</td>
<td>419</td>
<td>3,114</td>
<td>3,331</td>
</tr>
<tr>
<td>Audit fees</td>
<td>76</td>
<td>76</td>
<td>0</td>
<td>76</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>31,876</td>
<td>0</td>
<td>31,876</td>
<td>33,540</td>
</tr>
<tr>
<td>General ophthalmic services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>125</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>2,409</td>
<td>0</td>
<td>2,409</td>
<td>1,540</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>205</td>
<td>140</td>
<td>65</td>
<td>574</td>
</tr>
<tr>
<td>Education and training</td>
<td>190</td>
<td>100</td>
<td>90</td>
<td>424</td>
</tr>
<tr>
<td>Provisions</td>
<td>(232)</td>
<td>(232)</td>
<td>0</td>
<td>(174)</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>297</td>
<td>0</td>
<td>297</td>
<td>743</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>164</td>
<td>0</td>
<td>164</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>414,364</td>
<td>2,773</td>
<td>411,591</td>
<td>402,559</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>421,512</td>
<td>6,504</td>
<td>415,008</td>
<td>407,706</td>
</tr>
</tbody>
</table>
### 6 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2016-17 Number</th>
<th>2016-17 £'000</th>
<th>2015-16 Number</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>9,208</td>
<td>60,829</td>
<td>10,201</td>
<td>72,130</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>8,972</td>
<td>58,450</td>
<td>9,772</td>
<td>70,136</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td><strong>97.44%</strong></td>
<td><strong>96.09%</strong></td>
<td><strong>95.79%</strong></td>
<td><strong>97.24%</strong></td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>3,154</td>
<td>325,857</td>
<td>3,104</td>
<td>321,737</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>3,125</td>
<td>323,565</td>
<td>3,065</td>
<td>318,735</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td><strong>99.08%</strong></td>
<td><strong>99.30%</strong></td>
<td><strong>98.74%</strong></td>
<td><strong>99.07%</strong></td>
</tr>
</tbody>
</table>
7 Property, plant and equipment

2016-17

<table>
<thead>
<tr>
<th>Information technology</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2016</td>
<td>£'000</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>345</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2017</td>
<td>345</td>
</tr>
<tr>
<td>Depreciation 01 April 2016</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation at 31 March 2017</td>
<td>0</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2017</td>
<td>345</td>
</tr>
<tr>
<td>Purchased</td>
<td>345</td>
</tr>
<tr>
<td>Total at 31 March 2017</td>
<td>345</td>
</tr>
</tbody>
</table>

Asset financing:

| | Information technology | Total |
|------------------------|-------|
| Owned | 345 | 345 |
| Total at 31 March 2017 | 345 | 345 |

7.1. Economic lives

<table>
<thead>
<tr>
<th>Information technology</th>
<th>Minimum Life (years)</th>
<th>Maximum Life (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information technology</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
8 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17</th>
<th>Current 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>2,235</td>
<td>577</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,390</td>
<td>1,405</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>1,128</td>
<td>476</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>6,989</td>
<td>4,213</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>323</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>2,040</td>
<td>928</td>
</tr>
<tr>
<td>VAT</td>
<td>170</td>
<td>158</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>14,284</strong></td>
<td><strong>7,766</strong></td>
</tr>
<tr>
<td><strong>Total current and non current</strong></td>
<td><strong>14,284</strong></td>
<td><strong>7,766</strong></td>
</tr>
</tbody>
</table>

Non-NHS receivables relate to a range of payments from the Southwark London Borough Council and is mainly the Section 75 arrangement.

The main items on NHS prepayments and accrued income related to maternity pathway work in progress from NHS Trust organisations.

NHS Southwark CCG did not hold any collateral against receivables at 31 March 2017.

