Annual report
2013/14
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COMMISSIONING GROUP

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The best possible health outcomes for Southwark people
Welcome

NHS Southwark Clinical Commissioning Group's annual report for 2013/14 is a milestone that marks our first year of achievements. It has been a busy year and we have made great progress in many areas, including developing our plans for care out of hospital through our Primary and Community Care Strategy and our plans for developing health services in Dulwich and the surrounding areas. These projects should make better quality services available to all who need them no matter where they are in the borough.

We are an organisation led by GPs and other clinicians; we understand the needs of patients and are committed to working with other health and social care organisations to create services that are patient-centred. By having local clinicians working together with patients to plan and commission health services, we can focus on the quality and clinical effectiveness of care more than ever before.

This report highlights what we have achieved in 2013/14 through our planning and commissioning activities. A major theme is how working with and listening to local people, patients and partner organisations has helped us to understand what needs to improve. Our plans have been shaped by what people have told us and we intend to continue to talk to local people as we develop and implement them. We have also continued to work with partner organisations to better integrate services and this will continue to be a key focus of our work in 2014/15.

It has been a momentous year for us and we are proud of our achievements with much to look forward to in the coming year. There have been and will continue to be many challenges as demand for healthcare services continues to grow without a corresponding growth in funding. However, we are confident that our plans will help us to address these challenges. We would like to thank our members, patients, partner organisations and stakeholders for their valuable contribution to ensuring that people in Southwark have access to services that are the best they can be. We look forward to continuing to work in partnership to deliver our plans for the coming year.

Dr Amr Zeineldine
Chair
Membe
r Practices Introduction

On 1 April 2013 NHS Southwark CCG took on full statutory responsibility for planning, funding, monitoring and assuring the quality of most of the hospital, community and mental health services provided to people in the London Borough of Southwark. We are a membership organisation; all 45 general practices are members of the CCG, and all GPs vote for the eight GP clinical lead governing body positions. In addition to GP clinical leads, we also have a practice nurse clinical lead in Southwark, voted for by practice nurses.

We, the member practices, are the CCG. We are well placed to be advocates of our patient populations in the commissioning process and to use this knowledge to shape local health services.

We have put a number of structures in place to harness the voice of GPs and nurses into developing plans and informing the CCG decision making processes, as well as holding the governing body to account. One of our challenges is to balance the new roles of clinical commissioners amongst our other roles, which include delivering and coordinating patient care. Moving into our second year of operation we want to explore the opportunities that clinical leadership of commissioning presents and to create new ways of working, bring a new dynamic to the work of the CCG and “build a buzz”.

Our progress through the year

Our biggest projects during the year have been the development of our Primary and Community Care Strategy and the continued engagement and consultation on health services in Dulwich and the surrounding areas. These projects support our ambition to radically improve health services out of hospital and we have worked hard to talk to local people and interested parties to ensure that their views have shaped the way that we have developed our plans. Following a three month consultation in 2013, we plan to develop a new centre to provide primary and community health services and with a focus on supporting people with long term conditions to manage their own...
health. Our preferred option for the site of the centre is the old Dulwich hospital site. This plan is supported by the Primary and Community Care Strategy which sets out our plans to improve quality of care and ensure equitable access across the borough by building capability within primary care to deliver services on a population health basis.

These are exciting developments and we will continue to engage with local communities as these projects progress.

Developing our plans

In July 2014 NHS England launched a national “Call to Action” setting out the key challenges and opportunities that a renewed vision for the health service must address. The challenges included the need for integrated services, more personalisation, better patient experience, consistent and safe care and an increasing shift of emphasis toward prevention and long-term conditions management. NHS Southwark CCG supported “Call to Action” engagement through a specific event held with members of the public in October 2013. We were also able to draw on all the engagement we had done around primary and community care, health services in and around Dulwich, urgent care and mental health.

We were able to use the feedback gained from our engagement events and activities to support the development of our five year strategy and more detailed two year operating plan. These plans include our agreed approach to the Southwark Better Care Fund with Southwark Council details of which are available on page 17.

Working with partners

We work closely with Southwark Council and other partners including other CCGs and health care providers in south east London to improve patient care.

We want to develop increasingly integrated services across health and social care, which offer a pro-active and person-centred approach to care. We are working with Southwark and Lambeth Integrated Care to shape care around the patient, and this is described in more detail in the full report on page 27.

2013/2014 saw the establishment of Health and Wellbeing Boards as key statutory forums for improving the health of the population. Southwark Health and Wellbeing Board has strong input from the CCG and has developed a Health and Wellbeing Strategy to tackle health improvement across the borough, including the wider determinants of health. We are working with colleagues in the Council and other agencies to take this strategy forward.

Planning across south east London

In addition to our local plans we are developing a five year south east London strategic plan with other CCGs and local authority partners and with NHS England. This seeks to ensure that our strategies will complement each other to improve health services across south east London.

Financial Position

In 2013/14, we had a budget of £357 million, received from NHS England and other NHS agencies. At the year end, the CCG had managed its cash flow and stayed within the target balance of under £250,000. We have also achieved a 1% surplus on our overall budget for the year.
Looking ahead

The NHS faces significant pressures. People are living longer with chronic illness and the impact of other conditions such as obesity is forecast to significantly increase the demand for health and social care services in the near future. To respond to this challenge, NHS Southwark CCG will need to transform the services we commission. In 2013/14 we began this transformation through our primary and community strategy, through our approach to integrated, planned and urgent care and through our collaboration on developing a strategy for south east London. In 2014/15, we will be working with public, patients and partner organisations to deliver the changes that are needed through these programmes. Full details of our strategic plans are available on our website at: http://www.southwarkccg.nhs.uk/our-plans/Pages/default.aspx.

In spring 2014, we carried out a survey of the CCG’s governing body members to assess their views on the effectiveness of the governing body in its first year. You can read more about this on page 92 in the Governance Statement. The tenure of four governing body GP clinical leads comes to an end at the end of June 2014 and the CCG is working with Electoral Reform Services to run a selection and election process. All GPs working in Southwark can apply for the roles and are interviewed by a panel including a clinician external to Southwark before the ballot is opened to all GPs to elect the new leads. The new leads take up their positions in July 2014.
Strategic Report

1. Who we are and what we do

NHS Southwark Clinical Commissioning Group (CCG) is a new statutory body established in April 2013 to plan and commission high quality health services for Southwark residents. All 45 GP practices in the borough are members of the CCG and guide the organisation through the governing body. In 2013/14 we were responsible for a budget of £357 million which we used to plan, monitor and pay for hospital, community and mental-health services for the people living in the borough.

More information about how we work with our membership is available on page 47.

You can read our full audited accounts on page 117 of this report. The accounts have been prepared under a Direction issued by NHS England’s Commissioning Board under the National Health Service Act 2006 (as amended). Below is a breakdown of spending for the period from 1 April 2013 to March 2014.

1.1. Break down of spending and who we commission from
1.2. 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)

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 clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

1.3. Our vision for health in Southwark

Our aim is simple - we want to work with the hospitals, community teams and GPs who provide care locally to make sure that the people of Southwark receive the best care possible and live longer, healthier, happy lives.

We continue to work to make sure that all Southwark residents receive high quality, safe and
accessible health services and that, over time, we narrow the gap in life expectancy between the richest and poorest people in the borough.

As a CCG our three top priorities are to:

1. Reduce the number of early deaths (premature mortality) in Southwark.
2. Narrow the health divide between the richest and poorest in the borough.
3. Provide more consistent, high-quality services across Southwark.

1.4 Priorities for improvement

Our priorities for improvement for 2013/14 are listed below. We have made good progress against these priorities and will continue to work on these areas in 2014/15 as set out in our strategic plan and operating plan for 2014/15.

Patients in need of urgent care

We plan to offer more support for people in their homes and improve access to primary care services across the borough to support people better in the community and reduce the need for them to attend hospital. With partner CCGs we also plan to set up urgent care services at King's and St Thomas' hospitals to reduce the pressure on their A&E departments.

People with long term conditions

We want to support more people to better manage their medical conditions. We will invest in developing services in GP surgeries and in community settings that mean people with ongoing health conditions can access specialist services without having to travel too far. Our work with patients and the public to develop health services in Dulwich and the surrounding areas supports this approach to helping people with long-term health conditions.

Integrating health and care services

To make sure that the local health system delivers the best possible health benefits and experience of care for patients, we will be working with local health networks to support the co-ordination of services across health and social care.

People with mental health conditions

We want to improve access to therapy services for people with anxiety and depression and to make sure those patients using these services benefit from the treatment they receive. We want more mental health services to be provided in the community and at patients' GP practices.

Primary and community health services

We want patients to be able to find it easy to see their GP and to receive high quality services at whichever practice in Southwark they are registered with. We want to increase the range of NHS services provided at patients' GP surgeries and in community settings.
Health and wellbeing

Working with Public Health and through the Health and Wellbeing board we want to support the public in adopting healthier lifestyles, optimising their wellbeing and reducing their risk of becoming ill.

2. Working with local people

2.1. Engaging patients and the public

Local patients and residents are at the heart of what NHS Southwark CCG does. The CCG has developed a number of ways in which local people can get involved in having a say and informing the development of our plans.

Over the last year the CCG has progressed a consultation on Improving Health Services in Dulwich and the surrounding areas and organised a number of deliberative events and focus groups as well as attending a range of other community meetings. This resulted in 855 people being actively involved in the project prior to the improvement plans being received and agreed by the governing body in September.

Within a few days of being established, the CCG hosted a well-attended stakeholder engagement event to enable patients, local residents and colleagues working in primary and community care to feed in their views and experiences of both receiving and delivering health care locally. This contributed to the development of the CCG’s Primary and Community Care strategy. Engagement continued over the summer before the strategy was agreed by the governing body in September.

We have run a number of other engagement events to inform service reviews and the development of our plans including the review of the urgent care centre at Guy’s Hospital, the review of the physiotherapy and osteopathy services and the development of extended access to primary care.

We also helped to organise an engagement event jointly with Lambeth CCG, Lambeth and Southwark Councils and the Southwark and Lambeth Integrated Care Programme to better understand what outcomes are important to patients and their families and help us identify how best to support people to stay as healthy and independent as possible.

As part of the government’s Call to Action to gather ideas and potential solutions to inform the development of health plans, the CCG organised a large event which took place in October 2013. Building on feedback the CCG had gained through previous engagement, we used this engagement opportunity to focus on areas directly relating to people’s use and experiences of services and their own health.

Chair: Dr Amr Zeineldine
We focused on the following questions which also included an unfinished statement to enable participants to try and focus on solutions:

1. Is there anything the NHS does which we should stop doing?
   - *The money for our local health services will go further if we…*

2. What should the CCG be doing over the next 3-5 years in order to improve your experience of services?
   - *The NHS will be doing well when services…*

3. What can the CCG do over the next 3-5 years to help more patients to self-manage their long term health conditions and illnesses?
   - *People can be helped to manage their own health by…*

4. What can the CCG and our partners do to help people stay healthy?
   - *People in Southwark will be healthier when they…*

To help ensure the event was as accessible as possible a palantypist was used to provide a complete speech to text service for all participants to benefit from during the presentations and videos.

In order to maximise participants’ input we provided paper tablecloths with the above statements on them so people could write down their own ideas. This was well received by participants.

“The great idea to write stuff down on tables”.

The key messages from these conversations were then fed back to the graphic facilitator to inform the production of a large visual representation of the event and the discussions which took place.

A report from the event was produced which was presented to the governing body and to the Engagement and Patient Experience Committee. Feedback and ideas were given to NHS England as well being incorporated into CCG plans.
The CCG has continued to develop our patient engagement structures throughout the last year and developed a range of resources to support patients who want to become involved. We have in place a pyramidal engagement structure to enable the patient voice to feed into decision-making at every level of the CCG. Each practice based Patient Participation Group (PPG) has one or two patient representatives who attend one of four locality PPGs. The agendas of the locality PPGs reflect the work of the CCG and enable patients to have a say and contribute to commissioning health services on a locality basis. In turn, the locality PPGs have two patient representatives on the Engagement and Patient Experience Committee (EPEC) of the CCG governing body. This is chaired by one of the clinical leads who sits on the governing body. Healthwatch Southwark, Community Action Southwark and the Forum for Equality and Human Rights in Southwark are also members of EPEC.

We have developed a programme of patient leadership training. Working with a group of patients we established a training programme to develop skills for effective meetings and to inform patients of how the NHS is organised in England; the role and responsibilities of the CCG and our engagement structure. The training has been very well received and will run on a continuing basis for patient members of patient participation groups any anyone who wants to get more involved in the CCG.

We have also developed a number of resources including feedback templates, a glossary of terms and an information pack for patient members of PPGs: [http://www.southwarkccg.nhs.uk/get-involved/Pages/default.aspx](http://www.southwarkccg.nhs.uk/get-involved/Pages/default.aspx).

In our first year we have started to use social media to engage with local people who may not have the time to attend meetings by posting on local neighbourhood forums asking for views. We use twitter and have more than 3,000 followers at [https://twitter.com](https://twitter.com). We have also developed a

‘Thank you for taking the time to put this event on… it has been very interesting.’

‘Well done! Tasks are really good, local and specific, very imaginative and fun’.

Chair: Dr Amr Zeineldine
YouTube account and have filmed people giving feedback after events. Over the next year we also want to film local people giving their views about local health services: http://www.youtube.com/channel/UCWZ_8stULEFc-qQUK7SGyQ.

2.2. How we support CCG staff

2.2.1. Training and development

As a new organisation in a new NHS landscape, NHS Southwark CCG was particularly aware of the importance of providing training and development to enable staff to effectively do their jobs. An appraisal scheme was introduced for all members of staff and for the governing body, supported by a personal development plan tailored to individual’s needs. Over 80% of the CCG had an appraisal during 2013/14 and approximately 90% completed generic training seen as mandatory for their role. The CCG was also able to make available over £15,000 during 2013/14 for training specifically defined in individuals’ personal development plans, as a result of an allocation from Health Education South London.

In addition we held a series of all staff development workshops to involve employees in defining priorities of the new organisation, and to promote team working. The workshops were supported by regular monthly staff meetings which are well attended.

To review our progress on training and development the CCG has participated in a CCG specific staff survey, and a Board Effectiveness (governing body) survey. Response rates are high at over 70%, indicating good engagement from staff and the governing body. The results of these will influence our training and development plan for 2014/15.

There is also a Training Study Leave policy for supporting training and development with an application policy for access to funds to support training agreed as part of Personal Development Plans (PDPs) and other vocational training.

Employee consultation is covered by an agreed CCG wide Organisational Change policy. The contents of which are based on employment legislation and human resources best practice. Additionally we ensure that staff are regularly engaged and can feedback through team meetings, full staff briefings and via the CCG staff intranet.

Disabled staff are protected under the terms of the Equality Act 2010. 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 chart below gives a breakdown of the number of CCG members and staff:

<table>
<thead>
<tr>
<th>Number of people on governing body</th>
<th>Number of senior managers on the VSM pay scale</th>
<th>Number of employees of the CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>13</td>
<td>12</td>
<td>2</td>
</tr>
</tbody>
</table>
3. Health and Wellbeing in Southwark

3.1. Health needs in Southwark

Southwark is a densely populated, geographically small inner London borough. Our population is relatively young, ethnically diverse, with significant differences in poverty and wealth. There is wide distribution in educational achievement, access to employment and housing quality.

3.1.1. Population

Estimated at 288,200, Southwark is London’s second largest inner borough. This increased by 31,488 over the last 10 years and is estimated to increase by 33,200 between 2010 and 2020.

A major challenge in improving the health of the population is that a significant proportion of Southwark residents live in the borough only for a short time before moving on. The proportion of people leaving the borough was estimated as being between 16 - 28% in 2009/10. Turnover is highest in the most deprived areas – Peckham, Camberwell, and Walworth.

3.1.2. Southwark health and life expectancy

The main causes of early death or ‘premature mortality’ are heart disease, lung conditions and cancer. Major health indicators such as mortality and life expectancy have improved, but there are significant inequalities for people living in more deprived parts of the borough.

Women in Southwark can expect to live for 83 years and men for 78 years. Despite improvement there is still a significant gap in life expectancy between the best and worst-off areas, for both men and women. The difference in life expectancy between men from the wealthiest parts of Southwark and men from the poorest areas is just over 10 years. This has increased by three years from a decade ago.

3.1.3. Health of children

The number of children under age one who die each year in Southwark continues to fall and in 2009-11, Southwark ranked 19th highest in London.

In 2012, 43% of year 6 children were classified as either overweight or obese. This level is the highest in the country.

Teenage pregnancy rates have seen significant reduction and have halved over past 10 years.

3.1.4. Long term conditions

Long term illnesses such as diabetes, high blood pressure, heart disease and breathing problems affect a large percentage of the population in Southwark. We suspect that around 60,000 people have at least one long-term condition and up to half of them are not aware of their condition.

You can read full details of the health profile of Southwark in Southwark’s Joint Strategic Needs Assessment which can be found at www.southwarkjsna.com.
3.1.5. Improving health

We continued to work closely with the Southwark and Lambeth Public Health Team on projects to prevent ill health. Last year these projects included:

- development of a needs-based population approach to accessing primary care as part of the Primary Care and Community Strategy
- working with the acute trusts on reducing alcohol-related harm and smoking
- development of a primary care incentive scheme to help people with chronic obstructive pulmonary disease (COPD) to stop smoking and increasing the number of people on long term conditions registers
- development of a prescribing incentive scheme to increase statin prescribing, so reducing heart and circulation problems in people at risk
- developing a service to prevent diabetes in those with impaired glucose tolerance called "walk away from diabetes"
- further development of the cardiovascular risk checks programme in 13/14 to improve uptake and intervention in those at risk.

3.2. Southwark’s Health and Wellbeing Board

The Health and Wellbeing Board is a statutory committee of Southwark Council and the forum where we work with key partners from the health and care system to improve the health and wellbeing of our local population and to reduce health inequalities.

Established in April 2013 and replacing the Shadow Health and Wellbeing Board, membership includes the council, NHS Southwark CCG, Healthwatch Southwark, voluntary sector and the Metropolitan Police Service.

The board’s priorities are set out in its Joint Health and Wellbeing Strategy which focuses on three strategic objectives. These are:

- Giving every child and young person the best start in life
- Building healthier and more resilient communities and tackling the root causes of ill health
- Improving the experience and outcomes of care for our most vulnerable residents and enabling them to live more independent lives.

The health and wellbeing strategy is built on a vision shared by the partner organisations and underpinned by shared values and common principles:

"Every child, family and adult has improved health and wellbeing, and accesses a choice of high-quality local integrated services that meet their needs. Together we will invest to make a difference earlier in the lives of local residents, promoting resilience and self-management of health, and giving everyone the best and fairest start. Working together to build a healthier future, we will tackle the root causes of ill health and inequality. We will equip the most vulnerable in our communities to access bespoke and personalised services, and better overcome the impact of disadvantage."

Chair: Dr Amr Zeineldine
3.2.1. **1000 lives – using residents’ stories to develop the strategy**

In spring 2014, the Health and Wellbeing Board launched *1000 Lives – Let’s talk about your health and wellbeing*, a large-scale engagement with people in Southwark to understand their health and wellbeing experiences. The feedback from this work will be used to refresh the Health and Wellbeing Strategy in 2014.

3.2.2. **Better Care Fund**

Announced in June 2013, the Better Care Fund is a national initiative aimed at promoting integration between health and social care, which creates a pooled fund for integration, transferred from health to social care. Local areas are required to develop plans for the use of this fund, overseen by Health and Wellbeing Boards.

The Better Care Fund submission formed part of our Operating Plan submission and was developed jointly between the CCG and Southwark Council, with engagement with other stakeholders including hospitals, staff in health and social care and local residents.

The Better Care Fund for Southwark will total £1.3m in 2014-15, increasing to £22m in 2015-16. This is not all new money but includes existing funding transferred directly from the NHS with pre-existing commitments from both the CCG and Southwark Council from this funding. The CCG has taken account of the transfer from its allocation in 2015/2016 in its financial plans, which are part of our operating plan submission. The Better Care Fund will support a range of schemes to better join up care and support, including social care teams and reablement services, services to help prevent admission, better quality home care and support for discharge and better access to services seven days a week.

The pooled governance and financial arrangements for the Better Care Fund are under discussion and will be agreed over the coming year between the CCG and Southwark Council.

Our Better Care Fund plan is underpinned by a vision for improving services in the community through better joined up working that has been developed over several years and shaped by a range of engagement activity led by the CCG, Southwark Council and Southwark and Lambeth Integrated Care (SLIC). This has included engagement with local residents on the outcomes and benefits that people want to see from integrated services.

There will be further engagement activity as detailed implementation plans for 2015/16 are developed.

**Better Care, Better Quality of Life in Southwark**

*Our vision is for integrated care and support for our local population through well co-ordinated personalised health and care services.*

We want people to live healthy, independent and fulfilling lives, based on choices that are important to them.

Our vision for integrated care in Southwark is for people to stay healthier at home for longer by doing more to prevent ill health, by supporting people to manage their own health and well-being and by providing more services in people’s homes and in the community. We want people to feel in
control of their lives and their care, with the services they receive co-ordinated and planned with them around their individual needs.

We will build upon our existing work to integrate services around people's needs, but recognise that we now need to transform the way we work together across health and care to really achieve this.

Our key aspirations for integrated care in Southwark are to deliver:

- More care in people’s homes and in their local neighbourhoods
- Person-centred care, organised in collaboration with the individual and their carers
- Better experience of care for people and their carers
- Population based care that is pro-active and preventative
- Better value care and support at home, with less reliance on care homes and hospital based care
- Less duplication and ‘hand-offs’ and a more efficient system overall
- Improvements to key outcomes for people’s health and wellbeing
- Stronger, more resilient communities
- Southwark as a great place to live and work.

We will know we have achieved our ambition for integrated health and care in Southwark when we need to rely less on hospital-based care and care homes, because more care that gives patients a better experience and is better value will be delivered in people’s homes and in their local neighbourhoods. People will be admitted to hospital quickly when they need to be, to access to world class facilities and services. Hospitals will be able to discharge people quicker, because effective and proactive services at home and in the community will help people get back on their feet and stay healthy and independent for longer.

We will take a population based approach to health, so that rather than just treating sickness, we recognise and address the wider determinants of ill-health across Southwark and the role of different services in promoting the public’s health. This is set out in Southwark’s Health and Wellbeing Strategy.

4. **Working in partnership**

We have a strong history of partnership working in Southwark. We believe that health in the borough can only be improved by working closely with local partners and we are committed to working even more closely through integrated work programmes. You can read about our integrated work programmes on page 27. Our partners are listed below:

**NHS organisations in Southwark**

- [King's College Hospital NHS Foundation Trust](#)
- [Guy's and St Thomas' NHS Foundation Trust](#)
- [South London and Maudsley NHS Foundation Trust (SLaM)](#)

Chair: Dr Amr Zeineldine
4.1. Carers Strategy

With an estimated 14,000 'hidden' carers in the borough, many of whom are under the age of 18, Southwark Council and NHS Southwark Clinical Commissioning Group created a range of initiatives to identify and support people who look after family or friends who are ill, frail or disabled. From September to December 2013, the council and CCG asked residents, especially carers, to give their views on the draft Carers Strategy, which proposed to introduce a support package to keep carers healthy as well as pro-actively go out and find carers to make them aware of the support available, rather than wait for them to come for help – which can often be at a crisis point. Feedback from this engagement process has supported the development of our joint pledges in relation to investment and support to carers. You can read the full strategy on our website.

4.2. South east London five year commissioning strategy programme

The six Clinical Commissioning Groups in south east London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) and their co-commissioners from NHS England - London region began working together on the south east London commissioning strategy programme in October 2013.

This is a new start, taking a fresh look at the health needs of people across south east London. It focuses on priority health issues for people across south east London which need collective action to address them successfully.

The strategy aims to improve health, reduce health inequalities and to ensure the provision of health services across south east London that meet safety and quality standards consistently and are sustainable in the longer term.
The commissioners are working together and in partnership with local councils, hospitals, community services, mental health services, patients, carers and local people on developing this new strategy. Many health challenges in south east London have been around for a long time. The strategy runs for five years to give everyone time to think about, agree and make improvements.

The strategy is commissioner-led and clinically-driven. It builds on what already works well and is shaped and developed by the views of all the partners and local stakeholders - especially patients and local people. These views are being used from the beginning and throughout the planning process to make sure the strategy is right for south east London.

Borough-level Joint Strategic Needs Assessments, commissioning plans and Health and Wellbeing strategies will continue to be produced locally to identify borough-specific issues and challenges and the plans to address them.

4.3. Community Based Care Strategy

The south east London Community Based Care (CBC) Strategy was written and approved by the six shadow CCGs in south east London in 2012/13. The strategy set out aspirations for community based care which all south east London CCGs committed to deliver.