8.1. Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>6,941</td>
<td>577</td>
</tr>
<tr>
<td>By three to six months</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>By more than six months</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,951</strong></td>
<td><strong>626</strong></td>
</tr>
</tbody>
</table>

£3,533k of the amount above has subsequently been recovered post the statement of financial position date, (31 March 2016 = £473k).
9 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2016</td>
<td>108</td>
<td>27</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(69)</td>
<td>81</td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>39</td>
<td>108</td>
</tr>
</tbody>
</table>

Made up of:
Cash with the Government Banking Service | 39 | 108 |

Balance at 31 March 2017 | 39 | 108 |

10 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £'000</th>
<th>Current 2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>4,977</td>
<td>4,003</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>7,424</td>
<td>4,859</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>8,462</td>
<td>3,844</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Capital</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>13,226</td>
<td>14,572</td>
</tr>
<tr>
<td>Social security costs</td>
<td>85</td>
<td>51</td>
</tr>
<tr>
<td>Tax</td>
<td>88</td>
<td>63</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>343</td>
<td>308</td>
</tr>
<tr>
<td>Total Trade &amp; Other Payables</td>
<td>34,650</td>
<td>27,700</td>
</tr>
</tbody>
</table>

Total current and non-current | 34,650 | 27,700 |

The main non NHS liability relates to amounts owed for prescribing (two months). The NHS liability mainly relates to amounts owed to NHS organisations from the Agreement of Balances exercises.

Other payables include £100k outstanding pension contributions at 31 March 2017, (31 March 2016 = £64k).
11 Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17</th>
<th>Current 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Restructuring</td>
<td>25</td>
<td>252</td>
</tr>
<tr>
<td>Legal Claims</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>257</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Restructuring £’000</th>
<th>Legal Claims £’000</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2016</td>
<td>252</td>
<td>5</td>
<td>257</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>25</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>(252)</td>
<td>(5)</td>
<td>(257)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td><strong>25</strong></td>
<td><strong>(0)</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

**Expected timing of cash flows:**

- **Within one year**
  - 25 £’000

**Balance at 31 March 2017**

25 £’000

12. Financial instruments

12.1 Financial risk management

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

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

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

12.1.1 Currency risk

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

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

12.1.3 Liquidity risk

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

12.2 Financial assets

<table>
<thead>
<tr>
<th>Loans and Receivables</th>
<th>Total 2016-17</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- NHS</td>
<td>3,363</td>
<td>3,363</td>
</tr>
<tr>
<td>- Non-NHS</td>
<td>9,029</td>
<td>9,029</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td><strong>12,440</strong></td>
<td><strong>12,440</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loans and Receivables</th>
<th>Total 2015-16</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- NHS</td>
<td>1,054</td>
<td>1,054</td>
</tr>
<tr>
<td>- Non-NHS</td>
<td>5,141</td>
<td>5,141</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>108</td>
<td>108</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total at 31 March 2016</strong></td>
<td><strong>6,311</strong></td>
<td><strong>6,311</strong></td>
</tr>
</tbody>
</table>
12.3 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>Other 2016-17</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>12,401</td>
<td>12,401</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>22,076</td>
<td>22,076</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td><strong>34,477</strong></td>
<td><strong>34,477</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Other 2015-16</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>8,862</td>
<td>8,862</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>18,724</td>
<td>18,724</td>
</tr>
<tr>
<td><strong>Total at 31 March 2016</strong></td>
<td><strong>27,586</strong></td>
<td><strong>27,586</strong></td>
</tr>
</tbody>
</table>

13 Operating segments

NHS Southwark CCG considers it has only one segment: commissioning of healthcare services.
14 Pooled budgets

NHS Southwark Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td></td>
<td>4,979</td>
<td>5,749</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td>(4,979)</td>
<td>(5,749)</td>
</tr>
</tbody>
</table>

For 2016/17, the CCG has entered into a S75 agreement with Southwark Council on the Better Care Fund (BCF). The Council hosts the BCF under a pooled budget 'jointly controlled operation' arrangement.