Each CCG started from a different point and through their operating plans set out plans for year one delivery. These were then embedded into contracts with providers or developed into specific work programmes such as service redesign and other change programmes to be implemented throughout the year. The strategy adopted an approach of ‘Shared Standards, Local Delivery’ whereby each CCG committed to delivering to a standard as set out in the strategy through working with its member practices, local authority and providers. The premise of the shared programme is that by working collectively we can get further faster, learning from one another and implementing some programmes collectively and at scale.

In the first year of the programme (2013/14), a number of projects and programmes of work were successfully delivered across south east London. These include: the publication of an agreed Primary Care Strategy; the launch of a pathfinder programme to support GP practice development; the launch of NHS 111 in some south east London boroughs and in-year handover to a new provider (London Ambulance Service); sharing of learning across all CCGs in each work stream; a ‘Not Always A&E’ campaign to encourage use of appropriate services; the pilot of a self-management booklet; and securing funding from external sources such as Health Education South London, bringing in in principle an agreed £1.6m over three years into the health economy in south east London to support community based care.

4.4. Stakeholder Reference Group

In April 2013, the Clinical Strategy Committee established by the six south east London CCGs decided to form a Stakeholder Reference Group (SRG) that would be accountable to it. The SRG meets four times a year and has an independent chair.

The principal roles of the SRG are to:

- consider how best to engage patients, the public and local authorities in proposed major changes in health services that will impact on more than one CCG
• provide independent and objective assessment and advice to the south east London CCGs regarding patient and public engagement in area-wide change programmes and how that engagement could be strengthened and deepened
• advise the organisations proposing changes how patients and public can be engaged in assessing the impact of their proposals on patient choice
• advise how the diversity of the population is recognised and engagement is responsive to the needs of the different communities in south east London
• enable institutions with potentially far reaching ideas about their future but which are not yet ready to publish firm proposals, to brief a wide range of organisations on emerging thinking.

All those on the SRG are very experienced in and committed to making sure that patients and public have the best change to engage with proposals for changes in health and related series in south east London.

The south east London CCG stakeholder reference group is a unique group in England bringing together:

• CCG clinicians, lay members of the governing bodies, chief officers and engagement leads
• the six Healthwatch organisations
• the six elected member chairs of the borough health and overview scrutiny committees (HOSCs)
• senior representatives of the six umbrella organisations for the voluntary sector
• equalities expertise
• senior representatives of the South London Commissioning Support Unit (SLCSU) and SE London Programme Management Office (PMO)
• representatives as required from NHS England, the acute and mental health trusts and the London Ambulance Service.

The initial meeting of the SRG (May 2013) was very much a transitional event as the group took on and understood its new role and its accountability to the Clinical Strategy Committee. Its subsequent meetings took place in workshop format so that presenters could receive input to their thinking about engagement with public and patients. The process was focused and cost effective in receiving a broad based range of advice and ideas that might have taken some weeks if undertaken through a series of individual meetings with stakeholder groups.

4.4.1. Looking ahead

The focus of the SRG in 2013/14 and looking ahead to 2014/15 has been on south east London wide programmes as they evolve and as patient and public engagement elements change in response, such as:

• SE London Community Based Care Transformation Programme (May and November 2013)
• SE London five year Commissioning Strategy Programme (December 2013 and March 2014)
• Local campaigns such as the ‘Not Always A&E’ winter campaign (November 2013)
• Major institutional developments such as King’s Health Partners (December 2013)
• Collaboration for Leadership in Applied Health Research and Care (CLAHRC) (March 2014)
• Developments with the Academic Health Sciences Network (planned for December 2014)
4.5. Trust Special Administrator (TSA) programme for South London Healthcare NHS Trust

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

- The transfer of the Queen Mary's Sidcup site to Oxleas NHS Foundation Trust, with a range of acute hospital services to be delivered on that site by Dartford and Gravesham NHS Trust, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust.
- The acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust
- The transfer of the Queen Elizabeth Hospital to Lewisham NHS Trust, as a merger by acquisition.

The Secretary of State's remaining decisions were implemented as follows:

- Implementation of the efficiency savings decision for the transferred hospitals is continuing as part of the efficiency programmes of the NHS organisations to which the hospitals were transferred.
- Oxleas NHS Foundation Trust working with NHS Bexley Clinical Commissioning Group, the local authority, other NHS organisations and other partners to implement the decision to develop the Queen's Mary's Hospital site in Bexley as a vibrant hub for local services.
- The decision that vacant or under-used premises should be vacated and sold where possible was partially implemented by South London Healthcare NHS Trust prior to dissolution and the NHS organisations to whom premises were transferred are continuing the programme.
- The decision that the Department of Health should pay the additional annual funds to cover the excess costs of the Private Finance Initiative buildings at Princess Royal and Queen Elizabeth hospitals was implemented.

The decisions made to aid implementation that:

- The Department of Health should write off South London Healthcare Trust’s accumulated debt was implemented.
- The Department of Health should provide additional funds to cover the implementation of the recommendations was implemented. Additional funds were provided by the Department of Health and commissioners. The detail is set out in the NHS Trust Development Authority’s board report ‘Securing sustainable healthcare for the people of South East London’.
- A programme board be appointed under an independent Chair, reporting to the Chief Executive of the NHS Commissioning Board and the Chief Executive of the NHS Trust Development Authority, to ensure the changes are effectively delivered. A programme board was appointed to oversee the implementation of the changes delivered by the TSA programme. The TSA continued to act as chair of the programme board until the dissolution of South London Healthcare NHS Trust, in line with the TSA report.

The decision relating to operational service changes across south east London, subject to the amendments proposed by Sir Bruce Keogh, could not be implemented due to the outcome of Judicial Reviews.

Chair: Dr Amr Zeineldine
5. **NHS Southwark CCG’s programmes for improving health outcomes**

5.1. **Primary and community care**

5.1.1. **Primary and community care strategy 2013/14 - 2017/18**

Our first major project since our launch in April 2013 was to develop our primary and community care strategy. After five months of engagement, planning and development, our governing body approved the strategy at our meeting held in public on 12 September 2013.

Within Southwark we have an ambitious vision for the provision of care out of hospital. To deliver on this vision we need to make sure that our primary and community care services are fit for the future. This will mean that the way that services are organised will need to change, to ensure viability for the future and to be able to meet the requirements of the population.

Our plan concentrates on the provision of services by GP practices and community health services. It describes how we will achieve our aim to improve outcomes for patients as well as providing better value for money. Some of the care provided for Southwark patients is excellent and there are many examples of innovative and high quality care. We know that Southwark people value primary and community care services highly, and want to see a better range of services available outside of hospital, either in or close to their home.

However, our primary and community care services are under pressure from increasing demand as well as constraints on funding. Despite improvements in some areas over recent years, overall the quality of care and outcomes from Southwark’s primary care services are not as good as we would like them to be. The range of services and the quality of those services is sometimes patchy across the borough, and patients do not all receive the same range and standard of services. This plan outlines how we will improve the consistency and equity of services available to Southwark people, supporting improved outcomes.

The full strategy is available on our website at:


5.1.2. **Engagement so far**

Over the past year the CCG has carried out a range of patient and public engagement including engagement events about primary and community care and an event for the review of the urgent care centre. These have provided a greater understanding of what local people feel is important in accessing primary care for both routine and urgent care needs. The key themes from our programme of engagement are that our residents want services that:

- Provide improved access to care for both urgent and routine needs
- Are easy to navigate and consistent
- Deliver joined up services and care
- Support flexible means of accessing care to suit patient needs
- Support continuity of care for patients with long-term conditions

Chair: Dr Amr Zeinedine
We have also engaged with other stakeholders as part of our review of the Lister Walk-in Centre, including our practices, our local acute trust and SELDOC, the GP Out-of-Hours provider. Practices were asked for their views on why their patients accessed the Walk-in Centre rather than their own practice. The common themes were:

- ease of access - both in terms of same day appointments and location
- convenience - opening times
- inability to book appointment with own GP or GP closed
- seeking a second opinion

Following the approval of the CCG’s Primary and Community Care strategy by our governing body, the CCG has worked extensively with all member practices to progress implementation and engage them in exploring new ways of working to deliver enhanced care targeted at the needs of local population groupings. In early 2014 the CCG held two Southwark wide events and a series of locality focused and smaller meetings to progress this work.

5.1.3. Extended Primary Care Access

We have used the feedback from our programme of engagement to inform our plans for extended primary care access. We also hosted two specific engagement events in November 2013 and February 2014 on extended primary care access. Responding to what patients and members of the public have told us, we want to deliver extended access to primary care, 8am – 8pm, seven days a week, which is consistent and equitable, through neighbourhoods of practices working together. Currently there are a number of routes through which patients access both routine and urgent primary care. Our proposal for extended access seeks to use existing resources in a more effective way, in addition to enhancing the current level of primary care access.

5.1.4. Looking ahead

During February and March, we continued to develop a service model informed by further patient engagement with the intention of rolling out across the borough as part of the second phase of work.

A core component of the Primary and Community Care Strategy is building capability within primary care to deliver services on a population health basis and deliver on the strategy’s four key objectives - reducing variation, improving access, supporting integration and extending the range of services available in the community. This includes the establishment of general practice neighbourhoods where practices work collectively to deliver extended services, and improve the quality of services and outcomes for the registered population within their neighbourhood. Going forward, the CCG will continue to provide organisational development support for the 45 general practices within the borough to focus on reducing variation, improving access, improving quality through innovation, service improvement and spreading good practice at a neighbourhood level.

In addition, NHS Lambeth and Southwark CCGs have received funding from Guy’s and St Thomas’ Charity to deliver a leadership and development programme across the two boroughs. This will enable investment in a cohort of 18 emerging leaders from local general practice and will focus on giving providers the time and headspace to begin to shape the role of primary care providers within integrated service models.
5.2. Community Health Services

We wanted to improve the quality of the district nursing service to housebound patients so that patients referred to the service would receive timely visits. We also wanted to clarify for GPs what the service can do.

Working with the service provider, Guy’s and St Thomas’ NHS Foundation Trust (GSTT), we introduced clearer referral guidance for GP practices and hospitals and introduced secure email referral processes. We also set up monthly meetings between GPs and district nurses to enable clear and timely communications between the service, patients and GP practices. GSTT strengthened management of the service by introducing a deputy to offer more operational management support.

Patients are now getting a better service and we have seen a reduction in the number of issues raised by GP practices about the service. In 2014/15 we will continue to monitor and improve the service.

5.3. Improving health services in Dulwich and the surrounding areas

5.3.1. Background

The Dulwich Programme was set up in 2011 to consider what health services should be provided in the south of the borough, and to decide therefore 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 the nearby parts of Lewisham and Lambeth as some of them use health services in Dulwich.

In 2012 we did 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.

5.3.2. The public consultation phase - 28 February to 31 May 2013

The public consultation ran from 28 February to 31 May 2013. We received over 235 written responses. We actively engaged over 620 participants in discussions about the proposals at a range of meetings and events that we ran in the area. We also attended a range of public meetings organised by other stakeholders including Southwark Council where we promoted the consultation.

We consulted on two different options - either having specialist community based care at a smaller centre and in several GP practices across the area, or the option which was most preferred during consultation – a more centralised approach with a single larger centre. Based on what people told us, we plan to develop a larger health centre, and our preferred location is the Dulwich Hospital site.

We also conducted an equalities impact assessment, which examined in more detail the potential impact of our proposals on a number of defined equalities groups. We used the report to inform our decision making and it was updated following the consultation to reflect feedback we received.

Chair: Dr Amr Zeineldine
5.3.3. The consultation outcome

An independent organisation called Opinion Leader collected and analysed all the feedback we received and we held an event on 8 August 2013 to share this feedback with local stakeholders.

The consultation feedback report and equalities impact assessment were discussed at the CCG governing body meeting on 11 July 2013 and again on 12 September 2013 when they agreed plans for improving health services in and around Dulwich.

Based on what local people told us, we plan to develop a new centre to provide improved community health services. Our goal is to improve community services and make them more accessible, joined up and convenient for patients, including a focus on long term conditions.

5.3.4. Next steps

From September 2013 we worked to refine the list of services and look at patient numbers in order to determine the size of the new centre. The service list incorporates the results of the consultation and calculations to determine size using data about current activity, assessments of likely future activity and population changes.

Since January 2014, the owners of the Dulwich Hospital site – NHS Property Services – have begun to progress their work on the development of the whole site including a “soft market testing” process where they worked with a number of developers to see what else could be located on the site and how it could be configured. The developers will be selected from the London Development Panel, set up by the GLA to help release surplus public sector land for housing.

NHS Property Services also consulted the local planning authority and the Southwark Education Department. NHS Southwark CCG and NHS Property Services worked very closely together throughout this process.

At the time of writing, we expect a recommended option in May 2014. At that point, we will know where on the site the health centre building will be and the design process for it can begin. We intend this to be a process that will involve users of services - both clinicians and patients.

5.3.5. Managing the Programme

This work is managed by the Dulwich Programme Board which is a sub-committee of our governing body. It has representation from relevant local NHS organisations, Southwark Council, Healthwatch and two 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
5.4. Integrated care – care shaped around the patient

5.4.1. Southwark and Lambeth Integrated Care

Developing services that are coordinated around the individual is one of the CCG’s key strategic objectives. Over the last two years, we have been working to progress integration with partners including Southwark Council, as part of Southwark and Lambeth Integrated Care (SLIC).

During 2013/14, with support from Guy’s and St Thomas’ Charity and each of our partners, we focused on care for older people and people with long-term conditions.

The Older People’s Programme works with local people, clinicians and professionals to improve the services people aged over 65 receive, so that they experience joined-up care, with less unnecessary time spent in a hospital or care home, and more time receiving care where they want it: in their home or local community.

The key features of this programme are:

- Better proactive identification of need and co-ordination of care
- Provision of alternative urgent responses for people when they are unwell and in crisis
- Maximising independence before long-term care is finalised
- Development of clinical pathways in relation to Falls, Infection, Nutrition and Dementia
- Development of IT infrastructure to support integrated care delivery

The work on testing new approaches to service delivery has begun.

Over the last year*:

- 1514 people have had a Holistic Health Assessment within General Practice to generate their care plan
- 821 people have had their care supported with enhanced nursing, therapy and social care support in community so they do not need to be in hospital
- General Practice and community staff have gained immediate advice from a Consultant in Geriatric Medicine 90 times
- 390 people have had their care discussed at a Community Multi-Disciplinary Team Meeting
- 169 people have had their care co-ordinated by an Integrated Care Manager

*(Please note, these figures are for April 2013 to February 2014 and are about Southwark patients)

To ensure better joined up working, our acute and mental health providers can now securely send clinical documentation directly into the GP system, for example a discharge summary without the dependency of an email or fax.

Our community multi-disciplinary teams are enthusiastically proving that joined up care is possible. They now make better decisions together since we introduced an online tool called Collaborator for them to share, safely and securely, relevant information about people.

We have tested a way that primary care records can be viewed by our hospitals. We are now rolling this out and will also offer primary care access via a locally developed clinical King’s Health Partners online portal.

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We continue to promote the work of ‘myhealthlocker’ (SLaM’s patient portal) and the expansion of it into different health and social care arenas.

We have tested providing GP access to a geriatrician for advice and support 24 hours a day 7 days a week over the last year and this service has been successful. We expect it to be used by more GPs to prevent avoidable A&E attendances and we will test further approaches over the next few months that will provide urgent provision for older people in crisis.

Enhanced Rapid Response and @Home are two schemes that support older people to remain in their own home. They provide immediate access to enhanced levels of therapy, social work and nursing support that people previously would only have received in hospital. Both schemes have been successful in supporting people to either be discharged from hospital earlier, or to prevent them needing to go into hospital in the first place. The success of the @Home pilot, within Southwark, has meant that this service has received funding to expand to cover the whole of Southwark and Lambeth throughout 2014/15.

We have successfully tested new approaches within falls, infections, nutrition and dementia, for example, in addition to the existing falls service, citizens who are at risk of falling will be offered ‘Community Strength and Balance’ classes to help to reduce that risk. The research and testing work was concluded in 2013/4 and will be rolled out 2014/5.

We are reducing avoidable infections. We are testing the use of catheter passports to accompany people on discharge from hospital to ensure that primary care, community services and nursing homes have this information to better manage catheters and reduce the likelihood of infections; a similar approach is being taken with Urinary Tract Infections and cellulitis in the community.

We will ensure that older people are not admitted to hospital because of poor nutrition. A dietetic team is being recruited to test three models of nutritional interventions within the community.

For people with dementia there is a real focus on bringing the dementia pathway together by better aligning health, social and voluntary sector partners to support the dementia journey. Looking ahead, we are working with the SLIC programme to develop plans for further integration including how we commission differently to support more radical integration of services. This work includes developing more outcomes based commissioning and using different contractual and financial incentives to transform the way that care is delivered. We are working with the SLIC Citizen Board to agree which outcomes are most important to local people, and that we should be focusing on improving in future.

Our work within the SLIC programme supports our work with the Council on the Better Care Fund, and includes a number of the schemes within the Better Care Fund.

Our vision for integrated care, developed jointly with Southwark Council, is to develop better joined-up services based around neighbourhoods, and working with neighbourhood groups of GP practices to support better care. We have made progress on developing community based multi-disciplinary teams to support elderly care and will build on this in 2014/2015, seeking to include a wider range of agencies and services, including long term conditions services and housing.
5.5. Planned care

5.5.1. Review of physiotherapy and osteopathy services in Southwark

In early 2013 we reviewed the provision of physiotherapy and osteopathy in Southwark. The review found that, as well as the provision of physiotherapy at hospitals, several GP surgeries also provided physiotherapy or osteopathy services.

We concluded that the provision of physiotherapy and osteopathy within the community was inequitable. It was, therefore, agreed that locality based hubs would be developed in order for patients to receive a more equal opportunity for receiving appropriate community based care. We highlighted the importance of ensuring that any future services were in line with our principles:

- Patients should have consistent access to high quality care, including enhanced services, regardless of where in the borough they live
- Services should be safe, evidence-based and focused on improving outcomes for patients.
- Services should target health inequalities
- Services should be patient centred, seamless and accessible
- Where services can be effectively provided out of hospital and closer to patients' homes, they should be.

5.5.2. Using patients' views

We held an event on 25 September 2013 to talk to patients about their experiences to help shape our plans and we have included patients’ feedback as well as analysis of activity and clinical evidence in a report that will be taken to the CCG governing body with options for a new model of providing these services.

5.5.3. New referral system for dermatology and ear, nose and throat services

In 2013 we launched newly enhanced referral review support functions for dermatology and ear, nose and throat services. The new services offer a single point of referral for all routine GP referrals and support patients to be seen in the right place first time. They also collate and report referrals, conditions and trends to the CCG which inform the development of local referral guidelines and GP training.

A further contribution to quality improvement is via the advice and guidance functions where GPs can seek support from a specialist in order to ensure any appropriate treatment has been provided in Primary Care. The dermatology service also offers treatment to patients in the community.

In 2014/15 the CCG will be reviewing diagnostic pathways. This will inform us of whether any capacity issues exist, identify any required improvements within the patient pathways and support the development of guidelines to ensure appropriate tests for patients are being requested. We are also working with clinical colleagues across primary and secondary care to identify how capacity and waiting times can be managed more effectively for ophthalmology, gynaecology and hepatology.
5.5.4. Supporting patients with long term conditions

Diabetes
Working with the Diabetes Modernisation Initiative we have continued our focus on improving the identification and management of patients with diabetes within primary and community care. We have concentrated on ensuring patients with diabetes feel supported and confident to manage their condition.

Breathlessness
We want to improve our approach to breathlessness across primary, community and secondary care. Key to this will be improving the diagnosis of breathlessness in primary care. We have set up a Breathlessness Working Group to develop a process for improving diagnosis.

Hypertension Community Service
In 2013/14 we set up a community hypertension service to support the management of patients with high blood pressure being cared for out of hospital, this pilot will continue in 14/15.

Integrated respiratory care
During 2013-2014 we have worked on embedding the Integrated Respiratory Care Team (a multi-disciplinary team) to improve the management and outcomes for people with lung disease and adult asthma in Southwark. The service has supported appropriate long term management of patients with respiratory disease within primary care, developed integrated pathways of care for patients with acute exacerbations and worked to improve discharge after an acute admission.

We will also be setting up quality assured diagnostic spirometry services in the north and south of the borough in order to support accurate and early diagnosis of lung disease and adult asthma within primary care.

Helping people to manage their own health
During 2014/15 we plan to widen our focus on helping people with a range of long term conditions to manage their health. We will commission a self-management course helping anyone living with any long term condition to learn new skills to better manage their condition. We also plan to adapt the course for adults who care for someone with a long term health condition. Additionally, the CCG will continue to pilot for a second year Living with Diabetes, a co-delivered self-management course which is jointly led by a person living with diabetes and diabetes trained health care professional and enables people living with diabetes to develop and improve their skills and knowledge to manage their own health.

5.5.5. Award for Southwark Community Diabetes Team

In October 2013, the work of Southwark’s community diabetes team was recognised in the Quality in Care Awards. Quality in Care Awards are run by the publishing company PMGroup and recognise good practice in patient care and joint working in key therapy areas allowing these schemes to be shared and disseminated on a national level.

The team received a commendation from the judges for good practice and collaboration in diabetes. The judges were impressed by the team’s success in bringing together staff from across the health and social care system in Southwark in order to radically improve diabetes care. The impact of bringing specialists in diabetes together to co-design and co-deliver a wide-reaching...
service were highlighted as key achievements. The Community Diabetes Services are provided in Southwark by Guy’s and St Thomas’ NHS Foundation Trust.

5.6. Urgent and emergency care

Urgent care

We have a number of local Urgent Care services operating locally which provide timely advice and treatment. In the past year, we have undertaken reviews of both the Urgent Care Centre at Guy’s Hospital (formerly Minor Injuries Unit) and Lister Walk-in Centre in Peckham. These reviews demonstrated clinical effectiveness and good patient experience. Engagement with patients through mechanisms like events, social media and patient interviews, provided valuable insight and a greater understanding of the factors affecting patient behaviour when accessing urgent care. A recurrent theme from our engagement has been the complexity of the current healthcare system and the need to support patients to access the right service at the right time.

Not Always A&E – winter campaign

The provision of clear information, effective signposting and supporting self-management are key elements of our commissioning intentions for urgent care and access. To support these elements, we worked with CCGs in south London to commission a winter sign-posting campaign. The campaign used eye-catching yellow people with various ailments to highlight common illnesses and indicate the local services that people can access if they need treatment or advice. The campaign used posters on bus-shelters, bill-boards and in pharmacies and GP practices and leaflets distributed to health and social care outlets and all Southwark primary schools. All materials linked to a Not Always A&E website http://www.notalwaysaande.co.uk/ which gave the nearest appropriate service to you according to the illness you put in. In Southwark, we launched the campaign on 10 December 2013 in Peckham Square, engaging with members of the public and drawing them in with 7 feet tall yellow figures.

An evaluation published in April 2014 found that the campaign had significant impact on levels of awareness; 70% of those who had seen or heard about the campaign said they were ‘very likely’ and ‘fairly likely’ to think about non-A&E options in the future.

NHS Southwark CCG works closely with partners across the local health economy. The Lambeth and Southwark Urgent Care Working Group has been operating for over 10 years and has representation from secondary care, primary care, community, mental health, London Ambulance Service and social care. It reviews acute performance and ensures wider whole system actions to support admission avoidance and discharge processes are in place. Our local acute trusts continue to review how the emergency care pathway is operating and identify opportunities for improvement. They have a number of plans in place which include the following:

- Redevelopment of A&E departments creating additional space and improved flow through the department.
- Staff recruitment and increasing availability of senior consultants at weekends and other peak times to facilitate senior decision making
- Increasing the number of beds and operating theatres
- Improving the mental health pathway to provide a better experience for patients
- Improving access to tests/diagnostics and timely results
- Working with community services and social care to simplify the discharge process
5.7. Commissioning for specific groups

5.7.1. Commissioning services for children and young people, adults with physical disabilities, older people, carers and learning disabilities

NHS Southwark CCG works closely with Southwark Council and other partners to ensure that we improve health and social care outcomes for children and young people, adults and older people in Southwark, making best use of joint resources and shaping our services to meet the needs of this population.

We work with Southwark Council to raise the standard and quality of nursing care within care homes and we have developed a joint Southwark Care Home Quality Improvement Strategy. We are implementing this though our My Home Life initiative in Southwark. We have been part of a pan-London Any Qualified Provider procurement process to develop a quality framework for the purchase of continuing health care beds. This framework is supporting our commitment to ensure the quality outcomes for clients placed out of borough.

Southwark CCG with local partners has signed up to the Department of Health Winterbourne View Review Concordat. We are working through our joint Winterbourne View Steering Group to ensure that we jointly consider our commissioning arrangements for people with learning disabilities in order to ensure that we are meeting the requirements of the Programme of Action.

We are committed to person centred planning for adults and older people and, in order to ensure that this is achieved, we have introduced Personal Health Budgets for clients meeting the criteria for NHS Fully Funded Healthcare living in their own homes. From April 2014 we will be extending our Personal Health Budgets offer to clients with a mental health diagnosis and children in receipt of continuing healthcare funding.

We are working with Southwark Council to ensure that our processes allow seamless care for clients whose care funding responsibility transfers across organisation boundaries.

The CCG is committed to ensuring the provision of quality, person centred care for people receiving care in their own homes including adults, children and young people. We have worked in partnership with neighbouring CCGs to procure a Children’s Provider Framework for domiciliary care provision which sets out our expectations for safe, high quality care. Similarly we are working with Southwark Council and provider organisations to review home care provision for adults in Southwark.

For people who have advanced, progressive and incurable illness it is important to support them to live as well as possible until their death. Our goal is to ensure that all patients at the end of their life have effective, high quality services and are given more choice in the decisions about care and preferred place of death. The CCG has appointed a GP Clinical Associate for Cancer and End of Life Care who is supporting the continued use of the Co-ordinate My Care Register and working with staff to ensure the development of end of life skills including advance care planning to support end of life choices.
During 2013/14 we have developed a joint Carers Strategy with Southwark Council, which has been widely engaged on with partners and stakeholders. Feedback from this process has supported the development of our joint pledges in relation to investment and support to carers.

5.7.2. Commissioning Mental Health Services

Southwark CCG continues to commission mental health services based on evidence of need, clinical effectiveness, patient experience, and in response to defined local and national strategic priorities, and health inequalities.

Our 2013/14 mental health commissioning intentions and QIPP (Quality, Innovation, Productivity and Prevention) programme brought together the elements of physical and mental wellbeing with the aim of reducing the onset of mental ill health and helping people to develop the skills to protect and improve their mental health. We also focused on preventing deterioration in those experiencing mental ill health, promoting recovery from mental ill health and preventing suicide. We achieved this by focusing on reviewing and enhancing the areas below.

5.7.3. Adult Mental Health Model

The CCG re-designed services to focus on early identification and early intervention in the community to prevent people experiencing psychosis from requiring admission to hospital. The ‘front-end’ assessment and triage function was enhanced to make it easier and quicker for GPs (and others) to refer patients into the system and ensure that patients are directed to the most appropriate mental health service to meet their needs.

For those patients who are admitted to hospital, the enhanced model of care improves patient flows along the pathway and facilitates discharge from inpatient settings to the most appropriate setting in a timely fashion. In 2014/15, we will continue to develop community services provision to support the new model.

5.7.4. Dementia and memory service

We continued to work with Southwark Council and other key stakeholders to ensure the continued development of dementia services and implementation of the dementia action plan.

We invested in the memory service to increase assessments, stabilise waiting times, and address the continued predicted growth in referral numbers for 2014/15.

In 2013/14 the CCG commissioned a Dementia Adviser service from the Alzheimer’s Society to provide personalised information, advice and signposting services for people with dementia. We also appointed a clinical lead for dementia to roll out a training and awareness campaign for GPs and other health professionals to recognise the early signs of dementia. Working with South London and Maudsley NHS Foundation Trust and GPs, we developed a shared care protocol for the management of medication for people with dementia.

Our GP Lead for learning disabilities has been working with us to identify best practice in early diagnosis of dementia with people with learning disabilities during the annual health check.
5.7.5. Services for older adults

During the past year, we reviewed the level of care provided by the specialist mental health service for older people, focusing on time limited assessment, treatment and successful placement of dementia sufferers with difficult/complex problems.

A full review of the service was carried out and Southwark CGG moved from commissioning from two sites to one site, with a new focus on outcome based care.

The new model of specialist care units will be to provide intensive interventions by concentrating on the effective treatment and care of people with complex behavioural and psychological symptoms of dementia, stabilising individuals with a view to discharge into local care homes.

We are in the process of commissioning an Older Adults Mental Health Specialist Integrated Care Team to support diagnosis and care for older vulnerable people with challenging behaviour at home, in care homes and nursing homes. The team will work with care homes to support the development of knowledge, skills and attitudes of staff in a way that could be transformative to practice. The team will also provide brief interventions that will enhance skills of care home staff.

5.7.6. Child and Adolescent Mental Health Services (CAMHS)

In 2013/14, we carried out a review of referral protocols for CAMHS in both targeted and specialist services, with a focus on CAMHS transitions. We continued to work closely with Southwark Council to improve the way that integrated services are delivered.

5.7.7. Safeguarding Adults and Children

Integrated multi-agency working is the key to our robust joint approach to key safeguarding issues. Keeping adults and children safe is a key priority for us and is an integral part of all our planning, commissioning, contracting and monitoring of delivery of services. We are members of the Southwark Safeguarding Adults Partnership Board and the Southwark Safeguarding Children Board (SSCB) which ensure best practice safety and that any lessons learned from internal management reviews and serious case reviews are embedded in practice at the earliest opportunity.

Safeguarding Children

Southwark CCG has named clinical leads for safeguarding children and adults and designated nurses and doctors for safeguarding children and looked after children (LAC). The designated nurse continues to offer Level 2 training in child protection to all GP Practices in Southwark and additional LAC resource has been identified and work initiated to assess and meet the health needs of this group of vulnerable children.

All GP Practices have signed up to ‘My Learning Source’, a website providing free training on safeguarding children and adults. This supports the training undertaken by the safeguarding lead from each Southwark GP practice in the previous year.

Progress has been made in ensuring the views of children and young people are heard and considered in the planning and development of safeguarding services. A process is now in place to
include the views of young people and carers, through interviews and discussions, as part of multi-agency case audits.

Looking forward safeguarding children work will include contributing to early intervention / early help work through commissioning in order for children, young people and families to be able to access help and have their health needs met at the earliest possible stage; ensuring health service planning and developments consider the views made by children and young people; and strengthening the safeguarding of young people through transition into adult services.

**Safeguarding Adults**

This year we have developed our Safeguarding Adults Commissioning Strategy which sets out our safeguarding expectations for commissioners of services for adults and older people. We are working in partnership with the Southwark Adult Safeguarding and the Learning Disability Partnership Boards to ensure that all the recommendations from the Winterbourne Review are implemented locally.

In preparation for the statutory requirements for adult safeguarding indicated in the new care bill a review of the Safeguarding Adults Partnership Board was undertaken with agreement reached to adopt a new Board Assurance Framework across the partnership. This supports the long history of joint working arrangements for the provision of adult safeguarding across health and social care in Southwark involving all relevant partners.

We are developing our commissioning priorities for adult safeguarding taking account of recommendations from key guidance and legislation and also reflecting local priorities. This includes developing systems for assurance of health providers, monitoring of training on Mental Capacity Act and Deprivation of Liberty and working jointly with Adult Social Care and care home providers to ensure the quality of care delivered within commissioned care homes and intermediate care placements safeguards this vulnerable client group. We will also ensure appropriate safeguarding processes are in place to protect clients placed both in and out of borough who have nursing and continuing care needs, e.g. clients with learning disability and complex needs, including end of life.

6. **Improving quality**

The CCG has a clear duty under law to act to secure improvement in the quality of commissioned services on behalf of the population we serve. We have a further duty to ensure we work as a membership organisation and with NHS England to improve the quality of primary care. The CCG must also act to reduce variation between the different health services commissioned by the CCG and used by the people of the borough.

Improving the quality of commissioned services is the highest priority for the CCG. This means acting to see that the services we commission result in better outcomes for the population of Southwark as a whole as well as for the individuals using commissioned services.

Over the course of the last year the CCG has established and refined our approach to assurance so that we are better able to comprehensively assure the services we commission are providing
care that is of good quality. The CCG has put systems in place to monitor quality and patient outcomes on an on-going basis and to intervene (in partnership with other supervisory and regulatory agencies) where quality and safety standards are not being met to support and oversee improvement.

The CCG has undertaken the following actions over the course of the last year with the aim of improving the quality of patient care delivered by the providers of NHS services that we commission:

- Together with Southwark Council the CCG has responded to the report into Winterbourne View by reviewing all current residential placements for people with learning disabilities and by developing a local plan to ensure that all people with challenging behaviour receive good quality care. See page 44 for further details.
- The CCG has set out a comprehensive response to the Francis Report into Mid-Staffordshire and has taken steps to implement changes in Southwark, which respond to the issues identified in the report. See page 45 for further details.
- The CCG has developed a quarterly Quality Report, which has been designed as a quarterly appraisal of key quality issues across all commissioned providers. The report outlines the key quality issues identified and sets out the approach to resolving the issues identified. The report is reviewed carefully every month by the Integrated Governance and Performance Committee (IGPC) and, in turn the IGPC’s conclusions are reviewed regularly at governing body meetings.
- The CCG has rolled-out a primary care Quality Alert System that looks at quality issues in primary care.
- The CCG has initiated a programme of clinically-led multi-disciplinary site visits to look at services commissioned for the population of Southwark. The CCG has completed site visits to King’s Emergency Department, older adult wards, maternity services and mental health inpatient facilities provided by SLaM.
- The CCG has completed a number of ‘deep-dive’ reviews into areas of quality concern. These reviews have looked in detail at a number of areas including patient complaints; pressure ulcers, falls and healthcare acquired infections. The deep-dives provide assurance to the CCG governing body that known quality issues are being addressed adequately. ‘Deep-dive’ reviews also propose specific recommendation to support rapid resolution of issues identified, overseen by Clinical Quality Review Group meeting. These are joint meetings between commissioners and providers to review the quality and safety of services at providers.
- The CCG has run a number of engagement events to understand patients’ experiences of local health services. This includes a Call to Action engagement event attended by over 70 people as well other large events looking at urgent care and mental health. The CCG also completed a very broad engagement and consultation programme about services in the Dulwich locality. All engagement looked at the quality of care and has informed our approach to making improvements in the year ahead. The CCG is active in the local community; attending community councils and continuing to work closely with the voluntary sector and other local organisations.
- The CCG is further exploring the use of outcome-based approaches to commissioning and contracting with providers. We have also run procurement exercises, which have been informed by the views of patients and by clinical experts.
- The CCG established a number of governing body committees – Integrated Governance & Performance, Commissioning Strategy, Engagement and Patient Experience, Audit – to
assure and scrutinise the quality of care which is currently being delivered and plans for future service change.

- The CCG plays a leadership and assurance role on provider Clinical Quality Review Groups, Serious Incident Committees and provider performance groups. CCG clinical leads and members of the CCG Senior Management Team work formally with providers to identify issues of quality and work through resolutions to these.
- The CCG has instituted a patient engagement 'pyramid', which has been operational since April 2013. Each CCG member practice runs a patient participation group (PPG) for local members of the public to discuss the quality of current services and contribute ideas on service improvement. Practice PPGs feed into locality groups, which themselves contribute members and also issues for consideration at the Engagement & Patient Experience Committee.
- The CCG has developed a Primary and Community Care Strategy (see page 23) in order to reduce the variation in quality and outcomes for Southwark patients using general practice services across the borough.
- We have developed a joint strategy with Southwark Council - My Home Life: Southwark Care Home Quality Improvement Strategy 2013-2015. The strategy sets out how we will work together to improve the quality of care in our local homes. Care homes in Southwark provide essential support to people who are no longer able to live in their own homes. Our vision is that each individual is supported to live their life in accordance with their own beliefs, preferences and culture so they feel comfortable and ‘at home’.

6.1. Quality priorities for next year

The CCG has established a number of programmes to run over the next year with the aim of enhancing our understanding of the quality of commissioned services and enabling us to act to secure further improvement. Key priorities for 2014/15 include:

- Enhancing the number of patients we hear from on a regular basis through our PPG engagement ‘pyramid’ and other channels of communication
- Better understanding patients’ experience of hospital discharge and working to support a better patient pathway from hospital to home
- Addressing capacity and patient flow pressures at the King’s Denmark Hill site
- Improving outcomes for people with anxiety and depression
- Reducing the rate of avoidable emergency admissions
- Reducing the variation in the quality of care received by patients in primary care; enhancing the range of available services and supporting better access.

6.2. Using complaints to improve quality

From the 1 April 2013 NHS England became the commissioner of most Primary Care Services such as GPs and dental services. It now takes the lead in managing complaints relating to Primary Care Services which were previously managed by Primary care Trusts.

CCGs are responsible for managing complaints about directly commissioned local healthcare services. Southwark CCG purchases a PALS and Complaints service from the South London Commissioning Support Unit which manages this on behalf of the CCG. We encourage feedback, positive and negative, so that we can make improvements based directly on the concerns of patients and the public.

Chair: Dr Amr Zeineldine
We regularly analyse the number of PALS queries and Complaints to identify patterns and trends which will both inform current service provision as well as ensuring that fairness and transparency is exercised. Information relating to the number of queries and complaints redirected to NHS England is provided in a monthly report to the CCG.

During 2013/14, there were 19 formal complaints, compared with 175 in 2012/13. The reduction is the result of handing over responsibility for all primary care complaints to NHS England on 1 April 2013.

Of the 19 complaints, one was a legacy complaint first received within the 2012/13 period. Thirteen of the complaints received were found to relate to primary care; information and guidance on these was given to complainants to enable them to contact NHS England as commissioners of that service.

Of the remaining six complaints received during 2013/14 two related directly to treatment and care provided by acute hospital trusts, and the CCG worked in collaboration with these organisations to resolve the complaint.

The final four complaints related directly to the CCG and are described below. The themes from these were access and eligibility for services, for example Individual Funding Requests considered by the CCG:

1. Complaint regarding a funding decision, which resulted in the case being reassessed and funding for continuing health care granted.
2. Complaint regarding communication from continuing care services in order to plan discharge from hospital. This complaint is open and ongoing, and any lessons learned and actions will be reflected in future reports.
3. Complaint regarding treatment at community ear, nose and throat (ENT) service. The complaint has been acknowledged, and the CCG is awaiting the consent of the patient to send on to the ENT service for response.
4. A complaint from a GP practice related to the CCG’s engagement on local strategy. The CCG has reviewed the way it engages and communicates with practices to ensure that systems and processes for consultation are clear.

All complaints relating to services commissioned by the CCG undergo investigation by the commissioning manager appropriate to the nature of the complaint. Information regarding complaints is provided quarterly to the Integrated Governance and Performance Committee, a committee of the governing body, for review and to ensure they are sighted on any themes.

Both routes of exposure allow the nature and trend of complaints to inform future decisions for service redesign and provision.

6.2.1. Provider Trust Complaints

The monitoring of complaints received by King’s College Hospital NHS Foundation Trust and Guy’s and St Thomas’ NHS Foundation Trust is primarily undertaken and reviewed as part of the Clinical Quality Review Groups between the CCG and each of the Trusts. Both Trusts recognise the need to improve the speed of addressing complaints, and both are reviewing their systems in light of the national Clywd report.

Chair: Dr Amr Zeineldine
The CCG’s contract for 2014/15 with the South London and Maudsley NHS Foundation Trust will incorporate a requirement for complaints information to be submitted to the CCG. This data will be monitored and reviewed robustly as part of the core contract meetings between the CCG and the Trust.

6.2.2. Complaints about care – following the Ombudsman’s principles

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

- Get it right
- Be customer focused
- Be open and accountable
- Act fairly and proportionately
- Put things right
- Seek continuous improvement

The CCG continues to work hard to meet the standards set within these principles, working closely with partner agencies such as Healthwatch Southwark, hospital trusts and NHS England to ensure a robust service which reflects the principles of being open and enabling continuous improvement to meet the needs of residents within the borough. A key principle of this policy is to ensure that all complainants will be treated equally and will not be discriminated against because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age, disability or marital status.

6.2.3. Patient Advice and Liaison Service

The CCG provides a Patient Advice and Liaison Service (PALS) to deal with information requests, issues and concerns raised by patients and members of the public.

In addition to the complaints received, there have been 209 PALS enquiries received in 2013/14. In 2012/13, the PALS office took 1234 calls from residents and patients, so there is a clear reduction in the number of enquiries received, which again is a result of handing over responsibility for all primary care PALS enquiries to NHS England. The majority of enquiries related to primary care and were redirected to NHS England. There were a number of enquiries for contact details for CCG services, for example continuing care or mental health commissioning.

The PALS office works closely with the CCG directly commissioned services to ensure that concerns are dealt with promptly and services are improved.

Benefits from the involvement of PALS in 2013/14 included wider sharing of the shared care agreement with GPs to enable the prescribing of medication recommended by specialist services. In one case this related directly to a child for whom the GP had declined to prescribe specialist medication, and this was resolved positively following the sharing of the information.
7. How services performed

The CCG plays a pivotal role in monitoring the performance of our providers and ensuring that Southwark residents receive the best possible healthcare. The CCG manages the performance of providers primarily through contract monitoring meetings and clinical quality review group meetings. These two forums report directly into the Integrated Governance and Performance committee (a sub-committee of Southwark CCG’s governing body) which monitors governance, performance and compliance across all commissioned services.

NHS Southwark CCG’s performance is measured against key performance indicators (KPIs) set out in the CCG Assurance Framework and against NHS Constitutional standards. The KPIs listed below cover a number of treatment waiting time targets as well as key patient safety and quality indicators.

In 2013/14 NHS Southwark CCG has achieved the requisite level of performance in a number of key areas (based on December 2013 ‘year-to-date’ positions unless otherwise stated).

7.1 Performance on NHS National Standards 2013/14

The following table shows NHS Southwark CCG performance against the National Performance Measures included in the Operating Framework for the NHS in England 2013/14. The below performance data reflects the CCG’s position against the indicators in the period stated.
<table>
<thead>
<tr>
<th>National priorities</th>
<th>Year end position 12/13</th>
<th>Target 13/14</th>
<th>M12 YTD 13/14</th>
<th>Traffic light</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT admitted</td>
<td>87.0%</td>
<td>90%</td>
<td>87.5%</td>
<td></td>
</tr>
<tr>
<td>RTT non-admitted</td>
<td>98.0%</td>
<td>95%</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>RTT incomplete pathway (most recent)*</td>
<td>91.8%</td>
<td>92%</td>
<td>93.1% (M12)</td>
<td></td>
</tr>
<tr>
<td>Diagnostic waits &gt; 6 weeks</td>
<td>97.4%</td>
<td>99%</td>
<td>98.2%</td>
<td></td>
</tr>
<tr>
<td>A&amp;E waits (King's Denmark Hill)**</td>
<td>95.4%</td>
<td>96%</td>
<td>93.4%</td>
<td></td>
</tr>
<tr>
<td>Cancer 2 weeks (GP referral)**</td>
<td>98.6%</td>
<td>93%</td>
<td>96.0%</td>
<td></td>
</tr>
<tr>
<td>Cancer 2 weeks (breast symptoms)**</td>
<td>98.0%</td>
<td>93%</td>
<td>96.2%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 days (first definitive)**</td>
<td>98.6%</td>
<td>96%</td>
<td>97.1%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 days (subsequent treatment - surgery)**</td>
<td>100.0%</td>
<td>94%</td>
<td>97.6%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 days (subsequent treatment - drug)**</td>
<td>99.4%</td>
<td>98%</td>
<td>98.9%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 days (subsequent treatment - radiotherapy)**</td>
<td>97.3%</td>
<td>94%</td>
<td>95.5%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 days (GP referral)**</td>
<td>84.2%</td>
<td>85%</td>
<td>87.0%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 days (referral NHS screening)**</td>
<td>93.9%</td>
<td>90%</td>
<td>91.7%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 days (first definitive - Consultant)**</td>
<td>94.4%</td>
<td>85%</td>
<td>88.9%</td>
<td></td>
</tr>
<tr>
<td>Ambulance response times (south east London)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cat. A (Red 1) calls response within 8 mins</td>
<td>NA</td>
<td>75%</td>
<td>77.4%</td>
<td></td>
</tr>
<tr>
<td>Cat. A (Red 2) calls response within 8 mins</td>
<td>NA</td>
<td>75%</td>
<td>75.3%</td>
<td></td>
</tr>
<tr>
<td>Cat. A response within 19 mins</td>
<td>98.2%</td>
<td>95%</td>
<td>97.9%</td>
<td></td>
</tr>
<tr>
<td>Mixed-sex accommodation</td>
<td>115</td>
<td>0</td>
<td>132</td>
<td></td>
</tr>
<tr>
<td>52 weeks waiters</td>
<td>758</td>
<td>0</td>
<td>109</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile (C. diff.) cases</td>
<td>55</td>
<td>49</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>MRSA bacteraemia (assigned to the CCG)</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Smoking quitters****</td>
<td>1,538</td>
<td>796 (Q3)</td>
<td>873 (Q3)</td>
<td></td>
</tr>
<tr>
<td>Proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care</td>
<td>94.0%</td>
<td>95%</td>
<td>98.4%</td>
<td></td>
</tr>
</tbody>
</table>

**IAPT**

- Proportion of people with depression referred for psychological therapy: 9.3%
- Proportion who complete therapy who are moving to recovery: 39.4%

* Month 12 performance
** YTD to month 10
*** YTD to month 11
**** YTD to quarter 3

Chair: Dr Amr Zeineldine
7.2 Biggest achievements

7.2.1 Healthcare Acquired Infections

The incidence of C. difficile was lower than last year and there were fewer than cases than the target for 2013/14. Post infection reviews were completed whenever an MRSA case was reported and learning embedded to ensure incidence remained minimal.

7.2.2 Cancer waiting time standards

All cancer waiting time targets were achieved for Southwark patients.

7.2.3 Four week smoking quitters

Southwark helped to support 520 people to quit smoking by quarter 2 2013/14, more than over the same period last year.

7.2.4 Care programme approach follow up in seven days

There is a requirement for service users discharged from mental health in-patient services who are receiving care under the care programme approach (CPA) process to be followed up within seven days of discharge. Southwark improved performance from 2012/13 and achieved the performance target (95%) in every quarter in 2013/14.

7.3 Challenges addressed

7.3.1 A&E 4 hour wait standard

The target is for 95% of patients to be seen, treated and then admitted or discharged within four hours from arriving in an A&E department. This was achieved at King’s College Hospital in quarters one and two; however it was narrowly missed in quarter three with King’s achieving 94.2% at the Denmark Hill site. The Trust aims to improve performance through the implementation of a number of improvement schemes. Guy’s and St Thomas’ NHS Foundation Trust achieved this target for the year.

7.3.2 Ambulance response times

Most ambulance response times targets are achieved performance targets for Southwark patients. Ambulance response performance red 2; defined as those ‘who present with conditions which are life threatening but less time critical’ has been slightly under target, however the London Ambulance Service has undertaken a series of actions to address performance to ensure that targets are achieved by year end.

7.3.3 Referral to Treatment Times

The CCG maintained a strong performance on Referral to Treatment (RTT) waiting times for Southwark patients who complete treatment without admission to hospital and patients who are still waiting to complete treatment within 18 weeks of referral, consistently achieving these
performance targets in 2013/14. Performance for Southwark patients who complete treatment by being admitted to hospital was not achieved in 2013/14 although performance improved on 2012/13. The CCG is working with partners to ensure that admitted waiting times improve in 2014/15. Long waiting patients are clinically reviewed and kept informed of delays to their treatment.

7.3.4 Improving access to psychological therapies (IAPT)

Recovery rates were below the target of 50% in 2013/14, however the service was focusing on high intensity patients, which resulted in lower recovery rates. The CCG invested in additional resource to increase access to the service which resulted in a significant increase in people entering treatment in the latter part of the year.

7.3.5 Mixed sex accommodation

According to the NHS Constitution, providers of NHS funded care are expected to eliminate mixed sex accommodation except where it is in the best overall interest of the patient involved, or reflects their personal choice. There were 131 mixed sex accommodation breaches for Southwark patients in 2013/14 with the majority occurring at King's College Hospital. The issues that caused the breaches were resolved resulting in no breaches in January 2014.

8 Sustainability report

The health system is committed to reducing its carbon emissions in line with the UK Climate Change Act (2008). The act enables the UK to become a low carbon economy. It sets in place a legally binding framework allowing the government to introduce measures which will achieve carbon reduction and mitigate and adapt to climate change.

As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet these statutory targets. In order to achieve these targets the NHS has committed to reducing its carbon footprint by 10% by 2015. It will then be on track to achieving its legal obligations to reduce emissions by 34% by 2020 and 50% by 2025.

Nearly one third of the NHS carbon footprint can be attributed to pharmaceuticals, medical equipment and devices. This is more than from buildings use or travel. Using pharmaceuticals and equipment appropriately minimises waste, saves money and reduces the carbon footprint of the service.