The financial contributions of the CCG and Southwark Council are set out in Item 10 1 Part 10.1 of the S75 agreement. Subject to the requirements of Law, the Standing Orders and Standing Financial Instructions of both organisations and the Better Care Fund Plan, the usage of any underspend is to be agreed by the CCG and the Council. As part of this process, £177,809 was identified as a forecast underspend in the 2016/17 financial year, and the CCG and Council agreed additional schemes to be funded in-year.

The share of the income and expenditure handled by the pooled budget in the financial year were:

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contribution of Funds</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Southwark CCG</td>
<td>20,679</td>
<td></td>
</tr>
<tr>
<td>Southwark Council</td>
<td>1,149</td>
<td>21,828</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditure met by the Pooled Fund</strong></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Southwark CCG</td>
<td>(4,979)</td>
<td>(21,828)</td>
</tr>
<tr>
<td>Southwark Council</td>
<td>(16,849)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surplus arising on the pooled fund during the year</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

The CCG expenditure met by the pooled fund consists of:

- Guy's & St Thomas’ NHS Foundation Trust: £3,966
- Improving Health Ltd: £374
- Quay Health Solutions: £374
- Self Management UK: £86
- Aston Court: £49
- Solidarity in Crisis: £40
- Big White Wall: £30
- Health Management Consultancy: £30
- Agreed funding for management of the fund: £30
15 Related party transactions

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>GP Practices:</th>
<th>GP Member</th>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Nunhead Surgery</td>
<td>Dr Yvonneke Roe, Member of Governing Body</td>
<td>1,154</td>
<td>0</td>
<td>211</td>
<td>0</td>
<td>42</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td>Queens Road Surgery</td>
<td>Dr Jacques Mizan, Member of Governing Body</td>
<td>575</td>
<td>0</td>
<td>88</td>
<td>0</td>
<td>40</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td>Surrey Docks Health Centre</td>
<td>Dr Noel Baxter, Member of Governing Body</td>
<td>830</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>103</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td>The Villa Street Medical Centre</td>
<td>Dr Nancy Kuchemann, Member of Governing Body</td>
<td>529</td>
<td>0</td>
<td>90</td>
<td>0</td>
<td>80</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td>Dr At Bradford (East Street)</td>
<td>Left at the end of June 2015</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>109</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td>Albion Street Health Centre</td>
<td>Dr Robert Davidson, Member of Governing Body</td>
<td>1,469</td>
<td>0</td>
<td>245</td>
<td>0</td>
<td>56</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td><strong>sub total</strong></td>
<td></td>
<td><strong>4,557</strong></td>
<td><strong>0</strong></td>
<td><strong>634</strong></td>
<td><strong>0</strong></td>
<td><strong>430</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

Each of these practices is a related party through the connection between the governing body of NHS Southwark CCG and either a partner or salaried GP at the practice.

The table above records payment to and amounts owed to the GP practice for the provision of healthcare services.
### 15 Related party transactions - continued

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>NHS Organisations:</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments to Related Party £'000</td>
<td>Receipts from Related Party £'000</td>
</tr>
<tr>
<td>Barts Health NHS Trust</td>
<td>1,688</td>
<td>0</td>
</tr>
<tr>
<td>Chelsea And Westminster Hospital NHS Foundation Trust</td>
<td>766</td>
<td>0</td>
</tr>
<tr>
<td>Croydon Health Services NHS Trust</td>
<td>631</td>
<td>(3)</td>
</tr>
<tr>
<td>Guy’s &amp; St Thomas’ Hospital NHS Foundation Trust</td>
<td>129,544</td>
<td>(339)</td>
</tr>
<tr>
<td>Health Education England</td>
<td>8</td>
<td>(200)</td>
</tr>
<tr>
<td>Homerton University Hospital NHS Foundation Trust</td>
<td>262</td>
<td>0</td>
</tr>
<tr>
<td>King’s College Hospital NHS Foundation Trust</td>
<td>92,794</td>
<td>(21)</td>
</tr>
<tr>
<td>Lewisham &amp; Greenwich NHS Trust</td>
<td>5,884</td>
<td>0</td>
</tr>
<tr>
<td>London Ambulance Service NHS Trust</td>
<td>12,872</td>
<td>0</td>
</tr>
<tr>
<td>London North West Healthcare NHS Trust</td>
<td>203</td>
<td>(9)</td>
</tr>
<tr>
<td>Moorfields Eye Hospital NHS Foundation Trust</td>
<td>1,285</td>
<td>0</td>
</tr>
<tr>
<td>NHS Bexley CCG</td>
<td>93</td>
<td>(34)</td>
</tr>
<tr>
<td>NHS Bromley CCG</td>
<td>485</td>
<td>(794)</td>
</tr>
<tr>
<td>NHS England</td>
<td>725</td>
<td>(1,419)</td>
</tr>
<tr>
<td>NHS Greenwich CCG</td>
<td>281</td>
<td>(74)</td>
</tr>
<tr>
<td>NHS Islington CCG</td>
<td>0</td>
<td>(38)</td>
</tr>
<tr>
<td>NHS Lambeth CCG</td>
<td>803</td>
<td>(233)</td>
</tr>
<tr>
<td>NHS Lewisham CCG</td>
<td>392</td>
<td>(115)</td>
</tr>
<tr>
<td>South London &amp; Maudsley NHS Foundation Trust</td>
<td>58,969</td>
<td>0</td>
</tr>
<tr>
<td>University College London Hospital NHS Foundation Trust</td>
<td>2,076</td>
<td>0</td>
</tr>
<tr>
<td><strong>sub total</strong></td>
<td><strong>309,761</strong></td>
<td><strong>(3,279)</strong></td>
</tr>
</tbody>
</table>

The Department of Health is regarded as a related party. During the year NHS Southwark CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. Details relating to these entities are outlined above.
### Related Party Transactions - continued

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th></th>
<th></th>
<th></th>
<th>2015-16</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments</td>
<td>Receipts</td>
<td>Amounts</td>
<td>Amounts</td>
<td>Payments</td>
<td>Receipts</td>
<td>Amounts</td>
<td>Amounts</td>
</tr>
<tr>
<td></td>
<td>to Related Party £'000</td>
<td>from Related Party £'000</td>
<td>owed to Related Party £'000</td>
<td>due from Related Party £'000</td>
<td>to Related Party £'000</td>
<td>from Related Party £'000</td>
<td>owed to Related Party £'000</td>
<td>due from Related Party £'000</td>
</tr>
<tr>
<td>Other Government Departments::</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>London Borough of Lambeth</td>
<td>1,186</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,282</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td>London Borough of Southwark</td>
<td>20,357</td>
<td>(7,291)</td>
<td>892</td>
<td>(1,510)</td>
<td>4,418</td>
<td>(13,978)</td>
<td>2,701</td>
<td>(10)</td>
</tr>
<tr>
<td><strong>sub total</strong></td>
<td><strong>21,543</strong></td>
<td><strong>(7,291)</strong></td>
<td><strong>892</strong></td>
<td><strong>(1,510)</strong></td>
<td><strong>5,700</strong></td>
<td><strong>(13,978)</strong></td>
<td><strong>2,701</strong></td>
<td><em>(10)</em></td>
</tr>
</tbody>
</table>

NHS Southwark CCG has had a number of material transactions with government departments and other central and local government bodies. The majority of the expenditure is with Southwark Council.