Commissioning for Sustainable Development is the process by which commissioners improve both the sustainability of an organisation and the way it provides services and interacts with people in the community. It also saves money and resources and benefits patients and staff.

NHS Southwark CCG’s Sustainability Policy adopted in spring 2014 will ensure that the organisation takes a sustainable development approach to its commissioning duties through a Sustainability Development Management Plan.
8.1 Responsibilities

The Chief Officer is responsible for ensuring that NHS Southwark CCG commissions services in a way that is sustainable and meets its statutory duties.

The Deputy Chief Officer is responsible for ensuring that NHS Southwark CCG has a Sustainability Policy and a Sustainable Development Management Plan which will achieve the carbon reduction targets set out in the Climate Change Act (2008) and which supports the NHS Carbon Reduction Strategy.

The Head of CCG Planning and Performance is responsible for ensuring that the Sustainable Development Management Plan is developed and monitored by the Integrated Governance and Performance Committee.

All members and employees of NHS Southwark CCG are responsible for the implementation of the actions from the Sustainable Development Management Plan and to ensure that they are incorporated into their day to day work where applicable.

Environmental sustainability is an important NHS priority. New developments brought into use in the year have conformed to the latest requirements providing better quality patient and staff environments as well as more efficient infrastructure. Capital has been invested in energy efficiency measures such as boiler replacement and new windows.

NHS Southwark shares office accommodation with Southwark Council which was designed to the highest environmental standards including a biomass boiler and rainwater harvesting.

9 Equality report

9.1 Equality, Human Rights and Health Inequalities 2013/14

Over the past year our focus has been on making equality, human rights and health inequalities ‘everyone’s business’ at all layers and levels. Moreover, both the Mid Staffordshire and Winterbourne View enquiries raised fundamental issues of humanity – fairness, respect, equality dignity and autonomy (The FREDA Principles) – all key human rights principles at the heart of high quality care. With this in mind, protecting human rights and enhancing quality and compassionate care are integral to the CCG’s core business and reflected throughout our Operating Plan.

We are making steady progress on our four-year Equality Objectives, a requirement by the Public Sector Equality Duty (PSED). These are:

1. Mental Health – focusing on equality in recovery, prevention and high quality accessible support, care and treatment services – particularly in relation to Black, Asian and Minority Ethnic (BAME) communities

2. Engagement and Patient Experience – engaging and involving patients, carers and stakeholder organisations to develop and improve service access/delivery for Southwark’s diverse population

3. Learning Disability – continue to improve quality of outcomes and autonomy with a particular
focus on the Winterbourne View recommendations

4. Contracts – ensuring that contracts, service level agreements (SLAs) and commissioning specifications are compliant with the Equality Act 2010 and the Human Rights Act 1998 and that compliance is reflected across our QIPP plans and contractual frameworks to support further development.

5. Care Homes in Southwark - improving quality and compassionate care – jointly working with Southwark Council to raise the standard of care in Southwark Care Homes as well as improve the support framework for those with dementia and nursing needs.

9.2 Achievements during 2013/14

9.2.1 Dulwich Health Services Consultation – Setting the Benchmark

We wanted to raise the bar on engaging our local people with a particular focus on the nine “Protected Characteristics” as defined by the Equality Act 2010. With the Dulwich Programme consultation, we feel that we have made some progress. An independent Equality Impact Assessment (EIA) review was conducted before and after the consultation. For over three months, the consultation team engaged and consulted with a wide range of diverse communities across Southwark. The EIA clearly demonstrated the length and breadth of community engagement across the protected characteristics with ‘reasonable adjustments’ identified going forward. The Dulwich Programme consultation represents the first of a series of reviews, which will be completed across other key localities in the borough over the course of the next five years, and this bodes well in terms of building on the high standard that has been set by this process.

Other achievements include:

- The rolling out of Personal Health Budgets (PHBs) for NHS Fully Funded Healthcare clients with learning disabilities
- The establishment of the Winterbourne View Steering Group
- Developed a joint vision for Care Homes in Southwark with the “My Home Life Southwark” Care Home Improvement Project including nursing provision and care for those with dementia
- Agreed a Carers Strategy with Southwark Social Services
- Conducted a comprehensive audit and EIA on improving access and quality of Practice Based Counselling services
- Conducted an EIA on the Primary and Community Health Services Strategy exhibiting the high level of scrutiny the CCG is applying to ensure compliance with the PSED, Equality and Human Rights legislation
- Jointly reviewed with Public Health the prevalence of psychosis amongst the Black Asian and Minority Ethnic (BAME) community to inform local intelligence and clinical/ community care interventions
- Piloted with the South London and Maudsley NHS Trust (SLaM), through its Charitable Trust, a “Faith and Mental Health” project aimed at training faith leaders to promote mental health awareness within their congregation
- Established a Quality Senior Management Team meeting which meets regularly to review our workplan on quality in response to the Francis Report.
9.3 Equality, Diversity and Inclusion

We are an inclusive organisation and pride ourselves on our strong track record of promoting equality of opportunity for all staff. We will ensure that no job applicant or employee is discriminated against either directly or indirectly or receives less favourable treatment on the grounds of age, disability, gender reassignment, marriage or civil partnership/marriage, pregnancy or maternity, race, religion or belief, sex, sexual orientation or trade union activity. Nor will they be disadvantaged by any rules, conditions or requirements unless justified. We aim to provide a professional working environment based on the principles of Fairness, Respect, Equality, Dignity and Autonomy that is inclusive, fosters equality of opportunity, values diversity and is free from bullying and harassment.
Members’ Report

Southwark has a strong history of clinical involvement in commissioning. GPs in Southwark came together as the Southwark Clinical Commissioning Group and were one of the first groups of GPs to have been granted pathfinder status in December 2010.

We are a membership organisation made up of 45 GP practices in Southwark and bound by an agreed constitution. The 45 member practices work together in three localities: Borough and Walworth, Bermondsey and Rotherhithe as well as South Southwark.

GPs meet on a monthly basis in both north and the south of Southwark to discuss local health services in focusing on quality and effectiveness. The issues raised inform clinical leads who chair the meetings and feed in the view of the wider membership to 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.

The CCG has put in place a Council of Members made up of a GP practice representative from every practice. 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 and early on in the year members chose five areas of CCG work on which it wanted regular updates: hospital waiting times, Improving Access to Psychological Therapies and practice-based counselling, community clinics and single point of referral, communication between district nursing and primary care and the Southwark and Lambeth Integrated Care Programme. 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. The Council of Members is responsible for approving the CCG budget and annual plans which it did in March 2014 prior to them being submitted to NHS England. You can find more information about our governance structure in the Governance Statement on page 92.

Multi-disciplinary focus groups have taken place with clinicians from primary care and secondary care to inform the development of the priority areas for the CCG to take forward next year in the areas of mental health, long term conditions, admissions avoidance and planned care.

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 which we developed in response to members’ feedback.

In addition, the CCG also organises ten 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.

We adopted our constitution in August 2012 following consultation with member practices. Signed up to by all Southwark member practices, the document sets out the governance arrangements for the organisation. Following publication of the Francis report in February 2013, we reviewed our constitution and concluded that we were satisfied that our working practices support openness and
transparency. Our constitution is available on our website at

10 Our member practices

<table>
<thead>
<tr>
<th>Borough and Walworth</th>
<th>Bermondsey and Rotherhithe</th>
<th>South Southwark</th>
</tr>
</thead>
<tbody>
<tr>
<td>301 East Street Surgery (East Street)</td>
<td>Albion Street Group Practice</td>
<td>3-Zero-6 Medical Centre</td>
</tr>
<tr>
<td>Aylesbury Medical Centre (Aylesbury Partnership)</td>
<td>Avicenna Health Centre</td>
<td>Acorn Surgery &amp; Gaumont House Surgery</td>
</tr>
<tr>
<td>Blackfriars Medical Practice</td>
<td>Bermondsey &amp; Lansdowne Medical Mission</td>
<td>Camberwell Green Practice</td>
</tr>
<tr>
<td>Borough Medical Centre (Dr Misra)</td>
<td>Bermondsey Spa Medical Practice</td>
<td>Concordia Melbourne Grove Medical Practice</td>
</tr>
<tr>
<td>Borough Medical Centre (Dr Sharma)</td>
<td>Falmouth Road Group Practice</td>
<td>Concordia Parkside Medical Centre</td>
</tr>
<tr>
<td>Maddock Way Surgery</td>
<td>Grange Road Practice</td>
<td>DMC Chadwick Road</td>
</tr>
<tr>
<td>Manor Place Surgery</td>
<td>The New Mill Street Surgery</td>
<td>Dulwich Medical Centre</td>
</tr>
<tr>
<td>Old Kent Road Surgery</td>
<td>Park Medical Centre</td>
<td>East Dulwich Primary Care Centre</td>
</tr>
<tr>
<td>Penrose Surgery</td>
<td>Silverlock</td>
<td>Elm Lodge Surgery</td>
</tr>
<tr>
<td>Princess Street Group Practice</td>
<td>St James Church Surgery</td>
<td>Forest Hill Road Group Practice</td>
</tr>
<tr>
<td>Sir John Kirk Close Surgery</td>
<td>Surrey Docks Health Centre</td>
<td>Hambleden Clinic</td>
</tr>
<tr>
<td>The Trafalgar Surgery</td>
<td></td>
<td>Lister Primary Care Centre - Dr Arumugaraasah</td>
</tr>
<tr>
<td>Villa Street Medical Centre</td>
<td></td>
<td>Lister Primary Care Centre - Dr Hossain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lister Primary Care Centre - Hurley Group Practice</td>
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<tr>
<td></td>
<td></td>
<td>Nunhead Surgery</td>
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<tr>
<td></td>
<td></td>
<td>Queens Road Surgery</td>
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<tr>
<td></td>
<td></td>
<td>St Giles Surgery, Drs Patel, Roseman &amp; Vasant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>St Giles Surgery, Drs Virji &amp; Begley</td>
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<td>Sternhall Lane Surgery</td>
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<tr>
<td></td>
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<td>The Lordship Lane Surgery</td>
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<td></td>
<td></td>
<td>The Surgery (The Gardens)</td>
</tr>
</tbody>
</table>

Chair: Dr Amr Zeineldine
11  Our governing body

The CCG governing body is clinically led and consists of eight elected GP representatives of member practices (currently one role is job shared but there are still only 8 GP votes), three lay members, a secondary care consultant, two nurse members (one from secondary care and one from primary care), the Chief Officer, the Chief Financial Officer, a Public Health representative and a Healthwatch representative. These members are all voting. In addition, the CCG has a number of non-voting members of its governing body: the Director of Service Redesign, the Director of Client Group Commissioning, one Local Authority representatives, a LMC representative and another secondary care doctor who is a representative of King’s Health Partners. The total membership of the governing body is 23, of which 14 are clinical and 12 of the clinical members are voting members. The CCG Chair is Dr Amr Zeineldine.

The governing body for NHS Southwark Clinical Commissioning Group is the body appointed with the main function of ensuring that a clinical commissioning group 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 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.

Andrew Bland has been the Chief Officer throughout the year and up to the signing of the annual report and accounts. Amr Zeineldine has been the Chair throughout the year and up to the signing of the annual report and accounts.

12  Committees of the governing body

The governing body has appointed the following committees and sub-committees, all of whom have delegated authority to form committees and sub-committees to assist them in the discharge of their duties:

- Audit Committee
- Remuneration Committee
- Integrated Governance and Performance Committee
- Commissioning Strategy Committee
- Engagement and Patient Experience Committee
- Dulwich Programme Board (limited to programme life)

All of the committees set out above are accountable to the governing body and 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. You can find more information about our committees and sub-committees in the Governance Statement on page 92. Profiles of our governing body are available in the remuneration report on page 53.

Chair: Dr Amr Zeineldine
13  Joint working with other organisations

The CCG works collaboratively with other CCGs across south east London in joint advisory arrangements for informal cross CCG working, to plan pan-sector wide approaches and to make recommendations to the governing body and the governing body’s committees on issues such as collaborative contracting with providers, system-wide pathways commissioned with primary care, Implementation of shared programmes and cross-clinical commissioning group QIPP initiatives, sharing thinking and learning in relation to clinical commissioning and develop joint strategies and plans.

The CCG works with Southwark Council on plans to collaborate on public health matters, integrated care pathways, reducing health inequalities and other areas through a joint advisory group, the “Southwark Joint Commissioning Group”. The CCG is also represented on the Safeguarding Adults Board, Local Safeguarding Children Board and the Health and Wellbeing Board.

14  Governing body elections in 2014

The tenure of four governing body GP clinical leads comes to an end at the end of June 2014 and the CCG is working with Electoral Reform Services to run a selection and election process. All GPs working in Southwark can apply for the roles and are interviewed by a panel including a clinician external to Southwark before the ballot is opened to all GPs to elect the new leads. The new leads will take up their positions in July 2014.

15  Managing our risks

Our approach to risk management and board assurance is in accordance with legislation and national and local guidance. It seeks to embed recognised and developed best practice through a process of on-going review and improvement whilst underpinning the production of the annual governance statement.

We believe that we have in place a sound governance structure to serve our local population. As part of this we use effective risk management to ensure that our corporate and key objectives are met, and all risks are mitigated and resolved.

Full details of the NHS Southwark CCG approach to risk management can be found in the Final Accounts and the Annual Governance Statement.

15.1  Pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. For full details of how pension liabilities are treated please see Note 16.5.4.5 in the Annual Accounts. For details of senior manager’s pension entitlements please see the CCG’s Remuneration Report on page 53.

Chair: Dr Amr Zeineldine
15.2 Sickness absence data

Sickness absence data is provided in the Financial Statements.

15.3 External audit

NHS Southwark’s external audit services i.e. the statutory audit and services carried out in relation to the statutory audit e.g. reports to the Department of Health are provided by Grant Thornton UK LLP. The fee for the service for 2013-14 is £93,000 +VAT. NHS Southwark CCG received no further assurance or non-audit services from Grant Thornton UK LLP during 2013/14.

15.4 Disclosure of Serious Incidents

The responsibilities of many facets of the NHS changed substantially in 2013. CCGs, new commissioning organisations which came into being in April 2013 as a result of the Health and Social Care Act, are not direct providers of care and have negligible access to patient data. Consequently the possibility for adverse incidents involving data breaches is considerably reduced. Southwark CCG did not have any data breaches or personal data incidents during 2013/14.

Southwark CCG takes data security very seriously. We have our own Senior Information Risk Owner (SIRO) – Malcolm Hines, and Caldicott Guardian – Gwen Kennedy. We buy in expertise on information governance from the South London Commissioning Support Unit. The CCG has an Information Governance Steering Group to monitor compliance; this is a sub-committee of the Integrated Governance and Performance Committee.

CCGs have a responsibility to ensure that provider organisations from who they commission healthcare services have robust systems to manage any Serious Incidents which occur. Southwark CCG does this via meetings with each provider by its governance team, lead clinicians, and relevant directors. During 2013/14 the CCG reviewed and refined its Serious Incidents management systems and updated the Integrated Governance and Performance Committee on a monthly basis.

There were no serious incidents reported for the CCG for the year 2013-14.

You can find details of incidents involving data loss or confidentiality breaches in the Governance Statement on page 91.

15.5 Setting of charges for information

We certify that the clinical commissioning group has complied with HM Treasury’s guidance on setting charges for information.

The CCG’s policy sets out the procedure when a request for information is received, and the timescale in which it is responded to. The CCG will not charge for the majority of requests however we are entitled to charge a fee for the photocopying and postage of information, although we will not make a charge if the cost of raising and processing an invoice is greater. If the request exceeds the appropriate time limit we have the right to make a charge or refuse the request. Such requests are considered by its Information Governance sub group.

Chair: Dr Amr Zeineldine
15.6 Principles for remedy

Principles for Remedy as prescribed by the Parliamentary and Health Service Ombudsman for the investigation and handling of complaints are reflected in the CCG’s Complaints Handling Policy and practices.

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

As per policy, NHS Southwark CCG will ensure that all complainants will be treated equally without discrimination ensuring openness and accountability. Staff handling complaints will ensure that patients and their carers are not discriminated against when a complaint is made and that their ongoing treatment will be unaffected. Every effort will be made to resolve the complaint to the satisfaction of the complainant whilst being fair to the staff/practitioner and each complaint taken on its own merit and responded to accordingly.

You can find more information about how we handle complaints on page 37.

15.7 Employee consultation

You can find information about how we engage and consult with staff on page 14.

15.8 Disabled employees

Disabled employees are protected under the “protected characteristics” of the Equality Act 2010. CCG’s policy confirms that we will make reasonable adjustments to working conditions or to the physical working environment where that would help overcome the practical effects of a disability. The policy also confirms that we will provide support to enable disabled members of staff to participate fully. Reasonable adjustments will be taken into account and full use will be made of the advice and assistance available via current government employment initiatives when consideration is being made of a disabled applicant’s suitability for a vacant post. Our sickness absence policy currently under review, confirms that every effort will be made to facilitate an employee’s return to work including making reasonable adjustments under the Disability Discrimination Act 1995 which may include applications for grants where appropriate and taking advice from Disability Advisers in the Employment Service.

You can find more information about how we support CCG staff on page 14.

15.9 Emergency preparedness

NHS Southwark CCG has an important role to play in Emergency Prevention Preparedness and Response with responsibilities under the Civil Contingencies Act with a key role in ensuring that health services in Southwark remain robust in planning for, and managing surges in demand. We are also required to assist NHS England in the event of a major incident.

Chair: Dr Amr Zeineldine
The CCG has an Emergency Preparedness Officer, currently the Deputy Chief Officer. This role ensures that the CCG has business continuity arrangements in place for its business, and contributes effectively to local and London wide emergency networks. These include the London Emergency Planning and Preparedness and Resilience Network, the London Local Health Resilience Partnership and the Southwark local resilience forum, which includes all the emergency services.

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the governing body.

15.10 Disclosure to auditors

Each individual who is member of the governing body at the time of the Member’s Report is approved confirms:

- So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group’s external auditor is unaware; and
- That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group’s auditor is aware of that information.
Remuneration report

The Remuneration Committee comprises of five members and has met on two occasions during the past year. The Chair of the committee is our lay member, Diane French. A full list of members, their roles and the number of meetings each attended is below.

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Role</th>
<th>Date joined committee</th>
<th>Date left committee (if applicable)</th>
<th>No of committee meetings attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diane French</td>
<td>Lay member (Chair)</td>
<td>April 2013</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Richard Gibbs</td>
<td>Lay Member</td>
<td>April 2013</td>
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<td>2</td>
</tr>
<tr>
<td>Robert Park</td>
<td>Lay member</td>
<td>April 2013</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Dr. Amr Zeineldine</td>
<td>GP Clinical Chair</td>
<td>April 2013</td>
<td></td>
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</tr>
<tr>
<td>Dr. Pat Holden</td>
<td>GP Clinical lead</td>
<td>April 2013</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Dr. Jonty Heaversedge</td>
<td>GP Clinical lead</td>
<td>April 2013</td>
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</tr>
</tbody>
</table>

In addition to the members listed above, the following CCG employees provided the committee with services and/or advice which was material to the committee’s deliberations. governing body profiles

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Bland</td>
<td>Chief Officer</td>
<td>CCG</td>
</tr>
<tr>
<td>Malcolm Hines</td>
<td>Chief Financial Officer</td>
<td>CCG</td>
</tr>
<tr>
<td>Gail Tarburn</td>
<td>Head of HR</td>
<td>CSU HR service</td>
</tr>
</tbody>
</table>

These officers were not present when their own remuneration was being discussed. To allow this diligence, the Southwark and Lambeth committees met together in June 2013, to agree arrangements for both CCG’s.

Remuneration policy

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

Senior managers' performance related pay

The CCG does not have a policy of paying performance related pay for senior managers. 2013-14 was the first year of the CCG, and it has just been announced that there will be a zero pay increase for those on very senior manager’s terms, for the coming year.

Chair: Dr Amr Zeineldine
Senior managers’ service contracts

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 are appointed from 1 April 2013 to 30 September 2014, by the appointments commission.

GP Clinical leads are subject to a two year fixed term, which for four leads ends in June 2014. Election processes are under way with members, to select the new governing body members, and then the Chair of the CCG, by the end of May.

There are no other employment liabilities for the CCG, for any of the above.

Payments to past senior managers

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

Senior managers’ salaries and allowances

See following table:
<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary &amp; Fees</th>
<th>Taxable Benefits (rounded to the nearest £00)</th>
<th>Annual Performance Related Bonuses (bands of £5,000)</th>
<th>Long-term Performance Related bonuses (bands of £5,000)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>TOTAL (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Amr Zeineldine</td>
<td>55-60</td>
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<td>55-60</td>
</tr>
<tr>
<td>Dr. Adam Bradford –GP clinical lead</td>
<td>35-40</td>
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<tr>
<td>Dr. Roger Durston–GP clinical lead</td>
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</tr>
<tr>
<td>Dr. Sian Howell- GP clinical lead</td>
<td>35-40</td>
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<td>35-40</td>
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<tr>
<td>Dr. Simon Fradd-GP clinical lead</td>
<td>35-40</td>
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<tr>
<td>Dr. Pat Holden- GP clinical lead</td>
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<td>35-40</td>
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<tr>
<td>Dr. Nancy Kuchemann-GP clinical lead</td>
<td>20-25</td>
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<td>20-25</td>
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<tr>
<td>Dr. Tushar Sharma – GP clinical lead</td>
<td>20-25</td>
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<td>20-25</td>
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<tr>
<td>Dr. Jonty Heaversedge –GP clinical lead</td>
<td>45-50</td>
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<td>45-50</td>
</tr>
<tr>
<td>Dr. Ruth Wallis-Director of Public Health</td>
<td>NIL</td>
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<td></td>
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<td>NIL</td>
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<tr>
<td>Prof. Ami David-community nurse member</td>
<td>10-15</td>
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<td>10-15</td>
</tr>
<tr>
<td>Dr. Suparna Das-secondary care doctor</td>
<td>0-5</td>
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<tr>
<td>Dr. Tan Vandal – secondary care Dr.</td>
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<td>(from March 2014)</td>
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<tr>
<td>Ms. Linda Drake-practice nurse</td>
<td>35-40</td>
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<td>202.5-205</td>
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<td>240-245</td>
</tr>
<tr>
<td>Ms. Alvin Kinch-Healthwatch</td>
<td>NIL</td>
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<td>NIL</td>
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<tr>
<td>Dr. Richard Gibbs-Vice chair and lay member</td>
<td>10-15</td>
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<td>10-15</td>
</tr>
<tr>
<td>Ms. Diane French-lay member</td>
<td>5-10</td>
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<td></td>
<td>5-10</td>
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</tbody>
</table>

Chair: Dr Amr Zeineldine
<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary &amp; Fees</th>
<th>Taxable Benefits</th>
<th>Annual Performance Related Bonuses</th>
<th>Long-term Performance Related bonuses</th>
<th>All Pension Related Benefits</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Robert Park – lay member</td>
<td>5-10</td>
<td>£000</td>
<td>£000</td>
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<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Mr. Andrew Bland- Chief Officer</td>
<td>120-125</td>
<td>132.5-135</td>
<td>255-260</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Malcolm Hines- Chief Financial Officer/ Deputy CO</td>
<td>110-115</td>
<td>17.5-20</td>
<td>130-135</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Tamsin Hooton- Director of Service Redesign</td>
<td>90-95</td>
<td>37.5-40</td>
<td>130-135</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Gwen Kennedy- Director of Client Group Commissioning</td>
<td>95-100</td>
<td>50-52.5</td>
<td>145-150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prof. John Moxham- Clinical lead for Kings Health Partners</td>
<td>NIL</td>
<td>NIL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Sarah McClinton- Director of Social Services LBS</td>
<td>NIL</td>
<td>NIL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Jane Cliffe- LMC representative</td>
<td>NIL</td>
<td>NIL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Kathy McAdam Freud- LMC representative</td>
<td>NIL</td>
<td>NIL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No taxable benefits were paid in 2013-14.

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.

No payments for loss of office have been made in 2013-14.

Chair: Dr Amr Zeineldine
16 Senior Managers’ Pension Benefits

NHS organisations are required to disclose the pension benefits for those persons disclosed as senior managers of the organisation, where the clinical commissioning group has made a direct contribution to a pension scheme. Due to the nature of clinical commissioning groups, some GPs have served as office holders of NHS Southwark CCG. However, for GPs who work under a contract for services with the CCG, they are not considered to hold a pensionable post and so no pension disclosure is required. From 1 April 2013, NHS England became the employing agency for all types of GPs and pensions contributions have been made by NHS England rather than the CCG. Where fees for service have been paid directly to GPs’ practice, the practice is the employing agency and not the CCG.