**Other Non-NHS Organisations:**

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th></th>
<th></th>
<th></th>
<th>2015-16</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments</td>
<td>Receipts</td>
<td>Amounts</td>
<td>Amounts</td>
<td>Payments</td>
<td>Receipts</td>
<td>Amounts</td>
<td>Amounts</td>
</tr>
<tr>
<td></td>
<td>to Related Party £'000</td>
<td>from Related Party £'000</td>
<td>owed to Related Party £'000</td>
<td>due from Related Party £'000</td>
<td>to Related Party £'000</td>
<td>from Related Party £'000</td>
<td>owed to Related Party £'000</td>
<td>due from Related Party £'000</td>
</tr>
<tr>
<td>Improving Health Ltd</td>
<td>2,314</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td>Quay Health Solutions</td>
<td>3,280</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
<td>N/I</td>
</tr>
<tr>
<td><strong>sub total</strong></td>
<td><strong>5,594</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</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>

N/A - not applicable
N/I - no information
16 Events after the end of the reporting period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2017. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Southwark CCG has been approved under delegated commissioning arrangements which mean that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2017.

17 Losses and special payments

NHS Southwark CCG does not have any losses and special payments cases.
## 18 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2008 (as amended). NHS Clinical Commissioning Group performance against those duties was as follows:

<table>
<thead>
<tr>
<th>Section Act 2006</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Performance</td>
</tr>
<tr>
<td>Expenditure not to exceed income</td>
<td>431,859</td>
<td>421,741</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>350</td>
<td>345</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>417,963</td>
<td>407,750</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>6,460</td>
<td>6,372</td>
</tr>
</tbody>
</table>

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Southwark CCG has released its 1% reserve to the bottom line. This additional surplus has been offset against other cost pressures from the current financial year, resulting in an additional surplus for the year of £2.54m and the agreed surplus will be carried forward for drawdown in future years.
3.1.6 Independent auditor’s report to the members of the Governing Body of NHS Southwark Clinical Commissioning Group

We have audited the financial statements of NHS Southwark Clinical Commissioning Group for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014 (the “Act”). The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the “2016/17 GAM”) and the requirements of the Health and Social Care Act 2012.

We have also audited the information in the Accountability Report that is subject to audit, being:
- the single total figure of remuneration for each director pages 82 to 83;
- CETV disclosures for each director on page 84;
- the analysis of staff numbers and costs pages on pages 86 to 87; and
- the table of fair pay (pay multiples) disclosures on page 85.

This report is made solely to the members of the Governing Body of NHS Southwark Clinical Commissioning Group (the CCG), as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the “Code of Audit Practice”) and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice as required by the Act.

As explained in the Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG’s resources. We are required under Section 21 (1)(c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report by exception where we are not satisfied.

We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.
Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Performance Report and the Accountability Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Opinion on financial statements

In our opinion:
- the financial statements give a true and fair view of the financial position of NHS Southwark Clinical Commissioning Group as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012.

Opinion on regularity

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

In our opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012; and
- the other information published together with the audited financial statements in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we have referred a matter to the Secretary of State under section 30 of the Act because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have made a written recommendation to the CCG under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above matters.

Certificate

We certify that we have completed the audit of the financial statements of NHS Southwark Clinical Commissioning Group in accordance with the requirements of the Act and the Code of Audit Practice.

Iain Murray

Iain Murray
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street
London
NW1 2EP

30 May 2017
4 GLOSSARY

A&E (Accident & Emergency): a hospital service which provides care for emergency, life threatening and critical conditions for patients of all ages, twenty-four hours a day, seven days a week. This is also known as ED – Emergency Department. It is common for paediatric (children) emergencies to be managed in a separate area of the departments.

Acute care: short-term treatment, usually provided in hospital.

Acute trust: an NHS Hospital Trust or Foundation Trust providing and/ or managing hospitals. Some acute trusts also provide community services, such as Guy’s and St Thomas’ NHS Foundation Trust.

Admission (to a hospital): needing (at least) an overnight stay in hospital, either for an emergency or following a planned procedure.

ALOS (Average Length of Stay – also sometimes LOS, Length of Stay): is an average of the length of time a patient stays in a hospital when admitted. Collection of this data is essential to service planners and audit.

Asthma – Chronic lung disorders with a variety of causes but all characterised by reversibility of small airway obstruction. Not to be confused with COPD (See below).

‘At scale’ provision: Existing or proposed services which are or can potentially be provided across a greater population or geographical area (larger scale). Usually used in the context of the whole of south east London or across more than one borough. In primary care, this term is also used to mean a service provided at a much larger scale than found in current GP practices e.g. serving populations of 50,000 or more.

CAMHS: Child and Adolescent Mental Health Services.

Care Pathway: the care and treatment a patient receives from start to finish for a particular illness or condition, usually across several parts of the health service and often including social care. Care pathways as planned for a condition can ensure full seamless integration of all the necessary services.

Carer/informal carer: a person who looks after or supports someone else due to illness or disability. This can be an unpaid, informal carer, who may be family members, including children and young people, who live with the person they care for; or family, friends or neighbours who live elsewhere. Carer is also used to describe paid staff working in care homes and/or supporting people at home, particularly staff who do not have professional qualifications.

CCG (Clinical Commissioning Groups): Statutory Organisations which plan and fund (commission) most local health services. These replaced primary care trusts (PCTs) in April 2013. CCGs are led by GPs and other clinicians. All GP practices in a CCG area are members. Each CCG in south east London covers one borough. CCGs do not commission or fund GP contracts (See NHS England).

CHD (Coronary Heart Disease): the narrowing or blockage of the coronary arteries, the major blood vessels around the heart. (See also CVD).

Commissioning: The planning, buying (procurement) and contract management of health and health care services. This can be for a local community a specific population or a specific condition. This can be done at National NHS, Local NHS or CCG levels.

Continuing Healthcare: CCG-funded packages of care given to those meeting set criteria.

COPD (Chronic Obstructive Pulmonary Disease): The name for a collection of lung diseases including chronic bronchitis and emphysema characterised by irreversible airways and lung damage. (see Asthma).

CSU (Commissioning Support Unit): An organisation providing back-office support (such as IT, HR, contract management and communications) to CCGs.

CQC (Care Quality Commission): An organisation funded by the Government to inspect all hospitals, care homes and care services in England to make sure they are meeting government standards and to share their findings with the public.
CQUINs (Commissioning for Quality and Innovation): A contractual mechanism that allows commissioners to pay providers for completing activities that directly relate to improving the quality of care received by patients.

CVD (Cardiovascular Disease): Also known as heart disease, this refers to diseases that affect the heart or blood vessels. (CVS). Hypertension (high blood pressure) is the most common form.

CVS (Cardiovascular system) the heart, arteries capillaries and veins.

Day case or day surgery: patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day.

Deficit: the net financial position of an organisation where expenditure (outgoings) is greater than income. (opposite: Surplus)

ECG (Electrocardiogram): a test of the electrical activity of the heart.

Elective centre: a hospital or a distinct part of a hospital which provides elective (planned) care, separated from urgent and emergency care.

Elective surgery: planned / non-emergency surgery (i.e. not immediately necessary to save life). This is usually carried out in a hospital either as a day case or an inpatient. Minor surgery may be carried out in a range of approved settings.

Emergency admission: a patient who is admitted to hospital on the same day due to urgent need (also known as urgent admission and unplanned care).

End of Life Care – dignified care of the dying planned as far as possible to include the patient’s wishes as to where they are cared for.

Financial surplus: the net financial position of an organisation where income is greater than expenditure (outgoings) – so there is a surplus of money at year end.

Foundation Trust: a NHS hospital that is run as an independent, public benefit corporation, controlled and run locally. Foundation Trusts have increased freedoms, including around funding of and investment in services. They are regulated by Monitor – The independent regulator of NHS Foundation Trusts.

General Practice – the medical specialty providing a range of health care services within the community. Now typically includes doctors and nurses, May include physiotherapists and other community services.

GP: General Practitioner (s), your local doctor (s). Usually practicing in groups).

GSTT: Guy’s and St Thomas’ NHS Foundation Trust, which runs Guy’s and St Thomas’ hospital and community services across Lambeth and Southwark.