Note: This table is only for senior managers disclosed in the Salaries and Allowances Table

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60 (bands of £2,500)</th>
<th>Real increase in pension lump sum at aged 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2013 (£000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2014 (£000)</th>
<th>Real increase in Cash Equivalent Transfer Value (£000)</th>
<th>Employer’s contribution to partnership pension (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Andrew Bland, Chief Officer</td>
<td>5.0-7.5</td>
<td>17.5-20.0</td>
<td>20.0-22.5</td>
<td>60-65</td>
<td>161</td>
<td>241</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Mr Malcolm Hines, Chief Financial Officer/ Deputy Chief Officer</td>
<td>0.0-2.5</td>
<td>0.0-2.5</td>
<td>47.5-50.0</td>
<td>145-150</td>
<td>994</td>
<td>1,054</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Ms Tamsin Hooton, Director of Service Redesign</td>
<td>0.0-2.5</td>
<td>5.0-7.5</td>
<td>20.0-22.5</td>
<td>60-65</td>
<td>272</td>
<td>312</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Ms Gwen Kennedy, Director of Client Group Commissioning</td>
<td>0.0-2.5</td>
<td>5.0-7.5</td>
<td>30.0-32.5</td>
<td>90-95</td>
<td>577</td>
<td>652</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Ms Linda Drake, Practice Nurse, clinical lead for community services and diabetes</td>
<td>7.5-10.0</td>
<td>25.0-27.5</td>
<td>12.5-15.0</td>
<td>35-40</td>
<td>88</td>
<td>297</td>
<td>209</td>
<td></td>
</tr>
</tbody>
</table>

Chair: Dr Amr Zeineldine
Cash Equivalent Transfer Value (CETV)

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 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 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. CETV’s are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation’s workforce. The banded remuneration of the highest paid director in the financial year 2013/14 was £120,000-£125,000. This was 2.53 times the median remuneration of the workforce, which was £48,387. In 2013/14 no employees received remuneration in excess of the highest paid member of the Membership Body/governing body. Remuneration ranged from £7,882 to £111,250. For the purposes of calculating pay multiples remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.
Off-payroll Engagements
Off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months are as follows:

| Total number of existing engagements as of 31 March 2014 | 3 |

The CCG confirms that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

| Number of new engagements or those that reached six months in duration between 1 April 2013 and 31 March 2014. | 3 |
| Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations. | 2 |
| Number for who assurance has been requested. | 3 |
| Number for who assurance has been received. | 2 |
| Number for who assurance has not been received. | 1 |
| Number for who assurance has been terminated as a result of assurance not being received. | 0 |

<p>| Number of off-payroll engagements of Membership Body and/or governing body members, and/or, senior officials with significant financial responsibility, during the financial year | 6 |
| Number of individuals that have been deemed “Membership Body and/or governing body members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both off-payroll and on-payroll engagements) | 26 |</p>
<table>
<thead>
<tr>
<th>GB member</th>
<th>Name and Job Title</th>
<th>Position</th>
<th>Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Amr Zeineldine</td>
<td>CCG Chair Clinical Lead for Integration of Care</td>
<td>Amr has been a GP at the Aylesbury Partnership in Southwark. Special interests - Amr’s areas of special interest include joint injections, rheumatology, sports injuries, and care of the elderly. Amr is leading on integration with a clear objective of joining up all NHS services (Primary and Specialist) with social care, to create seamless, easily accessible and responsive pathways providing the best care possible for our population.</td>
<td></td>
</tr>
<tr>
<td>Dr Patrick Holden</td>
<td>GP Lead for Unplanned Care and 111 and Planned Care</td>
<td>Pat has been a GP in Southwark for 25 years. He started working at the Surrey Docks Health Centre located in the old Surrey Commercial Docks in SE16 in 1988. In addition to being the lead for unplanned care, he is also a Locality Chair which means he leads the local GP members in Bermondsey and Rotherhithe and makes sure their voices are well heard when shaping CCG plans.</td>
<td></td>
</tr>
<tr>
<td>Dr Sian Howell</td>
<td>GP Lead for Medicines Management and GSTT Quality</td>
<td>Sian has been a GP in inner city London for 17 years. After 12 years working in Tower Hamlets, she came to work in Southwark in 2010. Sian provides clinical leadership for Primary and Community Care development, Safeguarding Children, Medicines Management and Clinical Quality at Guy's and St Thomas' Hospital Trust. Sian cares passionately about ensuring the best health services for residents in Southwark, and that this includes developing and supporting excellent general practice close to where people live.</td>
<td></td>
</tr>
</tbody>
</table>

Chair: Dr Amr Zeineldine
<table>
<thead>
<tr>
<th>GB member</th>
<th>Name and Job Title</th>
<th>Position</th>
<th>Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Adam Bradford</td>
<td>GP Lead for End of Life Care, Cancer and Screening and CHD</td>
<td>Adam has been a GP in Southwark for 25 years and works at East Street Surgery in Walworth. He leads the CCG work on cancer services, end of life care and support for long term conditions. He is passionate about helping patients to understand their health conditions so they can stay healthy. His experience as a clinician for a quarter of a century means he understands the health problems of local people and how to care for them. Adam is also a sports doctor and has been the match doctor to Blackheath Rugby Club for over 20 years.</td>
<td></td>
</tr>
<tr>
<td>Dr Roger Durston</td>
<td>GP Lead for Mental Health and SLAM Quality and Dulwich Programme</td>
<td>Roger has been a GP in Camberwell for 33 years and has lived locally for 58 years, attending medical school in south east London. He is the clinical lead for mental health and the local provider of mental health services, the South London and Maudsley NHS Foundation Trust. He also is the GP lead for the project Improving services in Dulwich and the surrounding areas which looks at making services outside hospitals in Dulwich, Camberwell and Peckham better. He has been actively involved in talking to local people about their experiences in order to shape plans.</td>
<td></td>
</tr>
<tr>
<td>Dr Jonty Heaversedge</td>
<td>GP Lead for Engagement, KCH Quality and Respiratory lead</td>
<td>Jonty has been a GP in Southwark for 12 years and prior to this trained as a GP in south east London. Jonty is passionate about the importance of involving and empowering patients – both in the management of their own health and in the work of the CCG, ensuring that all commissioning decisions are effectively informed by Southwark residents. He is the GP lead</td>
<td></td>
</tr>
</tbody>
</table>

Chair: Dr Amr Zeineldine
for engagement – both with CCG member practices and the public. He chairs the Engagement and Patient Experience Committee (EPEC) and regularly presents at local CCG engagement events.

Jonty is also GP Lead for quality and performance at King’s College Hospital and is Chair of the Clinical Quality Review Group (CQRG). He is currently working to ensure that all of the lessons learned following the Francis Report, and other reviews of care quality in England, are effectively incorporated into the work of the CCG and King’s College Hospital as one of the main providers of care to Southwark residents. He is also the clinical lead for long-term respiratory conditions and public health outcomes and he co-chairs the Borough and Walworth Locality meeting.

In addition to his roles in the CCG Jonty is currently providing clinical leadership on the Primary and Community Care Workstream for the South east London Community Based Care Programme and he sits on the Clinical Board for Primary Care Transformation in London.

Dr Simon Fradd
GP Lead for Continuing Care

Simon has been a GP in Southwark since July 2006 when he took over practices in Camberwell Green and East Dulwich. He was also a GP principal in Nottingham until leaving to take up his post as a clinical lead for Southwark PCT in October 2010. His experience means he is well suited to his role as clinical lead for continuing care.

Simon has a particular interest in depression and anxiety and in surgery and self-care. He is a member of the National Self Care Forum.

Also as a South Southwark locality chair he ensures the views of GP members in the area are used to develop CCG plans.

Chair: Dr Amr Zeineldine
<table>
<thead>
<tr>
<th>GB member</th>
<th>Name and Job Title</th>
<th>Position</th>
<th>Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Tushar Sharma</td>
<td>GP Lead for Dementia</td>
<td>Dr Tushar Sharma has been a practicing GP in South London for the past five years. He currently works in Bermondsey. He also has a Diploma from the Royal College of Obstetricians and Gynaecologists and completed an MBA from London Business School in 2013. Tushar is the clinical lead for dementia and has already undertaken work in Southwark to improve dementia diagnosis in Southwark. Currently Southwark's dementia services are ranked amongst the best services in the country by the Department of Health.</td>
<td></td>
</tr>
<tr>
<td>Dr Nancy Kuchemann</td>
<td>GP Lead for Learning disability, Carers and SLAM Quality</td>
<td>Nancy has worked as a GP in Southwark for twelve years, eight of them as a partner at Villa Street Medical Centre. She has previous experience as the GP representative on the Southwark Mental Health Partnership Board and was involved in service reconfigurations such as improving pathways into secondary mental health care following the closure of the Maudsley Hospital Emergency Clinic and the establishment of the Southwark Psychological Treatment Service. As well as mental health, her clinical interests include the care of people with substance misuse, the patient experience and health-related behaviour, medically unexplained symptoms and health promotion. In her GP Lead role her portfolios will include the quality of local mental health services, the health of adults with learning disabilities and the welfare of carers.</td>
<td></td>
</tr>
</tbody>
</table>

Chair: Dr Amr Zeineldine
<table>
<thead>
<tr>
<th>GB member</th>
<th>Name and Job Title</th>
<th>Position</th>
<th>Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linda Drake</td>
<td>Practice Nurse, Clinical Lead for Community services and Diabetes</td>
<td>Linda has lived in Southwark and worked as a practice nurse for 30 years. During this time she has seen the development of the role of Practice Nurse and its contribution to improving the standard of primary care and reducing inequalities. Linda spends most of her clinical time working with people living with diabetes, and has a special interest in supporting people with long term conditions to manage their own care. This work supports and informs her involvement in the commissioning of community services and services for people living with long term conditions. She also has a Master’s degree in Primary Care Development.</td>
<td></td>
</tr>
<tr>
<td>Professor Ami David MBE</td>
<td>Registered Nurse, Clinical Lead for Maternity</td>
<td>Ami is the Registered Nurse Member of NHS Southwark Clinical Commissioning Board. She is a Visiting Professor in Nursing London South Bank University and a Fellow of the Queens Nursing Institute. In the Queen’s honours list in January 2007 she was awarded an MBE for services to nursing and health care and was awarded the Commonwealth Fellowship in 1995.</td>
<td></td>
</tr>
<tr>
<td>Dr Richard Gibbs</td>
<td>Lay Member leading on audit, remuneration and governance</td>
<td>Richard is the Deputy Chair of Southwark CCG, as a lay member, with lead responsibility for audit and governance. He is a healthcare management consultant with a particular interest in strategies for improving the value of information analysis and IT, and has a long history of leadership within the NHS. He is a Trustee of Pembroke House, a charity in Walworth that helps disadvantaged communities. He has lived in Dulwich for 41 years.</td>
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<tr>
<td>GB member</td>
<td>Name and Job Title</td>
<td>Position</td>
<td>Profile</td>
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<td></td>
<td>Robert Park</td>
<td>Lay Member leading on quality of commissioned services</td>
<td>Robert is the Lay Member with responsibility for performance and quality, and also chairs the Dulwich Project Board of Southwark CCG. Since coming to London in 1964, he has lived mostly in Southwark. He has experience of working in industry and local government, but most of his career was spent working for UK banks, finally as a senior executive with NatWest. He has been a Trustee of Cambridge House, a community based charity in Camberwell for 40 years, and chair of Elephant Jobs, another community organisation on the Aylesbury Estate for nearly 30. He became involved with the NHS in 2005 as a non-executive director of Southwark Primary Care Trust.</td>
</tr>
<tr>
<td></td>
<td>Diane French</td>
<td>Lay Member leading on patient and public engagement</td>
<td>Diane has lived in south east London for over 10 years, currently in Peckham Rye. Her career to date has mainly been in the Health and Social Care sector and she is currently a Director of a national Mental Health charity which provides a range of services from care homes to employment support. Her early career involved front line work in homelessness, mental health, social housing and substance misuse. She then spent a number of years working in public health and partnerships; including roles in research and evaluation, outcome monitoring, commissioning, and leading implementation and change programmes.</td>
</tr>
<tr>
<td>GB member</td>
<td>Name and Job Title</td>
<td>Position</td>
<td>Profile</td>
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</tbody>
</table>
| Andrew Bland | Chief Officer | Chief Officer | Andrew has worked in the NHS for 15 years and in Southwark since 2009. As Chief Officer for the CCG he works closely with the Chair, our governing body and the CCG’s membership to lead commissioning in Southwark.  

His previous roles mean he is well placed to tackle the challenges the NHS currently faces. Throughout his career Andrew has led major programmes of service redesign across primary and secondary care and has experience of commissioning in all aspects of care and primary care contracting. He was appointed as Managing Director of Southwark Business Support Unit in April 2011 so has led the organisation through its transition from a Primary Care Trust to a CCG.  

Andrew is passionate about involving local residents in the work the CCG does. He believes that bringing together clinical expertise of the doctors and nurses leading the organisation and the knowledge and experiences of patients can bring about real sustainable change and make NHS services in Southwark the best they can be. |

Malcolm Hines | Chief Financial Officer | Malcolm’s current role as Chief Financial Officer includes managing Finance, Governance, Membership and Engagement, HR and a range of support services within Southwark CCG. He has been a Director in Southwark since 2002, and previously worked at Board level in Health Authorities and Trusts. He has 20 years’ experience as a NHS Finance Director. |
<table>
<thead>
<tr>
<th>GB member</th>
<th>Name and Job Title</th>
<th>Position</th>
<th>Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tamsin Hooton</td>
<td>Director of Service Redesign</td>
<td>Tamsin joined the NHS as a graduate trainee on the financial management training scheme. After qualifying as an accountant and working in a number of finance roles she switched paths to commissioning, and was one of the first employees of Southwark Primary Care Trust, as Head of Mental Health Joint Commissioning. Over the last 10 years Tamsin has held a number of senior commissioning roles across south east London and is a Southwark resident.</td>
<td></td>
</tr>
<tr>
<td>Gwen Kennedy</td>
<td>Director of Client Group Commissioning</td>
<td>Gwen has a background in nurse management, clinical leadership and commissioning. She has held a number of senior joint commissioning posts across both adult and children’s services and has over five years’ experience of working at Assistant Director Level in health and social care. Gwen is a registered nurse and health visitor and has a sound background in safeguarding. Gwen’s career includes experiences of heading transformational service re-design projects, leading and managing key clinical and management strategies across health and social care for specific client groups, including mental health, substance misuse, continuing care and community health services.</td>
<td></td>
</tr>
<tr>
<td>GB member</td>
<td>Name and Job Title</td>
<td>Position</td>
<td>Profile</td>
</tr>
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</tr>
<tr>
<td>John Moxham</td>
<td>Co-opted Member, Director of Clinical Strategy for King’s Health Partners</td>
<td></td>
<td>John is the Director of Clinical Strategy for King’s Health Partners. Prior to this he was appointed Medical Director at King’s College Hospital, now part of King’s Health Partners, an Academic Health Sciences Centre made up of King’s College London, King’s College Hospital, Guy’s and St Thomas’ Hospitals and South London Maudsley Mental Health. He has a longstanding interest in Public Health, particularly the reduction in smoking, and is the Chairman of Action on Smoking and Health (ASH). His family have lived locally to King’s College Hospital in Camberwell, for over 30 years and are enthusiastic “Camberwellians”.</td>
</tr>
<tr>
<td>Dr Ruth Wallis</td>
<td>Director of Public Health</td>
<td></td>
<td>Dr Ruth Wallis has been appointed as Director of Public Health heading up the new public health team for Southwark and Lambeth. Ruth became a consultant in public health medicine in 1990 and has been the Director of Public Health for NHS Lambeth since 2002.</td>
</tr>
<tr>
<td>Dr Tan Vandal</td>
<td>Secondary Care Specialist Doctor, governing body From February 2014</td>
<td></td>
<td>Tan has been a Consultant Urological Surgeon since 1988. Initially at Greenwich District Hospital, he moved to Barking, Havering &amp; Redbridge University Hospitals NHS Trust where he retired as Associate Medical Director. He began his surgical career at Punjab University Hospitals in Pakistan and Lusaka University Hospitals in Zambia before moving to London, where he underwent specialist training at Guy’s Hospital. After being appointed as a Consultant he held successive clinical leadership roles in Secondary Care, including Director of Surgical Division &amp; Associate Medical Director. He was Chair of Urology Tumour Advisory Board for North East London Cancer Network</td>
</tr>
</tbody>
</table>

Chair: Dr Amr Zeineldine
and Specialist Urology Cancer Peer Reviewer for London Zone. As Associate Medical Director his portfolio included CCG liaison, 7-day Quality Care, Internal Professional Standards, Consultant Job Planning and Appraisal. He was appointed Consultant Member of Southwark CCG governing body in February 2014 and serves on several other CCG Governing Bodies.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alvin Kinch</strong></td>
<td>Healthwatch Southwark representative</td>
<td>Healthwatch is an independent consumer champion for health and social care in England. Healthwatch works with health and social care partners in the planning, delivery and monitoring of services and hold them to account, and also share the direct experiences and needs of patients, children, young people and adults who use services in their local area. Healthwatch is commissioned by the local authority and is accountable to them.</td>
</tr>
<tr>
<td><strong>Dr Jane Cliffe</strong></td>
<td>Local Medical Council representative</td>
<td>Dr Jane Cliffe has been a full time GP at the Gardens Surgery for over 20 years. She qualified from Newcastle Medical School in 1981. She is interested in all General Practice but especially Dermatology and Child Health. Her sessions include sessions in a local GP special interest clinic in Dermatology.</td>
</tr>
<tr>
<td><strong>Alex Laidler</strong></td>
<td>Acting Director of Adult Social Care (acting from March 2014)</td>
<td></td>
</tr>
<tr>
<td><strong>Sarah McClinton</strong></td>
<td>Local Authority representative – Director of Adult Social Care until March 2014</td>
<td></td>
</tr>
<tr>
<td><strong>Dr Suparna Das</strong></td>
<td>Ex-Secondary Care Specialist Doctor until June 2013</td>
<td></td>
</tr>
</tbody>
</table>

Chair: Dr Amr Zeineldine
17 Register of interests

April 2014

NHS Southwark CCG’s Register of Interests is made publicly available at the governing body meetings of the CCG and can be found at http://www.southwarkccg.nhs.uk/about/Governance/Pages/ConflictOfInterest.aspx. The register is maintained by CCG Governance team (contact Sheetal Mukkamala, Corporate Governance Manager sheetal.mukkamala@nhs.net). The register is constructed in line with the CCG’s Constitution and 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 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 London 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.
<table>
<thead>
<tr>
<th>Name (Last / First)</th>
<th>Position Held</th>
<th>Declaration of Interest</th>
<th>Membership</th>
<th>Date Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander Julian</td>
<td>Dulwich Programme Board Member</td>
<td>Senior Estates Manager – Lambeth, Southwark, Lewisham - NHS Property Services</td>
<td></td>
<td>4 July 13</td>
</tr>
</tbody>
</table>
| Rosemarie Barber    | EPEC member | - Committee Member of Surrey Docks Patient Participation Group (PPG)  
- Chair of Bermondsey and Rotherhithe Locality PPG  
- Director of Acorn Yard (Surrey Docks) Management Co. Ltd.  
- Sole trader fo "At One"- alternative medicine and personal development - unlikely to do business with CCG in field of alternative medicine/ personal development.  
PA to Clinical Director (Interventional Radiology), employed by KCL but based at St. Thomas’ Hospital. | | 13 Jan 14 |
<table>
<thead>
<tr>
<th>Name (Last / First)</th>
<th>Position Held</th>
<th>Declaration of Interest</th>
<th>Membership</th>
<th>Date Reviewed</th>
</tr>
</thead>
</table>
| **Bland Andrew**   | Chief Officer | • Employed by NHS Southwark CCG  
 • Partner employed at NHS England as a primary care contracts manager for North West London. | √ | 15 Apr 14 |
| **Boaden Andy**    | EPEC Member   | • Employee of Community Action Southwark, an umbrella organisation for voluntary organisations. | √ | 29 July 13 |
| **Dr. Bradford Adam** | Clinical lead, governing body | • GP Partner at East Street GP Practice  
 • LMC member  
 • SELDOC GP member  
 • Quay Health Solutions, a not-for-profit Community Interest Company (CIC), practice is a shareholder. | √ | 13 Mar 14 |
| **Chappell Andrew** | Internal Auditor | • KPMG Internal Auditor  
 • None | √ | 28 Mar 14 |
<table>
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<th>Name (Last / First)</th>
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<th>Declaration of Interest</th>
<th>Membership</th>
<th>Date Reviewed</th>
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<tbody>
<tr>
<td>Dr. Cliffe Jane</td>
<td>LMC Representative</td>
<td>• GP with Special Interest – Dermatology SELDOC GP member</td>
<td>Audit</td>
<td>15 Apr 14</td>
</tr>
</tbody>
</table>
| Crichlow Nadia      | EPEC Member | • Member of Locality PPG  
• Member of Practice-based PPG  
• Member of Southwark Parent-Carers Council on Steering Committee for Southwark Contact a Family  
Transition worker for Contact a Family (CAF) | | √ | 13 Jan 14 |
| Prof. David Ami     | Registered Nurse Member of governing body | • Registered Nurse Member Lewisham and Lambeth CCG Governing Bodies.  
• Director - Prasand International Ltd, a registered company offering consultancy on risk management to healthcare organisations  
• AD Community Nursing Consultancy (a subsidiary of Prasand International Ltd offering consultancy services to NHS and private health care organisations and the Royal College of Nursing).  
• Fellow Queens Nursing Institute  
• Visiting Professor in Nurse Leadership and Expert Practice London Southbank University. | | 27 Mar 14 |

Chair: Dr Amr Zeineldine

Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people
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<tbody>
<tr>
<td>Dawe Angela</td>
<td>Dulwich Programme Board Member</td>
<td>● Director of Operations, Guy’s and St. Thomas’ Trust Community Services</td>
<td>governing body</td>
<td>25 July 13</td>
</tr>
</tbody>
</table>
| Drake Linda         | Practice Nurse Member of governing body | ● Practice Nurse Elm Lodge Surgery - salaried 15 hours  
● Management Group member South Southwark GP Commissioning Group  
● Husband is Consultant Paediatric Surgeon at GSTT (Evelina Children’s Hospital)  
● Sister is Assistant Practice Manager at Elm Lodge Surgery. | Audit, Remuneration, Integration & Performance, Commissioning Strategy, Engagement & Patient Experience, Senior Management Team, Dulwich Programme Board | 30 Jan 14 |
| Dr. Durston Roger   | Clinical lead, governing body | ● Principal in General Practice in Camberwell - 14% profit share  
● SELDOC GP member  
● Forensic Medical Examiner  
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</thead>
<tbody>
<tr>
<td>Fernandez Sharon</td>
<td>Dulwich Programme Board Member</td>
<td>South London Area Team, NHS England representative</td>
<td></td>
<td>5 Dec 13</td>
</tr>
</tbody>
</table>
| Jacquie Foster      | Head of Governance and Organisational Development | • Employed by NHS Southwark CCG  
• None | | 15 Apr 14 |
<table>
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<tr>
<th>Name (Last / First)</th>
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</thead>
</table>
| Dr. Fradd Simon     | Clinical lead, governing body | • Non Exec & Exec Director of Concordia Health & Concordia Health Group; personal & family members shareholding > 5%  
• Director & major shareholder of Health Workforce (staffing agency)  
• Major shareholder and company secretary of Canary Hall (Property company owning one GP premise in Nottingham)  
• Trustee of Ronald Macdonald Children’s Charities that provides accommodation for families of children in hospital  
• Consultant to Tunstall Health (telehealth)  
• SELDOC GP member  
• Director: Making Sense of Health  
• Member of Self Care Forum - forum of patients, doctors, nurses etc. for raising awareness of self-management of common minor ailments and for long term conditions | governing body | Audit | Remuneration | Integrated Governance & Performance | Commissioning | Strategy | Engagement & Patient Experience | Senior Management Team | Dulwich Programme Board | 17 Apr 14 |

Chair: Dr Amr Zeineldine

Chief Officer: Andrew Bland
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</thead>
</table>
| French Diane        | Lay member governing body | • Executive Director of Richmond Fellowship (not-for-profit provider of mental health services)  
• Board member of 2Care (subsidiary organisation)  
• Board member of new subsidiary “Croftlands” a mental health provider in Cumbria.  
• County of Northampton Council on Addiction (CAN), which provides drug, alcohol and homelessness services is now a subsidiary of Richmond Fellowship | governing body: √  
Audit: √  
Remuneration: √  
Integrated Governance & Performance: √  
Commissioning: √  
Engagement & Patient Experience: √  
Senior Management Team: √  
Dulwich Programme Board: √ | 17 Apr 14 |
| Furey Alison        | Deputy to Director of Public Health - Lambeth and Southwark | • Employed by Southwark Council  
• KPMG Associate  
• Sole trader Public Health Resources | governing body: √  
Audit: √  
Remuneration: √  
Integrated Governance & Performance: √  
Commissioning: √  
Engagement & Patient Experience: √  
Senior Management Team: √  
Dulwich Programme Board: √ | 18 Mar 14 |
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</thead>
</table>
| Gibbs Richard      | Lay member and Deputy Chair, governing body, Conflicts of Interest Guardian of the CCG | • Associate Consultant with Public Health Action Support Team (Public health consultancy), involvement with PHSAT work in SE London.  
• Freelance management consultant in field of healthcare information and analysis  
• Trustee of Pembroke House (Charity in Walworth) | governing body, Remuneration, Integrated Governance & Performance, Commissioning, Strategy, Engagement & Patient Experience, Senior Management, Team, Dulwich Programme, Board | 17 Apr 14 |
| Dr. Heaversedge Jonty | Clinical lead, governing body | • Salaried GP at Walworth Partnership  
• Work in the media both broadcast and print - related to work as a medical practitioner and not a health care commissioner or SCCG representative.  
• Quay Health Solutions, a not-for-profit Community Interest Company (CIC)], practice is a shareholder.  
• SELDOC GP member  
• Contribute to campaigns and conferences on an ad hoc basis which may be sponsored by pharmaceutical companies. | governing body, Audit, Remuneration, Integrated Governance & Performance, Commissioning, Strategy | 27 Mar 14 |
<table>
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<tr>
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<th>Membership</th>
<th>Date Reviewed</th>
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</thead>
</table>
| Hill Emily          | External Auditor | Audit Engagement Lead, Grant Thornton UK LLP  
None | not reviewed | 17 Apr 14 |
| Hines Malcolm       | Chief Finance Officer & Deputy Chief Officer | Employed by NHS Southwark CCG | not reviewed | 17 Apr 14 |
| Dr. Holden Patrick  | Clinical lead, governing body | GP partner at Surrey Docks Health Centre - 22% profit share  
Practice is a member of SELDOC, the only approved provider of OOHs for LSL at present and used by the PCT for opted in practices, but neither I nor any of my partners hold any office in it. I work sessions for SELDOC as deputising GP.  
Practice is a member of Quay Health Solutions, a not-for-profit Community Interest Company (CIC)]. Practice is a shareholder, I am the nominated shareholder but neither I nor my partners hold any office in the organisation. | not reviewed | 17 Apr 14 |
### Declaration of Interest

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<tr>
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<th>Membership</th>
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</thead>
</table>
| Hooton Tamsin       | Director of Service Redesign   | • Employed by NHS Southwark CCG  
• Health Foundation & Generation Q Award – value 5K                                     |                | 21 Jan 14     |
| Dr. Howell Sian     | Clinical lead, governing body  | • Salaried GP at Bermondsey & Lansdowne Medical Mission, including Urgent Care Centre work at Guy’s Hospital contracted to the surgery. |                | 21 Jan 14     |
| Kelly Katie         | Lay Member Development, EPEC   | • Partner is Trustee of 1st Place Children’s Centre, Southwark  
• Southwark registered patient                                                           |                | 13 Jan 14     |
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</table>
| Kennedy Gwen  | Director of Client Group Commissioning             | • Employed by Southwark CCG  
• Lions International Volunteer, Haywards Heath Lions- involved in fundraising activities for local, national and international projects and service duties for the local community. | Audit, Remuneration, Engagement & Patient Experience, Senior Management Team, Dulwich Programme Board | 21 Jan 14     |
<p>| Kinch Alvin   | HealthWatch Southwark Interim representative       | • Member of senior management team of Community Action Southwark - may have some members who are contracted by the NHS to deliver services. Healthwatch Southwark may have some supporters who are contracted by the NHS to deliver services. | Audit, Remuneration, Engagement &amp; Patient Experience | 13 Mar 14     |
| King John     | EPEC &amp; Dulwich Programme Board Member              | • Chair of Hambleden Patient Participation Group and delegate to South Southwark Locality Patient Participation Group.                                                                                                                                                     | Audit, Remuneration                            | 13 Jan 14     |</p>
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</table>
| Dr. Kuchemann Nancy | Clinical lead, governing body | • GP Partner at Villa Street Medical Centre providing medical cover for a residential alcohol and drug treatment Centre run by the charity Equinox.  
• Practice also works with staff from Blenheim Project to provide shared care clinics for people with drugs misuse, funded through the local enhanced service scheme. One GP Partner also contributes to local service development in her capacity as GP with Special Interest (GPwSI) in Substance Misuse.  
• 19.32% of total profit earned by Villa Street Medical Centre. GPwSI role income is variable.  
• Honorary Secretary of the Lambeth and Southwark British Medical Association division. | governing body | ✓ ✓ ✓ | 30 Jan 14 |
<p>| Kwasny-Spechko Ela   | EPEC member   | • Patient Participation Group member - Camberwell Green Surgery | Engagement &amp; Patient Experience | ✓ | 13 Sept 13 |</p>
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</thead>
<tbody>
<tr>
<td>Laidler Alexandra</td>
<td>Dulwich Programme Board Member</td>
<td>Acting Director – Adult Social Care – London Borough of Southwark</td>
<td>√</td>
<td>4 July 13</td>
</tr>
<tr>
<td>Li Leighann</td>
<td>Dulwich Programme Board Member</td>
<td>Head of Customer Services and Facilities Management – Guys and St Thomas Foundation Trust</td>
<td>√</td>
<td>29 Aug 13</td>
</tr>
<tr>
<td>Lynott-Shahumi Mary</td>
<td>EPEC Member</td>
<td>Volunteer HealthWatch, Volunteer Age UK</td>
<td>√</td>
<td>13 Jan 14</td>
</tr>
<tr>
<td>Dr McAdam-Freud Kathy</td>
<td>LMC Representative</td>
<td>LMC Joint Chair for Southwark, GPwSI Diabetes, GP lead in Diabetes for the Southwark Diabetes Community team (1.5session/wk), Support to practices as GP lead for diabetes Southwark Community Team, Clinical Lead for the DMI project (1session / week), Practice is the current pilot provider for Guys Urgent Care Centre.</td>
<td>√</td>
<td>15 Oct 13</td>
</tr>
<tr>
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</tbody>
</table>
| McClinton Sarah     | Director of Adult Social Care, Southwark Council | • None  
• Employed by Southwark Council | √ | 9 May 13  
(left March 14) |
| Professor Moxham John | Clinical Lead – Co-opted governing body Member | • Director of Clinical Strategy - King’s Health partners  
• Consultant Physician and Professor of respiratory medicine, King’s College Hospital NHS Foundation Trust  
• Chair of Board of Trustees, Action on Smoking and Health  
• King’s Health Partners receives substantial research funding/grants | √ | 13 Mar 14 |
| O’Hanlon Mairead    | EPEC Member   | • Chair MGP  
• Director - Cushmore Consultancy Ltd. | | 18 Nov 13 |

Chair: Dr Amr Zeineldine
Chief Officer: Andrew Bland
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<tr>
<td>Dr. Olufemi Osonuga</td>
<td>GP Lead- Dulwich Programme Board Member</td>
<td>• GP partner Manor Close Surgery and Sir John Kirk Close Surgery</td>
<td></td>
<td>17 Apr 14</td>
</tr>
<tr>
<td>Park Robert</td>
<td>Lay member governing body</td>
<td>• Trustee of Cambridge House (Cambridge House has contracts from health &amp; social care commissioners of the order of £2-300k)</td>
<td></td>
<td>15 Apr 14</td>
</tr>
<tr>
<td>Puddicombe Abi</td>
<td>EPEC Member</td>
<td>• Patient Participation Group Chair for Aylesbury Partnership</td>
<td></td>
<td>13 Jan 14</td>
</tr>
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Chair: Dr Amr Zeineldine

Chief Officer: Andrew Bland
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</thead>
</table>
| Rice Andrew        | EPEC member   | - PPG Member, Parkside Concordia MC, Camberwell Green  
- Chair of Board of Trustees - Faces in Focus  
- Board Member - Southwark HealthWatch  
- Trustee - Community Action Southwark - potential bidders to deliver health related services on behalf of SCCG  
- Chair of Southwark Disability Forum.  
- Member Forum for Equality and Human Rights in Southwark and its representative on EPEC. | | 13 Sept 13 |
| Scott Rebecca      | Director for Dulwich Programme Board | - Owner of Rebecca Scott Associates providing consultancy/contractor services to NHS organisations  
- Partner is GP in Camden | | 27 Mar 14 |
<table>
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<tbody>
<tr>
<td>Dr. Sharma Tushar</td>
<td>Clinical Lead, governing body</td>
<td>• Salaried GP – Spa Medical Centre</td>
<td></td>
<td>27 Mar 14</td>
</tr>
</tbody>
</table>
| Barry Silverman    | EPEC member   | • Borough and Walworth Locality PPG member  
• Trustee/Director Blackfriars Settlement  
• Governor GSTT NHS Foundation Trust  
• Member London Regional Committee National Institute for Health Research [Research for Patients’ Benefit Programme],  
• Member NHS England Clinical Priorities Advisory Group (CPAG)  
• Board member – Improving Urgent Care Programme Board – (NHS 111 Services) – NHS England | | 13 Jan 14 |
| Solly Jill          | Dulwich Programme Board Member | • Head of Primary and Secondary care interface at King’s College Hospital  
• Registered Nurse | | 9 Jan 14 |
<table>
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<th>Membership</th>
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</thead>
</table>
| Sturgeon David      | Dulwich Programme Board Member | • Head of Primary Care, South London NHS England  
• None | ✔ | 23 Apr 13 |
| Suttar Dadoo         | EPEC member  | • Peckham and Camberwell Locality Patient Participation Group member | ✔ | 13 Jan 14 |
| Swann Kieran        | Head of Planning and Performance  | • Employed by NHS Southwark CCG  
• None | ✔ ✔ ✔ ✔ | 27 Mar 14 |
| Thomas Neil         | Internal Auditor  | • Head of Internal Audit, KPMG  
• None | ✔ | 20 Dec 13 |
| Mr. Vandal Tan       | Secondary Care Specialist Doctor, governing body | • Secondary Care Doctor member of Governing Bodies for Lambeth, Lewisham, Bromley, Tower Hamlets, Havering, Barking & Dagenham Clinical Commissioning Groups  
• Co-Director Essex Urology Services  
• Consulting & Admitting Rights, Spire Hartwood Hospital, Brentwood Essex CM13 3LE | ✔ ✔ ✔ | 27 Mar 14 |

Chair: Dr Amr Zeineldine

Chief Officer: Andrew Bland
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</thead>
</table>
| Dr. Wallis Ruth     | Director of Public Health, Lambeth and Southwark | • Employed by Southwark Council  
• None | √ | 22 Aug 13 |
| Watts Rosemary      | Head of Membership and Engagement | • Employed by NHS Southwark CCG  
• None | | 21 Jan 14 |
| Dr. Zeineldine Amr  | GP Chair and Clinical Lead, governing body | • GP partner Aylesbury Partnership [PMS]- 20% share  
• Director Aylesbury Medical Services providing Community Dermatology in Southwark – 20% share  
• SELDOC GP member  
• Quay Health Solutions, a not-for-profit Community Interest Company (CIC)], Practice is a shareholder. | | 31 Jan 14 |
Statement by the Accountable Officer

18 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 the Clinical Commissioning Group.

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

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

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

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

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

Andrew Bland
Accountable Officer
4 June 2014
19 Governance statement

Southwark Clinical Commissioning Group

Annual Governance Statement 2013/2014

Organisation Code: 08Q

19.1 Introduction and Context

NHS Southwark Clinical Commissioning Group was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

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

As at 1 April 2013, NHS Southwark Clinical Commissioning Group was licensed without conditions.

19.2 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 in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

19.3 Compliance with the UK Corporate Governance Code

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

For the financial year ended 31 March 2014, 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 focused 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.

19.4 The Clinical Commissioning Group Governance Framework

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.*

19.5 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:

- Council of Members;
- governing body;
- CCG employees;
- Committees and sub-committees of the governing body;
- Member Practices in their Localities.
19.6 Governance Structure of the CCG

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.

Figure 1 – Governance Structure of NHS Southwark CCG

19.6.1 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 has elected its Chair and Deputy Chair and has met five times in the year.

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).
19.6.2 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.

19.6.3 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,
- three lay members - one of whom is the Deputy Chair of the governing body,
- two registered nurses - one from community care and one nurse from a Member Practice,
- one secondary care specialist doctor,
- Chief Officer,
- Chief Financial Officer,
- Public Health representative,
- Health Watch representative,
- LMC representative,
- Local Authority employee,
- CCG Director of Service Redesign and
- CCG Director of Client Groups and Partnerships,
- Secondary Care Doctor from local NHS trust (co-opted member)

The responsibilities and scope of work of the governing body is detailed in the CCG’s Constitution.

19.6.4 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. Highlights of the work carried out by the different committees are as follows:

**Audit Committee:** The Audit Committee met once every quarter and was well-attended by Lay Members and Clinical Leads. The committee is chaired by the Lay Member leading on governance, risk and audit. Some of the significant issues that the committee considered and reviewed were financial risks and CCG Board Assurance Framework and governance updates, internal audit reviews and recommendations, external audit
updates, counter-fraud and risk management arrangements in the CCG, appointment of auditors.

The Audit Committee will complete a self-assessment of its effectiveness in August 2014, following completion of the first full financial year.

**Remuneration Committee:** The Remuneration Committee met in June 2013 when remuneration arrangements for governing body members were discussed. This was a joint meeting with Lambeth CCG and Human Resources partners from the Commissioning Support Unit who provided professional advice. The Committee is chaired by a Lay member of the Southwark CCG governing body.

**Integrated Governance and Performance Committee:** this committee met every month of the year 2013/14. Every meeting held met quoracy requirements and regular agenda items included finance reports, integrated performance reports and governance updates. The agenda also included in-depth analysis on strategic performance and clinical risk areas such as urgent and emergency care performance, infection control, complaints, serious incidents and Never Events reporting. Also presented were stocktakes on Winterbourne View and Francis Report recommendations. The committee is informed by its sub-committees i.e. Information Governance Steering Group, Safeguarding Executive, Mental Health Programme Board and Southwark Medicines Management Committee.

**Commissioning Strategy Committee:** The Commissioning Strategy Committee met every month of the financial year 2013/14. Every meeting held met quoracy 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 informed by strategic Programme Boards including Urgent Care and Planned Care Programme Boards as well as the Primary Care and Community Steering Group which is its main sub-committee. Conflict of Interest Panel: Service commissioning and procurement decisions that are conflicted are referred to the Conflict of Interest Panel which is chaired by the CCG’s Lay Member for governance. Decisions taken by the COI Panel are adopted by the governing body.

**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 a governing body GP Clinical Lead and has representation from Healthwatch Southwark, Community Action Southwark and Forum for Equality and Human Rights in Southwark.

**Dulwich Programme Board** (limited to programme life) - The Dulwich Programme Board is a temporary committee of the governing body which will run for the duration of the programme.

In the past year the Dulwich Programme has delivered a formal consultation process which asked local people about the proposals the CCG developed to improve health services in Dulwich and the surrounding area.
Recommendations emerging from the consultation were approved by the governing body in September 2013 and work has since progressed to confirm the service model and to calculate the likely size requirements for a new health centre. This work is now complete.

All of the committees set out above are accountable to the governing body. 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.

Some changes to the terms of reference for committees were recommended by Internal Audit which have now been completed. The Scheme of Delegation internal audit review was conducted in order to strengthen governance arrangements around the functioning of the committees that inform and assist the governing body in the discharge of its functions.

19.6.5 Joint Committees

South East London Joint Prescribing Committee: The South East London Area Prescribing Committee was established in 2013 and is a partnership committee which discusses and makes recommendations on medicines issues.

South East London Commissioning Strategy Programme: All CCGs including Southwark CCG are required to develop 2 year plans and 5 year strategies. The South East London CCGs have agreed to work collaboratively on the elements of the strategy that cannot be addressed at CCG level alone, or where there is common agreement that there is added value in working collectively.

The South East London Commissioning Strategy Programme will build on the six individual CCG-level strategies developed locally. Other aspects of the programme approach and vision include a focus on improving health and reducing inequalities, working with Health and Wellbeing boards, a commitment to public and patient engagement, delivering local health and integrated care services to ensure safety, quality and sustainability.

Joint Health and Social Care Senior Management Team (Joint SMT): This joint Senior Management Team for Health and Social Care in Southwark discusses strategic and operational issues including integration of services.

Lambeth, Southwark and Lewisham Infection Control Steering Group: This committee is chaired by the Lambeth and Southwark Director of Public Health. It includes membership from all three acute trusts locally (including the community services Infection Control lead), a representative from the CCGs’ Medicines Management Teams (MMTs), a local GP (CCG Board member), PHE SEL Health Protection Team and community infection control staff based in the LSL councils PH services. The committee also invites representatives from the Care Homes Support Team, Brixton Prison and NHS England (London region). The committee will report in to the Integrated Governance Committees of the respective CCGs.

Health and Wellbeing Board: Established and hosted by the local authority, Health and Wellbeing Board brings together the NHS, 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.
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.
19.6.6 Attendance record for governing body meetings

*Figure 2 – Attendance record for GB meetings*

<table>
<thead>
<tr>
<th>Name (alphabetical order)</th>
<th>governing body member type</th>
<th>GB meeting attendance in 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Andrew Bland</td>
<td>Chief Officer</td>
<td>8 out of 8</td>
</tr>
<tr>
<td>Dr. Adam Bradford</td>
<td>GP Clinical Lead</td>
<td>7 out of 8</td>
</tr>
<tr>
<td>Dr. Jane Cliffe</td>
<td>Local Medical Committee representative</td>
<td>6 out of 8</td>
</tr>
<tr>
<td>Prof. Ami David</td>
<td>Nurse Member (Community)</td>
<td>7 out of 8</td>
</tr>
<tr>
<td>Mrs. Linda Drake</td>
<td>Nurse Member (General Practice)</td>
<td>5 out of 8</td>
</tr>
<tr>
<td>Dr. Roger Durston</td>
<td>GP Clinical Lead</td>
<td>6 out of 8</td>
</tr>
<tr>
<td>Dr. Simon Fradd</td>
<td>GP Clinical Lead</td>
<td>6 out of 8</td>
</tr>
<tr>
<td>Ms. Diane French</td>
<td>Lay Member</td>
<td>8 out of 8</td>
</tr>
<tr>
<td>Dr. Richard Gibbs</td>
<td>Lay Member</td>
<td>7 out of 8</td>
</tr>
<tr>
<td>Dr. Jonty Heaversedge</td>
<td>GP Clinical Lead</td>
<td>5 out of 8</td>
</tr>
<tr>
<td>Mr. Malcolm Hines</td>
<td>Chief Financial Officer</td>
<td>7 out of 8</td>
</tr>
<tr>
<td>Dr. Patrick Holden</td>
<td>GP Clinical Lead</td>
<td>8 out of 8</td>
</tr>
<tr>
<td>Ms. Tamsin Hooton</td>
<td>CCG Director for Service Redesign</td>
<td>5 out of 8</td>
</tr>
<tr>
<td>Dr. Sian Howell</td>
<td>GP Clinical Lead</td>
<td>7 out of 8</td>
</tr>
<tr>
<td>Mrs. Gwen Kennedy</td>
<td>CCG Director for Client Groups Commissioning</td>
<td>8 out of 8</td>
</tr>
<tr>
<td>Ms. Alvin Kinch</td>
<td>Healthwatch Representative</td>
<td>7 out of 8</td>
</tr>
<tr>
<td>Dr. Nancy Kuchemann</td>
<td>GP Clinical Lead (part-time)</td>
<td>7 out of 7</td>
</tr>
<tr>
<td>Ms. Sarah McClinton</td>
<td>Director of Adult Social Care, Southwark Council</td>
<td>3 out of 8</td>
</tr>
<tr>
<td>Prof. John Moxham</td>
<td>Clinical Lead (Co-opted member), Director of Clinical Strategy, Kings Health Partners</td>
<td>5 out of 8</td>
</tr>
<tr>
<td>Mr. Robert Park</td>
<td>Lay Member</td>
<td>8 out of 8</td>
</tr>
<tr>
<td>Dr. Tushar Sharma</td>
<td>GP Clinical Lead (part-time)</td>
<td>3 out of 7</td>
</tr>
<tr>
<td>Mr. Tan Vandal</td>
<td>Secondary Care Specialist Doctor</td>
<td>1 out of 1</td>
</tr>
<tr>
<td>Dr. Ruth Wallis</td>
<td>Public Health Consultant</td>
<td>4 out of 8</td>
</tr>
<tr>
<td>Dr. Amr Zeineldine</td>
<td>GP Clinical Lead (Chair)</td>
<td>8 out of 8</td>
</tr>
<tr>
<td>Dr. Suparna Das</td>
<td>Ex Member - Secondary Care Specialist Doctor</td>
<td>1 out of 2</td>
</tr>
</tbody>
</table>
19.7 Governing body Performance and Self-assessment of its Effectiveness

A survey of the CCG’s governing body members was carried out during early 2014 to individually assess how effective it viewed the Board had been over the past year – its first year as a statutory body. The survey achieved a response rate of over 80%.

Questions included views on clarity of the governing body’s responsibilities, opportunities to explore and challenge, action being delegated appropriately, and effective control of money. Members were very positive regarding how effective they felt the governing body and its supporting committees had been in steering the organisation. An area for more focus was identified as the ability of the governing body members to engage effectively with stakeholders and partners. This will be picked up during 2014/15 and the survey will be repeated.

Development for governing body members has been carried out both collectively and individually. Collectively, governing body members attended Away Days and workshop seminars through 2013/14. These were a mix of development – especially using scenario/role plays, and focussed discussions on quality, conflict of interest, and strategic planning. Additionally, each member of the governing body had an appraisal and Personal Development Plan during 2013/14 to better enable them to do their job.

19.7.1 The Clinical Commissioning Group Risk Management Framework

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

The Integrated Risk Management Framework for NHS Southwark Clinical Commissioning Group (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 reviewed in March 2014. 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.
19.7.2 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.

19.7.3 Identification and evaluation of risk

*Figure 3 – Risk Management Process*

NHS Southwark CCG has adopted the Australia/New Zealand (AS/NZS 4360/1999) standard which is internationally recognised standard providing a generic model for the identification, analysis, prioritisation, treatment, communication and monitoring of risks across clinical and non-clinical services and activities at local and corporate level. There are seven stages to managing risk in this model as shown above:

1. Establish the context
2. Identify hazards
3. Analyse risks
4. Prioritise risks
5. Treat risks
6. Monitor and review
7. Communicate and consult

This applies to all risk including corporate, financial, clinical, operational and reputational risks.
19.7.4 Risk Scoring

A risk score is achieved by multiplying an individual likelihood (probability) score with an individual severity (impact) score:

\[ \text{Likelihood} \times \text{Impact} = \text{Risk Score} \]

The CCG has adopted a 5x5 matrix for scoring risks, consistent with the NPSA guidelines (January 2008) and are aligned to the CCG adopted AS/NZS 4360:1999 risk management standard.

19.7.5 Risk Grading

The risk grading and prioritisation method adopted by the CCG is consistent with guidelines provided by the National Patient Safety Agency.

A summary of the potential ‘grades’ of risk issues, based on a risk score, are noted below, where:

<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>

Risks which attract the highest scores are therefore graded ‘red’ and warrant immediate attention by relevant personnel.

19.7.6 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 Senior Management Team and 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 through the CCG’s Risk Management Framework. This is supported by a range of policies which are in place for the CCG. The CCG’s risk management reporting structure Figure 4 illustrates how risk escalation and management in the CCG is carried out through Board Assurance Framework and Risk Registers.
Figure 4 - NHS Southwark CCG Risk Reporting and Management Structure

- **CCG governing body**
- **Integrated Governance and Performance Committee (IGPC)**
- **Audit Committee**

**ASSURANCE**
- Bi-Monthly Advice on management
- Quarterly

**SCRUTINY AND CHALLENGE**
- Strategic risks against Corporate Objectives
- Risks deemed significant for inclusion on the BAF + Red Risks

**INFORMATION AND ESCALATION**
- New risks

**OPERATIONAL MANAGEMENT**
- Advice on management

**Finance and Business Directorate Risk Register (DRR)**
- Team Risk Registers: e.g. Information Governance, Dulwich Programme etc.

**Service Redesign Directorate Risk Register (DRR)**
- Team Risk Registers: e.g. Pathway Commissioning, Primary and Community Care Development etc.