Governing Body: Sets the direction of the CCG by developing plans and priorities for improving NHS services to ensure people in their borough get the best healthcare services possible; and ensures strong and effective leadership, management and accountability. Governing Body members are primarily GPs, together with as CCG executive staff and lay members.

Health and Wellbeing Strategies: jointly-agreed and locally-determined set of priorities for local partners (including CCGs and local Authorities) to use as basis of commissioning plans.

Healthwatch England: an independent organisation giving people a local voice about their health and social care services. It supports and co-ordinates the activity of all the Local Healthwatch.

Healthwatch Southwark: an independent organisation giving people a local voice about their health and social care services. It aims to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. They have a seat on health and wellbeing boards, ensuring that the views and experiences of patients, carers and other service users are taken into account when preparing local needs assessments and strategies such as the Joint Strategic Needs Assessment (JSNA).

HESL: Health Education England – South London region. Health Education England (HEE) is responsible for the education, training and personal development of the workforce in the NHS, and recruiting for values; HESL is the organisation with responsibility for south London within the overall umbrella of HEE.

Home ward: a care pathway (system) in which professional care is delivered to patients in their own homes rather than on a ward in hospital, organising the care in a similar way to a ward. It is a cost effective system and avoids hospital admissions which can cause stress to elderly and vulnerable patients.

Implementation: putting into practice the plans and strategies that have been developed
Independent sector: a range of non-public sector organisations involved in service provision, including private, voluntary and charitable organisations.

Inpatient: a patient who stays overnight in hospital, either following an emergency admission or a planned procedure.

**Intervention**: term for the point at which a medical, social care or other professional gets involved in a person’s healthcare. Early intervention is when this happens before a person’s health is severely affected. This term is also used as a general name for a medical or nursing procedure.

**JSNA (Joint Strategic Needs Assessment)**: a document which analyses the health needs of a population to inform the commissioning of health, well-being and social care services. This document is updated annually.

**KCH**: King’s College Hospital NHS Foundation Trust.

**KHP (King's Health Partners)**: one of five Academic Health Science Centres in England, made up of Guy's and St Thomas’, King’s College Hospital, South London and the Maudsley (SLaM) and King’s College London. It works to transfer research into practice, teaching and clinical practice to the benefit of patients.

**LIS (Local Incentive Scheme)**: a process to encourage GPs to proactively look at specific health objectives for the local population. This has included long term conditions (such as COPD and diabetes), early cancer diagnosis and effective prescribing.

**London Clinical Standards**: These are the minimum standards of care that patients attending A&E / admitted as an emergency or using maternity services should expect to receive in every acute hospital in London. These standards are set out by NHS England and have been agreed by all CCGs. Although they are specific to London, they are consistent with, and sometimes build on, national standards.

**LTC (Long Term Condition)**: a long term or chronic condition or illness that cannot be cured (but can be managed through medication and/ or therapy) and that people live with for a long time, such as diabetes, heart disease, dementia and asthma.

**Mortality rate**: a measure of the number of deaths (in general or due to a specific cause) in a defined population, scaled to the size of that population, per unit of time. National and local mortality rates can be compared and are essential in determining local priorities for services.

**Multidisciplinary / multi-professional teams (MDTs)**: teams comprising different kinds of staff involved in patient care – this could include GPs, nurses, psychologists, occupational therapists, pharmacists, social care staff, hospital doctors and other specialists.

**NHS England**: This body oversees the day-to-day operation of the NHS from April 2013 as set out in the Health and Social Care Act 2012 and is responsible for commissioning some local services, such as GPs, and all specialised services such as prisons, HIV. It also assures the performance of CCGs.

**Our Healthier South East London**: In December 2015, NHS organisations in 44 areas of England were asked to work together to produce a five-year plan (covering up to March 2021) to implement the NHS Five Year Forward View. These plans are called Sustainability and Transformation Plans (STPs).