**Client Group Commissioning Directorate Risk Register (DRR)**
- Team Risk Registers e.g. Personal Health Budgets, Mental Health, Safeguarding

**Senior Management Team (SMT)**
- Advice on management

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The best possible health outcomes for Southwark people.
19.7.7 Board Assurance Framework and Risk Registers

The Board Assurance Framework (BAF) is formed of strategic CCG risks against corporate objectives. The 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.

The CCG BAF is reviewed by governing body members on a quarterly basis monthly basis through the Integrated Governance and Performance Committee reporting while the Directorate Risk Registers are produced bi-monthly for inspection and monitoring.

19.7.8 Committees reviewing BAF and Risk Registers

The Audit Committee and Integrated Governance and Performance Committee support the effective management of risk within the CCG through providing scrutiny and discussion of risks on the CCG BAF and Risk Registers.

In addition, the Audit Committee provides assurance to the governing body through:

- 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 external audit plan; 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 Risk Registers are also presented to governing body meetings. The risk report includes a Heat Map to ensure the CCG has easy oversight of its highest risks.

19.7.9 Policies supporting Risk Management

NHS Southwark CCG is in the process of updating its policies.

The policies that were updated in the year are:
Conflict of Interests Policy was updated in May 2013 in line with NHS England guidance (March 2013)
Integrated Risk Management Framework
Gifts and Hospitality Policy,
Anti-Bribery Policy,
Fraud Policy and Response Plan,
Complaints Policy,
Freedom of Information Policy,
Information Governance Framework and suite of policies,
IT policies,  
Joint Working with Pharmaceutical Industry Policy, 
Organisational Change Policy and 
Individual Grievance procedure

19.7.10 Training

The following training/workshops were conducted for the CCG during the year:
- Risk management and Board Assurance Framework training and development for governing body members and CCG staff
- Conflict of Interest workshop for governing body members in February 2014
- Counter-Fraud and Security Management training as part of mandatory training for all CCG staff

All CCG staff also completed the following mandatory training during the year:
- Information Governance Toolkit training
- Health and Safety Awareness
- Fire Safety Awareness
- Equality and Diversity
- Safeguarding Awareness
- Manual Handling

19.8 Embedding of risk management

19.8.1 Staff engagement

As mentioned above, various workshops and training sessions for governing body members and CCG staff were conducted in the year in an effort to boost embedding of risk management. This included a risk management workshop where CCG staff learned the importance of risk identification and management within their areas of work and participated in an exercise of identifying and scoring risks to the CCG's strategic business priorities. Staff scored risks for their own areas as well as areas from other directorates to get a holistic view.

Risk Registers are monitored and discussed in directorate team meetings where any new risks are flagged and current ones followed up for implementation of actions.

19.8.2 Incident reporting

The CCG has an Incident Reporting Policy which is currently under review and which will be made available to the CCG staff via the staff extranet. The policy will determine actions for the CCG as clinical commissioners as well as employers for staff health and safety and other non-clinical incidents.

19.8.3 Equality Impact Assessments

The CCG completes Equality Impact Assessments for are undertaken on all policies and support is provided on incident reporting and management.
19.8.4 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.

19.9 The Clinical Commissioning Group Internal Control Framework

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

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

The Audit Committee and Integrated Governance Committee provide crucial oversight of the risk management processes within the CCG, with bi-monthly reporting to the governing body from these committees.

In addition, the Senior Management Team reviews new risks as well as monitoring of issues through operational meetings and deep dive sessions.

19.9.1 Information Governance

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

We have contracted with the South London Commissioning Support Unit (SLCSU) to provide us expert advice and support on Information Governance. In addition, we have our own Senior Information Risk Owner (SIRO) and Caldicott Guardian. The CCG has an Information Governance Steering Group to monitor compliance, which includes membership from both the CCG and SLCSU. This group reports into the CCG Integrated Governance and Performance Committee.
IT Security
The CCG has purchased IT services from the South London Commissioning Support Unit (SLCSU). The CCG’s IT Security Policy and IT Assurance Plan were reviewed during 2013/14 and updated policies are in place.

Information Governance
The Information Governance Framework and a suite of Information Governance policies including the Information Security Policy have been approved by the CCG governing body and is in place.

The CCG has an Information Governance Framework in place comprising an approved strategy, a suite of approved policies and procedures, a programme of mandatory training, information risk management, incident management.

The CCG has adopted and implemented the Health and Social Care Information Centre’s (HSCIC), ‘Checklist for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigating’ for the reporting of Level 2 Information Governance incidents to the Information Commissioner. An incident reporting system is operational in the CCG with the support of the governance team and expert IG support from the South London Commissioning Support Unit.

The Information Governance Steering Group (IGSG) is a sub-group of the Integrated Governance and Performance Committee which in turn reports to the governing body. The CCG has also appointed a Caldicott Guardian and Senior Information Risk Owner.

Freedom of Information Requests:
The CCG complies with its statutory duty to respond to requests for information. During the year the CCG received 183 requests under the Freedom of Information Act 2000, of which 98% were completed within the stipulated 20 working days period.

Subject Access Requests
Southwark CCG also received a total of 2 Subject Access Requests (SARs) under the Data Protection Act 1998, which were dealt with within the required timeframes.

Serious Incidents
There were no lapses in data security reported to the Information Commissioner during 2013-14. There were no serious incidents relating to data security breaches that were reported during the year.

Thus, Southwark CCG places 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 information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.
19.10 **Pension Obligations**
As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

19.11 **Equality, Diversity & Human Rights Obligations**

Southwark Clinical Commissioning Group is required to comply with a number of key drivers for equality, diversity and human rights. These are:

- The Human Rights Act 1998
- The Equality Act 2010 (the nine protected characteristics)
- The Public Sector Equality Duty (PSED)
- The NHS Constitution

We have made equality and human rights, “everyone’s business”. We believe that taking a “human rights approach” to commissioning is the key to delivering quality, compassionate and personalised care pathways. To this end, our commissioning decisions are grounded in the human rights principles known as the “FREDA Principles”. This means that care pathways for Southwark people are subject to:

- Fairness
- Respect
- Equality
- Dignity
- Autonomy

The CCG is paying due regard to the Public Sector Equality Duty, and we are making steady progress on our 4-year Equality Objectives. In addition, we are adapting the latest version of the Equality Delivery System (EDS2) framework for the NHS to ensure that we are compliant with the key drivers for equality, diversity and human rights.

19.12 **Sustainable Development Obligations**

Southwark Clinical Commissioning Group is required to report its progress in delivering against sustainable development indicators. We have an approved Sustainability Policy in place and are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

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

We are also setting out our commitments as a socially responsible employer.
19.13 Risk Assessment in Relation to Governance, Risk Management & Internal Control

The principal risks to compliance with the CCG licence are identified and monitored by the various committees and sub-committees and the governing body through the board assurance framework.

Robust governance reporting on performance and finance issues and challenge on risk mitigation ensures actions required to mitigate these risks are appropriate and timely.

governing body seminars are scheduled every alternate month when the members focus and discuss ‘deep dives’ in to risks and issues facing the CCG for example, A&E and RTT performance and quality management.

Principal Risks:

There are 26 principal/ strategic risks on the CCG BAF. The risk profile for the CCG at the end of the financial year is as follows:

- extreme
- 8 high
- 15 moderate risks

These risks have been presented to the various committees and governing body as detailed before.
BOARD ASSURANCE FRAMEWORK - HEAT MAP
MARCH 2014

The best possible health outcomes for Southwark people
19.14 New risks identified during 2013-14

1. **Primary and Community Care Strategy approval and implementation:**

   The Primary and Community Care Strategy was signed off in Autumn 2013 and as we progress to implementation, this will involve practices working differently as neighbourhood models. We have significant number of services that we will tender next year in order to improve health outcomes.

2. **Dulwich Health Centre development:**

   In the past year, the Dulwich Programme has delivered a formal consultation process which asked local people about the proposals the CCG developed to improve health services in Dulwich and the surrounding area. The consultation was monitored by the Consultation Institute under its Consultation Compliance Assessment Scheme, and the Institute confirmed that it fully met its requirements for best practice. The process was also agreed with the London Borough of Southwark Health, Adult Social Care, Communities and Citizenship Overview and Scrutiny Sub-Committee. Recommendations emerging from the consultation were approved by the governing body in September 2013 and work has since progressed to confirm the service model and to calculate the likely size requirements for a new health centre. This work is now complete.

3. **Access to Personal Confidential Data (PCD):**

   Restricted access to Personal Confidential Data (PCD) emerged as a national issue for clinical commissioning groups resulting from changes to Health and Social Care Act (2012). The issue is largely resolved for certain services that require access to PCD for invoice validation e.g. mental health commissioning, continuing health care, etc. Mitigating actions included establishment of a legal basis for access to PCD for certain direct care areas such as continuing care and mental health commissioning, whereas internal data flows and asset registers are being mapped through the Information Asset Management Tool that has been procured by the CCG recently. In addition, South London Commissioning Support Unit (SLCSU) that provides finance and other key functions has achieved Stage 1 ASH status as mandated by the Health and Social Care Information Centre (HSCIC), and a Controlled Environment for Finance (CEfF) has been established.

   The CCG is currently in the process of assessing options for Risk Stratification that allow it to use data for commissioning without using PCD.

19.15 Major in-year risks

**Delivery of financial savings to achieve financial balance**

The CCG faced significant financial uncertainty following the transfer of responsibility to the new commissioning structure. This has meant that resources have had to be held back to deal with issues which have only been realised in the last quarter. All issues have now been managed. Achievement of targets for A&E and Referral to Treatment (RTT)

As lead commissioners for Kings College Hospital, we have been involved in discussions and agreed additional funding along with other CCGs to assist in improving A&E performance and reduce the backlog of RTT patients.

**Achievement of Improving Access to Psychological Therapies (IAPT) targets**

The CCG has acknowledged that it will miss IAPT targets for the year, however, there is an investment plan in place to tackle the issue in the forthcoming year. The risk is scored extreme and
is the focus of discussion at governing body and Commissioning Strategy Committee meetings as well as the Integrated Governance and Performance Committee where strategic risks to the CCG’s commissioning agenda are discussed.

19.16 Significant Issues/ Challenges during 2013/14

Continuing Care Retrospective Claims
There is significant work still on-going to agree claims and the accounting for the provision in respect of the claims relating to periods prior to the establishment of the CCG, remains with NHS England.

South east London Commissioning Strategy Programme
Following discussions, agreements was reached on the 1\textsuperscript{st} phase implementation of Trust Special Administrator recommendations for South London Healthcare Trust (SLHT) which includes transactional agreements that have now restructured hospital across SEL and for the future the programme is concentrating on clinical services redesign.

Maintaining and improving hospital waiting times and A&E waiting time for patients
As stated above, increase in elective care has led to a backlog at Kings College Hospital NHS Foundation Trust which is currently being cleared. Maintaining and improving waiting times for RTT and A&E has been a significant challenge for the CCG and its main provider Kings College Hospital NHS Trust.

19.17 Review of economy, efficiency and effectiveness of the use of resources

The CCG has a robust governance structure with regular committee and governing body reporting to ensure the CCG’s commissioning plans are well supported by the efficient and effective use of available resources.

Strategic plans are approved by the Commissioning Strategy Committee and governing body before final approval by the Council of Members.

The Integrated Governance and Performance Committee and the Audit Committee have regularly received and discussed the CCG’s Board Assurance Framework and strategic risks. The Audit Committee and the Integrated Governance Performance Committees have continually sought assurance that the Board Assurance Framework appropriately reflects the level of risk and incorporates mitigating action.

Independent assurance on the effectiveness of risk management and internal control has been provided through internal audit reviews in various areas of the CCG’s business. The findings of internal audit have been presented to the Audit Committee.

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

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.
19.19 Capacity to handle risk

The CCG’s Integrated Risk Management Strategy makes it clear that, whilst I have overall responsibility for risk, leadership for specific risk management areas have been delegated to individual Directors and Risk Management Specialists as mentioned below:

i) Chief Financial Officer
has responsibility for managing the development and implementation of systems of financial governance and financial risk management,
has the delegated responsibility for risk management, including the Board Assurance Framework, the Risk Register, claims management, and assurance from providers on clinical governance, including complaints and serious untoward incidents
is the CCG’s Senior Information Risk Owner and is responsible for the management and development of information governance systems
is the Accountable Emergency planning Officer (AEO) and is responsible for the assurance related to business continuity planning

ii) Director of Client Groups Commissioning
is the CCG’s Caldicott Guardian
is responsible for risks related to Continuing Care, Infection Prevention and Control, Safeguarding of Children and Adults and Mental Health across acute and community services

iii) Director of Service Redesign
is responsible for risk management in the areas of acute commissioning, primary care and community service redesign

iv) Lay Members
Lay Members have a responsibility to provide a strategic and impartial external view of governance ensuring the CCG behaves with the utmost probity at all times. One Lay Member has a specific role for governance including audit, risk management and managing conflicts of interest.

Clinical Leads
Will participate in debate and discussion of the risks facing the CCG through the IGPC, governing body, through their individual portfolios of work and provide assistance and advice in risk mitigation actions for the CCG’s BAF risks.

Head of Governance & Organisational Development
The Head of Governance & OD is responsible for developing and creating a risk aware culture and ensuring that this is reflected in all aspects of organisational business. They are also responsible for delivering an annual review of the risk strategy and supporting the governing body to identify and manage risks as part of good governance.

Risk & Assurance Manager
The Risk & Assurance Manager is responsible for assisting the Head of Governance and OD in developing and promoting a risk aware culture across SCCG, supporting Directors and staff in their identification and continuous management of risk, co-ordinating the reporting for CCG’s Risk Registers & Board Assurance Framework, and providing specialist risk management training and advice as necessary.

All CCG employees:
All CCG employees are encouraged to report all incidents/accidents and near misses using the NHS Southwark CCG Incident Reporting Policy and comply with the relevant legislation and regulations regarding health and safety at work.
All staff completed their mandatory training in the year.

**Commissioning Support Unit:**
Responsibilities for risk relating to provision of services purchased from the South London Commissioning Support Unit is laid out in the Service Level Agreement with the CSU. This includes Acute Contract Management, Finance, HR, IT, Procurement, Complaints, Information Governance. KPIs for the SLA are reviewed and monitored by the relevant CCG service leads and Directors throughout the year.

**Southwark Council:**
The CCG office premises at Tooley Street, equipment used by CCG staff, security, waste management (including confidential waste management), fire safety and environmental management, are part of the building services provided by Southwark Council, accommodated within the Council’s premises.

### 19.20 Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the final report of external and internal auditors, and internal management reports and other key reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the governing body, the Audit Committee and Integrated Governance and Performance Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

There were no lapses in data security reported to the Information Commissioner during 2013-14. There were no serious incidents relating to data security breaches that were reported during the year.

### 19.21 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 that:
• The Head of Internal Audit Opinion is that **adequate assurance** can be given that there is generally a sound system of internal control which is designed to meet your objectives and that generally controls are being consistently applied in all the areas reviewed.
• No high risk recommendations were made during 2013/14 reviews.

During the year the Internal Audit issued the following audit reports with a conclusion of ‘adequate’ assurance:
- Acute Contract Management
- 111/Out of Hours Provision
- Quality Management/Responding to Francis Report
- Budgetary Control and Contingency Plan
- Governance and Risk Management
- Conflicts of Interest
- Continuing Care
- Data Protection

During the year the Internal Audit issued the following audit reports with a conclusion of ‘requires improvement’:

Scheme of Delegation: as requested this report was delivered early in the organisation’s existence and highlighted a number of changes that were required to the delegation arrangements. Five recommendations were made for improvement four of which have been implemented. Consequently the conclusion is now assessed as ‘Adequate’.

During the year the Internal Audit issued no reports with a conclusion of ‘no assurance’:
Nil

**Data Quality**
The CCG has an Information Quality Policy in place as part of the IG policy suite. As part of the policy, reports provided to the CCG governing body and committees by commissioned services will be monitored for Information Quality requirements against the expected standards. The mitigating actions undertaken monitored as part of on-going contract management.

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

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

The QA framework in place for this model will be used for all future business critical models.
Data Security
The Information Governance Toolkit has been provided by the HSCIC to support performance monitoring of progress on Information Governance in the NHS. The CCG has submitted the HSCIC Information Governance Toolkit and has self-assessed as being 78% overall compliant, which confirms the organisation’s rating as overall ‘satisfactory’ in this regard. There have been no Information Governance serious breaches in the year 2013/14.

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

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

Conclusion
I believe that the above, combined with the outputs of the Governance Framework give me substantial assurance that the risk management processes and systems of internal control put in place are operating effectively.

In summary, the Council of Members and the governing body could take substantial assurance that the controls upon which the organisation relied to manage these risk/areas were suitably designed, consistently applied and effective.

I can confirm there are no significant internal control issues.

Andrew Bland
Accountable Officer
4 June 2014
## Annual Accounts

### 20  The Primary Statements

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

<table>
<thead>
<tr>
<th>Note</th>
<th>Administration Costs and Programme Expenditure</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administration Costs</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Gross employee benefits</td>
<td>3,495</td>
</tr>
<tr>
<td>5</td>
<td>Other costs</td>
<td>378,210</td>
</tr>
<tr>
<td>3</td>
<td>Other operating revenue</td>
<td>(20,769)</td>
</tr>
<tr>
<td></td>
<td>Net operating costs before interest</td>
<td>360,936</td>
</tr>
<tr>
<td></td>
<td>Investment revenue</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Other (gains)/losses</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Finance costs</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Net operating costs for the financial year</td>
<td>360,936</td>
</tr>
<tr>
<td></td>
<td>Net (gain)/loss on transfers by absorption</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Net operating costs for the financial year including absorption transfers</td>
<td>360,936</td>
</tr>
</tbody>
</table>

**Of which:**

**Administration Costs**

<table>
<thead>
<tr>
<th>Note</th>
<th>Administration Costs</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Gross employee benefits</td>
<td>2,550</td>
</tr>
<tr>
<td>5</td>
<td>Other costs</td>
<td>4,984</td>
</tr>
<tr>
<td>3</td>
<td>Other operating revenue</td>
<td>(364)</td>
</tr>
<tr>
<td></td>
<td>Net administration costs before interest</td>
<td>7,170</td>
</tr>
</tbody>
</table>

**Programme Expenditure**

<table>
<thead>
<tr>
<th>Note</th>
<th>Administration Costs</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Gross employee benefits</td>
<td>945</td>
</tr>
<tr>
<td>5</td>
<td>Other costs</td>
<td>373,226</td>
</tr>
<tr>
<td>3</td>
<td>Other operating revenue</td>
<td>(20,405)</td>
</tr>
<tr>
<td></td>
<td>Net programme expenditure before interest</td>
<td>353,766</td>
</tr>
</tbody>
</table>
### Other Comprehensive Net Expenditure

<table>
<thead>
<tr>
<th>Item</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant &amp; equipment</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangibles</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on available for sale financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on assets held for sale</td>
<td>-</td>
</tr>
<tr>
<td>Net actuarial gain/(loss) on pension schemes</td>
<td>-</td>
</tr>
<tr>
<td>Share of (profit)/loss of associates and joint ventures</td>
<td>-</td>
</tr>
</tbody>
</table>

**Reclassification Adjustments**

- **On disposal of available for sale financial assets**: -

**Total comprehensive net expenditure for the year**: 360,936

### Reconciliation of Cash Drawings to Parliamentary Funding

<table>
<thead>
<tr>
<th>Description</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total cash received from DH (Gross)</strong></td>
<td>315,236</td>
</tr>
<tr>
<td>Less: Trade revenue from DH</td>
<td></td>
</tr>
<tr>
<td><strong>Less://(Plus): movement in DH working balances</strong></td>
<td>(936)</td>
</tr>
<tr>
<td><strong>Sub total: net advances</strong></td>
<td>314,300</td>
</tr>
<tr>
<td>(Less)/plus: transfers (to)/from other resource account bodies</td>
<td></td>
</tr>
<tr>
<td>Plus: cost of Home Oxygen Therapy</td>
<td>326</td>
</tr>
<tr>
<td>Plus: cost of drugs reimbursement (central charge to cash limits)</td>
<td>25,591</td>
</tr>
<tr>
<td><strong>Parliamentary funding credited to General Fund</strong></td>
<td>340,217</td>
</tr>
<tr>
<td><strong>Adjustment for Partially Completed Spells</strong></td>
<td>(1,710)</td>
</tr>
<tr>
<td><strong>Net Funding</strong></td>
<td>338,507</td>
</tr>
</tbody>
</table>
### Statement of Financial Position as at 31 March 2014

#### Non-current assets:
- Property, plant and equipment
- Intangible assets
- Investment property
- Trade and other receivables
- Other financial assets
- **Total non-current assets**

#### Current assets:
- Inventories
- Trade and other receivables
- Other financial assets
- Other current assets
- Cash and cash equivalents
- **Total current assets**

#### Non-current assets held for sale
- **Total current assets**

#### Total assets

#### Current liabilities:
- Trade and other payables
- Other financial liabilities
- Other liabilities
- Borrowings
- Provisions
- **Total current liabilities**

#### Total Assets less Current Liabilities

#### Non-current liabilities:
- Trade and other payables
- Other financial liabilities
- Other liabilities
- Borrowings
- Provisions
- **Total non-current liabilities**
### Total Assets Employed

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(22,429)</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Financed by Taxpayers’ Equity

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General fund</td>
<td>(22,429)</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>-</td>
</tr>
<tr>
<td>Other reserves</td>
<td>-</td>
</tr>
<tr>
<td>Charitable Reserves</td>
<td>-</td>
</tr>
</tbody>
</table>

**Total taxpayers’ equity:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(22,429)</strong></td>
<td></td>
</tr>
</tbody>
</table>

The notes on pages 5 to 42 form part of this statement.

The financial statements on pages 1 to 42 were approved by the Governing Body on 30 May 2014 and signed on its behalf by:

**Accountable Officer**

Andrew Bland

**Chief Financial Officer**

Malcolm Hines
## 20.3 Statement of Changes in Taxpayers' Equity for the year ended 31st March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>General fund</th>
<th>Revaluation reserve</th>
<th>Other reserves</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2013-14</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adjusted CCG balance at 1 April 2013</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Changes in CCG taxpayers’ equity for 2013-14</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(360,936)</td>
<td>-</td>
<td>-</td>
<td>(360,936)</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant and equipment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total revaluations against revaluation reserve</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Description</td>
<td>2014</td>
<td>2013</td>
<td>2012</td>
<td>2011</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Net gain (loss) on available for sale financial assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain (loss) on revaluation of assets held for sale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net actuarial gain (loss) on pensions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Release of reserves to the Statement of Comprehensive Net Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reclassification adjustment on disposal of available for sale financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers by absorption to (from) other bodies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred under absorption</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reserves eliminated on dissolution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Recognised CCG Expenditure for the Financial Year</strong></td>
<td>(360,936)</td>
<td>-</td>
<td>-</td>
<td>(360,936)</td>
</tr>
<tr>
<td><strong>Net funding</strong></td>
<td>338,507</td>
<td>-</td>
<td>-</td>
<td>338,507</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>(22,429)</td>
<td>-</td>
<td>-</td>
<td>(22,429)</td>
</tr>
</tbody>
</table>
## Statement of Cash Flows for the year ended 31st March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(360,936)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
</tr>
<tr>
<td>Other gains (losses) on foreign exchange</td>
<td>-</td>
</tr>
<tr>
<td>Donated assets received credited to revenue but non-cash</td>
<td>-</td>
</tr>
<tr>
<td>Government granted assets received credited to revenue but non-cash</td>
<td>-</td>
</tr>
<tr>
<td>Interest paid</td>
<td>-</td>
</tr>
<tr>
<td>Release of PFI deferred credit</td>
<td>-</td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>-</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>17 (6,896)</td>
</tr>
<tr>
<td>(Increase)/decrease in other current assets</td>
<td>-</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>23 27,881</td>
</tr>
<tr>
<td>Increase/(decrease) in other current liabilities</td>
<td>-</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>-</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>30 1,452</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td>(338,499)</td>
</tr>
</tbody>
</table>

| **Cash Flows from Investing Activities** | |
| Interest received | - |
| (Payments) for property, plant and equipment | - |
| (Payments) for intangible assets | - |
| (Payments) for investments with the Department of Health | - |
| (Payments) for other financial assets | - |
| (Payments) for financial assets (LIFT) | - |
| Proceeds from disposal of assets held for sale: property, plant and equipment | - |
| Proceeds from disposal of assets held for sale: intangible assets | - |
| Proceeds from disposal of investments with the Department of Health | - |
| Proceeds from disposal of other financial assets | - |
| Proceeds from disposal of financial assets (LIFT) | - |
| Loans made in respect of LIFT | - |
| Loans repaid in respect of LIFT | - |
| Rental revenue | - |
| **Net Cash Inflow (Outflow) from Investing Activities** | - |

| **Net Cash Inflow (Outflow) before Financing** | (338,499) |

| **Cash Flows from Financing Activities** | |
| Net funding received | 338,507 |
| Other loans received | - |
| Other loans repaid | - |
| Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT | - |
| Capital grants and other capital receipts | - |
20.5 Notes to the financial statements

NHS Southwark Clinical Commissioning Group (the CCG) was constituted under the NHS Act 2012, and came into being on 1 April 2014.