Our STP is called **Our Healthier South East London** and has evolved from the commissioner-led strategy – established in 2013 by the six Clinical Commissioning Groups in south east London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) - into a partnership between local commissioners and providers, working with local authorities, patients and the public.

**OoH (Out of Hours)**: a term usually referring to services available between 6.30pm and 8.00am and sometimes also at weekends. This sometimes specifically refers to GP type services. OoH may also mean Out of Hospital.

**PHB: Personal Health Budgets**: A personal health budget is an amount of money to support an individuals’ identified health and wellbeing needs, planned and agreed between them and their local NHS team. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive.

Personal health budgets work in a similar way to the personal budgets that many people are already using to manage and pay for their social care.

**Planned Care**: where a patient is referred for treatment and there is a pre-determined pathway of care.
**Primary care**: Sometimes used to describe the services provided by GPs, NHS dentists, optometrists (opticians) and community pharmacists. This may also include other community health services.

**Primary Care Trust (PCT)**: NHS bodies that commissioned primary, community and secondary care from providers before April 2013.

**Proactive care**: care that actively seeks to prevent ill health or a deterioration in health by intervening and working with people before they get ill. (Also called preventive care)

**QIPP (Quality, Innovation, Productivity and Prevention)**: an NHS-wide initiative to deliver more and better services and care with fewer resources. RMS or RMBS: Referral management (Booking)

**Service**: Central referral system for agreed clinical pathways.

**RTT - Referral to Treatment Time**: standards included in the NHS Constitution that establish a patient’s right to be treated within a specified time frame. These standards are The Referral to Treatment (RTT) operational standards that 90 per cent of admitted (requiring at least overnight stay) and 95 percent of non-admitted (outpatient/day case) patients should start consultant-led treatment within 18 weeks of referral. In order to sustain delivery of these standards, 92 per cent of patients who have not yet started treatment should have been waiting no more than 18 weeks.

**Secondary care**: More specialised care, usually after referral from GP (primary care). This can be provided in a hospital or in the community.

**SEL**: south east London

**SELDoc – South East London Doctors On Call** – a co-operative organisation of member practices which provides Out of Hours Services across NHS Lambeth, Southwark and Lewisham CCGs, including telephone advice, GP consultations and home visits

**SLaM**: South London and Maudsley NHS Foundation Trust, providing a range of hospital and community mental health services.

**Social Care**: a range of non-medical services arranged by local councils to help people in need of support due to illness, disability, old age or poverty. Social care services are available to everyone, regardless of background. However rules about eligibility apply.

**Specialist hospital**: a hospital which provides specialist care for complex conditions. There are none in south east London but patients might be referred to one – for instance, the Royal Marsden cancer hospital or Moorfields Eye Hospital.

**Supporting strategies**: Workstreams (programmes of work) that have been set up to support the overall aims of the strategy programme. They are: Information and IT; Communications and Engagement; Workforce; Commissioning models; and Estates.

**STP**: In December 2015, NHS organisations in 44 areas of England were asked to work together to produce a five-year plan (covering up to March 2021) to implement the NHS Five Year Forward View. These plans are called Sustainability and Transformation Plans (STPs).

Our STP is called **Our Healthier South East London**. It has evolved from a commissioner-led strategy – established in 2013 - into a partnership between local commissioners and providers, working with local authorities, patients and the public.

**System-wide**: Across the whole of the health service or health and social care system, sometimes specifically in south east London

**Tertiary care**: very specialised care, usually provided in hospital, where a patient is referred by a secondary care provider. Tertiary care is supplied by Specialists to Specialists

**UCC (Urgent Care Centre)**: a centre which provides care and treatment for minor illnesses and injuries that require urgent attention but that are not critical or life-threatening.

**Unplanned Care**: is care that is not planned or pre-booked with your GP or hospital.

**Voluntary and Community Sector / Organisations**: not-for-profit organisations set up to offer services to specific groups in society. These can be run and staffed by paid professionals as well as volunteers.