This is a new organisation. All the previous assets and liabilities of Southwark PCT have transferred to the Department of Health legacy organisation from that date. Under the terms of the Act our principal activities are the commissioning and monitoring of health services, for the population of Southwark, defined as patients registered with GPs who are on Southwark's performers list.

We carry out our operations from 160 Tooley Street, London SE1.

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

20.5.1 Accounting policies

1 Accounting Policies

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

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

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

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

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

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

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty
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 had to exercise no material critical judgements in applying accounting policies during 2013-14.

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 2013-14.

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

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

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time 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 NHS Southwark’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.8 Other Expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
Expenses and liabilities in respect of grants are recognised when NHS Southwark CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.9 Property, plant and equipment
NHS Southwark CCG does not own any Property, Plant and Equipment. On the dissolution of the former NHS Southwark PCT, all Property, Plant and Equipment was transferred to other bodies and none to NHS Southwark CCG.

1.10 Cash & Cash Equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of NHS Southwark CCG’s cash management.
1.11 Provisions
Provisions are recognised when NHS Southwark CCG has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rate as follows:
- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when NHS Southwark CCG has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.12 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.

1.13 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.

1.14 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.

1.15 Financial Assets
Financial assets are recognised when NHS Southwark CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. Financial assets are classified into the following categories:
- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
Loans and receivables.
The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.15.1 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.

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

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

Other Financial Liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method. Due to all other financial liabilities being payable within significantly less than 12 months at the balance sheet date the Clinical Commissioning Group has other financial liabilities where the impact of the time value of money is material: all other financial liabilities are therefore recognised at their original transaction value.

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

1.18 Foreign Currencies
NHS Southwark’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.
1.19 **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).

1.20 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

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

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

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

### 20.5.2 Other operating revenue

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Total</th>
<th>2013-14 Admin</th>
<th>2013-14 Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patient transport services</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prescription fees and charges</td>
<td>0</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Dental fees and charges</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: NHS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>45</td>
<td>-</td>
<td>45</td>
</tr>
<tr>
<td>Receipt of donations for capital acquisitions: NHS Charity</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Receipt of Government grants for capital acquisitions</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>20,316</td>
<td>364</td>
<td>19,952</td>
</tr>
<tr>
<td>Income generation</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rental revenue from finance leases</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other revenue</td>
<td>408</td>
<td>0</td>
<td>408</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>20,769</strong></td>
<td><strong>364</strong></td>
<td><strong>20,405</strong></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Total £000</th>
<th>2013-14 Admin £000</th>
<th>2013-14 Programme £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>From rendering of services</td>
<td>20,769</td>
<td>364</td>
<td>20,405</td>
</tr>
<tr>
<td>From sale of goods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20,769</td>
<td>364</td>
<td>20,405</td>
</tr>
</tbody>
</table>

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.
### 20.5.4. Employee benefits and staff numbers

#### 20.4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits</td>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,918</td>
<td>2,568</td>
<td>350</td>
<td>2,129</td>
<td>1,950</td>
<td>179</td>
<td>789</td>
<td>618</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Social security costs</td>
<td>265</td>
<td>265</td>
<td>-</td>
<td>183</td>
<td>183</td>
<td>-</td>
<td>72</td>
<td>72</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>312</td>
<td>312</td>
<td>-</td>
<td>228</td>
<td>228</td>
<td>-</td>
<td>84</td>
<td>84</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other pension costs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Termination benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>3,495</td>
<td>3,145</td>
<td>350</td>
<td>2,569</td>
<td>2,371</td>
<td>179</td>
<td>945</td>
<td>774</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Less recoveries in respect of employee benefits</td>
<td>note 4.1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total - Net admin employee benefits including capitalised costs</td>
<td>3,495</td>
<td>3,145</td>
<td>350</td>
<td>2,569</td>
<td>2,371</td>
<td>179</td>
<td>945</td>
<td>774</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net employee benefits excluding capitalised costs</td>
<td>3,495</td>
<td>3,145</td>
<td>350</td>
<td>2,569</td>
<td>2,371</td>
<td>179</td>
<td>945</td>
<td>774</td>
<td>171</td>
<td></td>
</tr>
</tbody>
</table>

#### 20.4.1.2 Recoveries in respect of employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits - Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employer contributions to the NHS Pension Scheme</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
20.5.4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>Permanently employed</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>61</td>
<td>48</td>
</tr>
</tbody>
</table>

Of the above:
Number of whole time equivalent people engaged on capital projects

20.5.4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>369</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>48</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>8</td>
</tr>
</tbody>
</table>

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

Ill health retirement costs are met by the NHS Pension Scheme

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.
20.5.4.4 Exit packages agreed in the financial year

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Compulsory redundancies</th>
<th>Other agreed departures</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
<td>Number</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£25,001 to £50,000</td>
<td>1</td>
<td>34,000</td>
<td>-</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£100,001 to £150,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£150,001 to £200,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Over £200,001</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>34,000</td>
<td>-</td>
</tr>
</tbody>
</table>

Departures where special payments have been made

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than £10,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£25,001 to £50,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The best possible health outcomes for Southwark people
<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary redundancies including early retirement contractual costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mutually agreed resignations (MARS) contractual costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Early retirements in the efficiency of the service contractual costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Exit payments following Employment Tribunals or court orders</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-contractual payments requiring HMT approval*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.
20.5.4.5 Pension costs

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

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

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.
The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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

20.5.4.5.3 Scheme Provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

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

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Total £000</th>
<th>2013-14 Admin £000</th>
<th>2013-14 Programme £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>2,820</td>
<td>1,875</td>
<td>945</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>675</td>
<td>675</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>3,495</td>
<td>2,550</td>
<td>945</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>3,990</td>
<td>2,498</td>
<td>1,492</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>272,947</td>
<td>-</td>
<td>272,947</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>20,683</td>
<td>-</td>
<td>20,683</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>610</td>
<td>-</td>
<td>610</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>35,634</td>
<td>4</td>
<td>35,630</td>
</tr>
<tr>
<td>Chair and lay membership body and governing body members</td>
<td>67</td>
<td>67</td>
<td>-</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>291</td>
<td>349</td>
<td>(58)</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>2,178</td>
<td>432</td>
<td>1,746</td>
</tr>
<tr>
<td>Establishment</td>
<td>1,061</td>
<td>76</td>
<td>985</td>
</tr>
<tr>
<td>Transport</td>
<td>3</td>
<td>3</td>
<td>(0)</td>
</tr>
<tr>
<td>Premises</td>
<td>4,510</td>
<td>757</td>
<td>3,753</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inventories written down</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Depreciation</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Amortisation</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of property, plant and equipment</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of intangible assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Assets carried at amortised cost</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The best possible health outcomes for Southwark people
- Assets carried at cost - - -
- Available for sale financial assets - - -
  Impairments and reversals of non-current assets held for sale - - -
  Impairments and reversals of investment properties - - -
Audit fees 104 104 -
Other auditor’s remuneration
  - Internal audit services - - -
  - Other services - - -
General dental services and personal dental services - - -
Prescribing costs 31,150 - 31,150
Pharmaceutical services - - -
General ophthalmic services - - -
GPMS/APMS and PCTMS 2,576 - 2,576
Other professional fees excl. audit 651 649 2
Grants to other public bodies - - -
Clinical negligence - - -
Research and development (excluding staff costs) - - -
Education and training 131 45 86
Change in discount rate - - -
Other expenditure 1,624 - 1,624
Total other costs 378,210 4,984 373,226

Total operating expenses 381,705 7,534 374,171

Administration expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.
20.5.6.1. Better payment practice code
The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is to pay 95% of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. This is measured both in terms of the total value of invoices, and the number of invoices.

The CCG’s performance is reported below:

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-NHS Payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>6,822</td>
<td>39,272</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>6,259</td>
<td>32,983</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>91.75%</td>
<td>83.99%</td>
</tr>
<tr>
<td>NHS Payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>2,048</td>
<td>291,275</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>1,926</td>
<td>289,348</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>94.04%</td>
<td>99.34%</td>
</tr>
</tbody>
</table>

Thus, the CCG’s performance was below the recommended target for NHS and Non-NHS payments. The CCG is aspiring to achieve targets through improvement of payment processes.

20.5.6.2. The Late Payment of Commercial Debts (Interest) Act 1998

<table>
<thead>
<tr>
<th>Amounts included in finance costs from claims made under this legislation</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation paid to cover debt recovery costs under this legislation</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
</tr>
</tbody>
</table>

20.5.7. Income generation activities

The clinical commissioning group does not undertake any income generation activities.
### 20.5.8. Investment revenue

<table>
<thead>
<tr>
<th>Rental Revenue</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFI finance lease revenue (planned)</td>
<td>-</td>
</tr>
<tr>
<td>PFI finance lease revenue (contingent)</td>
<td>-</td>
</tr>
<tr>
<td>Other finance lease revenue</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total rental revenue</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interest Revenue</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIFT: equity dividends receivable</td>
<td>-</td>
</tr>
<tr>
<td>LIFT: loan interest receivable</td>
<td>-</td>
</tr>
<tr>
<td>Bank interest</td>
<td>-</td>
</tr>
<tr>
<td>Other loans and receivables</td>
<td>-</td>
</tr>
<tr>
<td>Impaired financial assets</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total interest revenue</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

| **Total investment revenue**                         | -             |

### 20.5.9. Other gains and losses

<table>
<thead>
<tr>
<th>Gain/(loss) on disposal of property, plant and equipment assets other than by sale</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain/(loss) on disposal of intangible assets other than by sale</td>
<td>-</td>
</tr>
<tr>
<td>Gain/(loss) on disposal of financial assets other than held for sale</td>
<td>-</td>
</tr>
<tr>
<td>Gain/(loss) on disposal of assets held for sale</td>
<td>-</td>
</tr>
<tr>
<td>Gain/(loss) on foreign exchange</td>
<td>-</td>
</tr>
<tr>
<td>Change in fair value of financial assets carried at fair value through the statement of comprehensive net expenditure</td>
<td>-</td>
</tr>
<tr>
<td>Change in fair value of financial liabilities carried at fair value through the statement of comprehensive net expenditure</td>
<td>-</td>
</tr>
<tr>
<td>Change in fair value of investment property</td>
<td>-</td>
</tr>
<tr>
<td>Recycling of gain/(loss) from equity on disposal of financial assets held for sale</td>
<td>-</td>
</tr>
</tbody>
</table>

| **Total**                                                                 | -             |
20.5.10. **Finance costs**

**Interest**
- Interest on loans and overdrafts
- Interest on obligations under finance leases

**Interest on obligations under PFI contracts:**
- Main finance cost
- Contingent finance cost

**Interest on obligations under LIFT contracts:**
- Main finance cost
- Contingent finance cost

Interest on late payment of commercial debt
Other interest expense

**Total interest**
Other finance costs
Provisions: unwinding of discount

**Total finance costs**

---

20.5.11. **Net gain/(loss) on transfer by absorption**

NHS Southwark CCG had no gains or losses on transfer by absorption during 2013-14.
20.5.12. **Operating leases**
Under the NHS Act 2012, all leases were transferred to NHS Property Services (NPSPS) or Guys and St Thomas' NHS Foundation Trust. Southwark CCG is recharged by NPSPS for the costs of its staff accommodation at 160 Tooley Street and running costs of Dulwich Hospital.
There are no formal agreements in place between NHPS and the CCG. Recharges were based on the budget transfers to those organisations from the former PCT, which were agreed by the CCG’s officers.

20.5.13. **Property, plant and equipment**
NHS Southwark CCG had no property, plant and equipment as at 31 March 2013.

20.5.14. **Intangible non-current assets**
NHS Southwark CCG had no intangible assets as at 31 March 2013.

20.5.15. **Investment property**
The clinical commissioning group had no investment property as at 31 March 2014.

20.5.16. **Inventories**
The clinical commissioning group had no inventories as at 31 March 2014.
### 20.5.17. Trade and other receivables

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,349</td>
<td>-</td>
</tr>
<tr>
<td>NHS receivables: Capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>2,429</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>3,056</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS receivables: Capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>55</td>
<td>-</td>
</tr>
<tr>
<td>Private finance initiative and other public private partnership</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>arrangement prepayments and accrued income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Finance lease receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Operating lease receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,896</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current and non current</strong></td>
<td>6,896</td>
<td>-</td>
</tr>
</tbody>
</table>

**Included above:**

- Prepaid pensions contributions

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.
### 20.5.17.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th>Duration</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>3,488</td>
</tr>
<tr>
<td>By three to six months</td>
<td>60</td>
</tr>
<tr>
<td>By more than six months</td>
<td>537</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,085</strong></td>
</tr>
</tbody>
</table>

£2,464k of the amount above has subsequently been recovered post the statement of financial position date.

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

### 20.5.17.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th>Description</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adjusted balance at 1 April 2013</strong></td>
<td>-</td>
</tr>
<tr>
<td>Amounts written off during the year</td>
<td>-</td>
</tr>
<tr>
<td>Amounts recovered during the year</td>
<td>-</td>
</tr>
<tr>
<td>(Increase) decrease in receivables impaired</td>
<td>-</td>
</tr>
<tr>
<td>Transfer (to) from other public sector body</td>
<td>-</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Receivables are provided against at the following rates:

- NHS debt -

The best possible health outcomes for **Southwark people**
20.5.18. Other financial assets

20.5.18.1. Current
The Clinical Commissioning Group had no other financial assets as at 31 March 2014.

20.5.19. Other current assets
The Clinical Commissioning Group had no other current assets as at 31 March 2014.
20.5.20. Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
</tr>
<tr>
<td>Net change in year</td>
<td>8</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>8</td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service: 8
- Cash with Commercial banks: -
- Cash in hand: -
- Current investments: -
- Cash and cash equivalents as in statement of financial position: 8
- Bank overdraft: Government Banking Service: -
- Bank overdraft: Commercial banks: -
- Total bank overdrafts: -

<table>
<thead>
<tr>
<th></th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 31 March 2014</td>
<td>8</td>
</tr>
</tbody>
</table>

Patients’ money held by the clinical commissioning group, not included above: -

20.5.21. Non-current assets held for sale

The clinical commissioning group had no non-current assets held for sales as at 31 March 2014.
20.5.22. **Analysis of impairments and reversals**
The clinical commissioning group had no impairments or reversals of impairments recognised in expenditure during 2013/14.

20.5.23. **Trade and other payables**

<table>
<thead>
<tr>
<th></th>
<th>Current 2013-14 £000</th>
<th>Non-current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest payable</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS payables: revenue</td>
<td>11,403</td>
<td>-</td>
</tr>
<tr>
<td>NHS payables: capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>3,591</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>3,102</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS payables: capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>9,151</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>40</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tax</td>
<td>50</td>
<td>-</td>
</tr>
<tr>
<td>Payments received on account</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other payables</td>
<td>544</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27,881</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

**Total payables (current and non-current)** 27,881

Non-NHS accruals includes a sum of £4,897k for prescribing in respect of two months outstanding invoices from the Prescription Pricing Authority, due to time lags in their processing of this information. This is in common with other CCGs treatment of this issue.

Other payables include £32k outstanding pension contributions at 31 March 2014.
20.5.24. Other financial liabilities

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

20.5.25. Other liabilities

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

20.5.26. Borrowings

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

20.5.27. Private finance initiative, LIFT and other service concession arrangements

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

20.5.28. Finance lease obligations

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

20.5.29. Finance lease receivables

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

<table>
<thead>
<tr>
<th></th>
<th>Current 2013-14</th>
<th>Non-current 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Pensions relating to former directors</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Pensions relating to other staff</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Restructuring</td>
<td>176</td>
<td>428</td>
</tr>
<tr>
<td>Redundancy</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Agenda for change</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Equal pay</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Legal claims</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Continuing care</td>
<td>357</td>
<td>366</td>
</tr>
<tr>
<td>Other</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>838</strong></td>
<td><strong>814</strong></td>
</tr>
</tbody>
</table>

**Total current and non-current**

<table>
<thead>
<tr>
<th></th>
<th>Pensions Relating to Former Directors £000s</th>
<th>Pensions Relating to Other Staff £000s</th>
<th>Restructuring £000s</th>
<th>Redundancy £000s</th>
<th>Agenda for Change £000s</th>
<th>Equal Pay £000s</th>
<th>Legal Claims £000s</th>
<th>Continuing Care £000s</th>
<th>Other £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2013</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adjusted balance at 1 April 2013</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Arising during the year</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Utilised during the year</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Reversed unused</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Unwinding of discount</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Change in discount rate</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Transfer (to) from other public sector body</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,452</td>
</tr>
</tbody>
</table>

**Expected timing of cash flows:**

<table>
<thead>
<tr>
<th></th>
<th>Within one year</th>
<th>Between one and five years</th>
<th>After five years</th>
<th><strong>Balance at 31 March 2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>604</strong></td>
<td><strong>428</strong></td>
<td><strong>366</strong></td>
<td><strong>1,452</strong></td>
</tr>
</tbody>
</table>

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March is £1,016k.
20.5.31. **Contingencies**

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

20.5.32. **Commitments**

20.5.32.1 **Capital Commitments**

NHS Southwark CCG had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2014.

20.5.32.2 **Other financial commitments**

NHS Southwark CCG had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2014.

20.5.33. **Financial instruments**

20.5.33.1 **Financial risk management**

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

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

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

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

20.5.33.1.2 Interest rate risk

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

20.5.33.1.3 Credit risk

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

20.5.33.1.3 Liquidity risk

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

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and Receivables</th>
<th>Available for Sale</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
</tr>
<tr>
<td>Embedded derivatives</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Receivables:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>· NHS</td>
<td>-</td>
<td>1,349</td>
<td>-</td>
<td>1,349</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>-</td>
<td>3,056</td>
<td>-</td>
<td>3,056</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>-</td>
<td>8</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Other financial assets</td>
<td></td>
<td>6</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td></td>
<td>4,419</td>
<td>-</td>
<td>4,419</td>
</tr>
</tbody>
</table>
20.5.33.3 Financial liabilities

<table>
<thead>
<tr>
<th>At ‘fair value through profit and loss’</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
</tr>
<tr>
<td>Embedded derivatives</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>-</td>
<td>14,995</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>-</td>
<td>12,253</td>
</tr>
<tr>
<td>Private finance initiative, LIFT and finance lease obligations</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other borrowings</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>-</td>
<td>27,248</td>
</tr>
</tbody>
</table>

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

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

20.5.36. NHS Lift investments
The clinical commissioning group had no NHS LIFT investments as at 31 March 2014.
### 20.5.37. Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables</th>
<th>Non-current Receivables</th>
<th>Current Payables</th>
<th>Non-current Payables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
<td>2013-14 £000</td>
</tr>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Central Government bodies</td>
<td>123</td>
<td>-</td>
<td>511</td>
<td>-</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>2,949</td>
<td>-</td>
<td>900</td>
<td>-</td>
</tr>
<tr>
<td>Balances with NHS bodies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS bodies outside the Departmental Group</td>
<td>1,629</td>
<td>-</td>
<td>962</td>
<td>-</td>
</tr>
<tr>
<td>NHS Trusts and Foundation Trusts</td>
<td>2,149</td>
<td>-</td>
<td>14,033</td>
<td>-</td>
</tr>
<tr>
<td>Total of balances with NHS bodies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public corporations and trading funds</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bodies external to Government</td>
<td>47</td>
<td>-</td>
<td>11,475</td>
<td>-</td>
</tr>
<tr>
<td>Total balances at 31 March 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 20.5.38. Related party transactions

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Related Party</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>Aylesbury Medical Centre</td>
<td>230</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aylesbury Medical Services Ltd</td>
<td>118</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aylesbury Partnership</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermondsey and Lansdowne Medical Mission</td>
<td>1,429</td>
<td>328</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermondsey Spa Medical Centre</td>
<td>61</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camberwell Green Surgery</td>
<td>105</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cambridge House</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concordia Health &amp; Concordia Health Group</td>
<td>192</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elm Lodge Surgery</td>
<td>58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guy's and St Thomas' NHS Foundation Trust</td>
<td>116,429</td>
<td>(338)</td>
<td>797</td>
<td></td>
</tr>
<tr>
<td>Kings College Hospital NHS Foundation Trust</td>
<td>97,201</td>
<td></td>
<td>2,986</td>
<td></td>
</tr>
<tr>
<td>NHS Lambeth CCG</td>
<td>352</td>
<td>(5,174)</td>
<td>49</td>
<td>(24)</td>
</tr>
<tr>
<td>Manor Place Surgery (Walworth Partnership)</td>
<td>197</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS England</td>
<td>767</td>
<td>(188)</td>
<td></td>
<td>(608)</td>
</tr>
<tr>
<td>SELDOC</td>
<td>258</td>
<td></td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>South London Healthcare NHS Trust</td>
<td>447</td>
<td>(121)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>London Borough of Southwark</td>
<td>4,749</td>
<td>(16,384)</td>
<td>190</td>
<td></td>
</tr>
<tr>
<td>Surrey Docks</td>
<td>86</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>The Gardens Surgery</td>
<td>82</td>
<td></td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>The Surgery East Street</td>
<td>134</td>
<td></td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Villa Street Medical Centre</td>
<td>103</td>
<td></td>
<td>32</td>
<td></td>
</tr>
</tbody>
</table>
The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Southwark.

**20.5.39. Events after the end of the reporting period**
There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group.

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

**20.5.41. Third party assets**
The clinical commissioning group held no third party assets as at 31st March 2014.
20.5.42. Financial performance targets

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>223H (1)</td>
<td>Expenditure not to exceed income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>223 I(2)</td>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>223I (3)</td>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>223J (1)</td>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>223J (2)</td>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>223J (3)</td>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>385,889</td>
<td>381,705</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>365,121</td>
<td>360,936</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>7,220</td>
<td>7,170</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: For the purposes of 223H(1): expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; an income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).
20.5.43. **Impact of IFRS**

Accounting under IFRS had no impact on the results of the clinical commissioning group during the 2013-14 financial year.
HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL FOR THE YEAR ENDED 31 MARCH 2014

Roles and responsibilities

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

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, 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;

• the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

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

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

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

A further component will be the assurances provided by the operation of the systems of internal control in three service organisations who provided key financial and other services:

• NHS South London Commissioning Support Unit

• NHS Shared Business Service.

• McKesson: NHS Electronic Staff Records
Reporting on the assurance provided by the systems of internal control operation within the service organisations is outside the scope of this opinion. Assurance on the arrangements will be provided by ISAE3402 Service Auditor reports provided by the Internal Auditors of these organisations.

**The Head of Internal Audit Opinion**

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

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

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

The basis for forming our opinion is as follows:
- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas.

**Commentary**

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

**Context for our opinion**

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

**The design and operation of the Assurance Framework and associated processes**

Overall our review found that the Assurance framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Governing Body. The review we have completed in this area has highlight areas for improvement that we believe could strengthen the process currently in place, although
do not hinder our ability to issue an overall substantial assurance opinion. We will follow up recommendations raised during 2014-15 period.

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

We have provided seven ‘adequate assurance’ opinions during 2013-14 for our reviews on Acute Contract Management, Scheme of Delegation, Quality Management and Responding to Francis, Budgetary control and contingency plan, Governance and Risk Management, Conflicts of Interest and Continuing Care. Within each review, areas of best practice have been highlighted to enhance the current arrangements that are in place.

The Scheme of Delegation review opinion was originally rated as requires improvement. The implementation of the recommendations made during the course of the year means that an adequate assurance opinion can be given.

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

KPMG LLP
Chartered Accountants
London
11 April 2014
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF NHS SOUTHWARK CLINICAL COMMISSIONING GROUP

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

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

- the table of salaries and allowances of senior managers and related narrative notes on page 55 to 57
- the table of pension benefits of senior managers and related narrative notes on pages 58 to 59
- the pay multiples and related narrative disclosure on page 59.

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

Respective responsibilities of the Accountable Officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the CCG; and the overall presentation of the financial statements.
In addition, we read all the financial and non-financial information in the annual report which comprises the Welcome, member Practices Introduction, Strategic Report, Members' Report, Remuneration report and Statement by the Accountable Officer to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report. In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

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

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

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

• our review of the Governance Statement;

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

• locally determined risk-based work arrangements in place to implement the Better Care Fund.

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

Certificate

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

Emily Hill
Associate Director for and on behalf of Grant Thornton UK LLP, Appointed Auditor

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5 June 2014