Annual report
2014/15
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**Chair:** Dr Jonty Heaversedge

**Chief Officer:** Andrew Bland

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Welcome

Welcome to NHS Southwark Clinical Commissioning Group’s annual report for 2014/15. This report is an opportunity to reflect on the past year, demonstrate the progress we have made and identify opportunities for greater improvement in the future.

The organisation continues to be committed to putting patients at the heart of commissioning. Over the past year we have engaged with local people to understand their needs and are dedicated to working with other health and social care organisations to create services that are patient-centred. We continue to work with partners to better connect services across the health and social care system. We want to join up and simplify the experience Southwark residents have of care, and enhance the impact local services have on the health of our population.

In our second year as a clinically led organisation, we have seen our plans to transform and improve services for our population begin to take effect. We have made great strides in implementing our Primary and Community Care Strategy; with all GPs in the north and south of the borough now collaborating to jointly deliver a range of enhanced services to Southwark residents. This coming together of practices has also given GPs a collective voice with which to engage with other local health and social care providers, enabling them to effectively participate in the development of new integrated models of care. It will also offer the opportunity for practices to collectively provide services that better reflect the needs of the diverse population we have in Southwark, and reduce the current variation in the quality of care patients receive across the borough. I would particularly wish to commend local practices for their commitment to working together, despite the tremendous pressures they are under as individual organisations. Their dedication has been rewarded by their successful bid to the Prime Minister’s Challenge Fund which has helped launch an extended primary care service across the borough - enabling people registered at Southwark GP practices to get a GP appointment between 8am-8pm, 7 days a week if they need one. We are the only CCG in the country to have fully launched an extended primary care service within the past year and we are already hearing about the positive impact it is having on the lives of Southwark residents.

We have continued our work with local partners to commission services that deliver better care for local people. This includes making sure that anyone with suspected cancer is seen, diagnosed and treated quickly and within the timeframes set by the national NHS. Southwark talking therapies services saw the highest number of patients of any CCG in London over the past year. This means that hundreds more people with anxiety and depression have received treatment compared to previous years. Local GP practices have also identified more patients with dementia than ever before. Over two thirds of local residents thought to have dementia are now known to the NHS meaning they can get the care and support they need to improve their quality of life as they live with the condition.

This year we continued our partnership with CCGs across south east London to deliver the Our Healthier South East London programme. This strategy aims to improve health and wellbeing, reduce inequalities of health outcome, ensure that health services across south east London consistently meet the high standards of safety and quality local people would expect, and that they are sustainable in the longer term given the very significant financial pressures currently faced by the NHS. It focuses on issues for people across south east London which need collective action to address them successfully, or where there is clear added value from health and social care commissioners and providers across the six boroughs of Lambeth, Southwark, Lewisham, Greenwich, Bromley and Bexley working together.

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland
Although we have seen success through our projects to redesign services, changing the way people use services takes time and the health economy has continued to face increasing pressure. Our A&E departments have experienced record attendance rates again this year and demand for all services continues to grow. There is no quick fix to these challenges, but we are confident that the changes we are making, alongside our partners and providers of care across the system, will help address them over time.

Over the next year we will be focussing on our plans to further promote integration, innovation and prevention in our local services. This will happen through collaboration with local partners including the jointly commissioned Better Care Fund with Southwark Council, the development of networks of health and social care provision centred around local communities, and our contribution to the Southwark and Lambeth Integrated Care (SLIC) programme – an alliance of all the health and social care commissioners and providers across Southwark and Lambeth with local citizens and the voluntary sector. Guiding us through all of this work is our vision for local residents to stay healthy for longer by doing more to prevent illness, giving people the information and support they need to better manage their own health and well-being, and enable those who require care to stay independent at home for longer by providing more services in their own homes and in the local 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.

Our extended responsibility for primary care co-commissioning also offers a real opportunity to make a difference for our population, and to go further in supporting effective and sustainable care that is closer to the local community and helps them to avoid trips to hospital.

I would like to thank our members, residents, partner organisations and stakeholders for their hugely 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 together to deliver our plans over the coming year.

Dr Jonty Heaversedge
Chair
Member practices introduction

NHS Southwark Clinical Commissioning Group (CCG) is the statutory organisation responsible 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 44 general practices are members of the CCG, and all GPs vote to appoint 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 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.

Our progress through the year

We are pleased with the performance of the governing body in leading the CCG during 2014/15. Our biggest projects during the year have been the implementation of our Primary and Community Care Strategy and development of our Joint Mental Health Strategy.

We have supported our members to develop geographically coherent neighbourhood GP provider organisations, where practices work collectively to improve the quality of services and outcomes for their combined registered populations. We have also launched an innovative new primary care service, available 8am-8pm, 7 days a week. These projects support our ambition to reduce variation in the quality of and outcomes from care; improve access and increase equity; better integrate and coordinate care; and increase the range of services in the community.
Through extensive stakeholder engagement, in partnership with the local authority, we have developed a local Joint Mental Health Strategy which outlines out plans and priorities to prevent and respond to mental ill health. The strategy and supporting action plan is an ambitious programme of activity to ensure we are delivering high quality, integrated services which aim to prevent mental ill health and reduce escalation of need, supporting more people to recover and stay well in the community. Read more in section 5.

**Putting quality at the heart of the organisation**

As a CCG, we have a clear duty under law to act to secure improvement in the quality of commissioned services on behalf of the population we serve. We also have a number of high-level aspirations around improving health outcomes and reducing variation in NHS services within the borough.

Last year we set out our response to the publication of the Francis and Winterbourne View reports and committed to review our processes and culture in respect of quality. We recognised the particular importance of meeting our statutory responsibilities whilst retaining a full focus on ensuring commissioned providers deliver the highest quality of patient care. As such, we have developed a Quality Framework. This is a set of standards and practices that our organisation should have in place to ensure that all commissioned services consistently provide safe and clinically effective care and deliver good patient outcomes and experience. Over the past year we have set about implementing changes. Read more in section 6.

**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 take this forward, and this is described in more detail in the full report in section 5.1.3.

Southwark Health and Wellbeing Board has strong input from the CCG to deliver its 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. We also agreed plans for the Better Care Fund pooled budget of £22m to strengthen and improve community based health and care services. You can read more about these plans in section 5.5.

**Planning across south east London**

In addition to our local plans we have developed a five year south east London strategic plan with our CCG 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. This work is being delivered through the Our Healthier South East London programme section 5.6.

**Financial position**

In 2014/15, we had a budget of £380 million, received from NHS England and other NHS agencies. At the year end, the CCG had managed its cash flow and stayed within the cash target of having less than 1.25 percent of the amount of cash drawn down in March remaining. We have also achieved a 1.9 percent (£7.3 million) surplus on our overall budget for the year.
Looking ahead

The NHS faces significant pressures and these pressures increase more with each passing year. People are living longer with chronic illnesses 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. We are responding to this challenge through transforming the services we commission. In 2015/16 this mission continues.

Full details of our strategic plans are available on our website at: http://www.southwarkccg.nhs.uk/our-plans/Pages/default.aspx.

In December 2014 NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Public Health England and Health Education England issued joint guidance called The Forward View into action: planning for 2015/16. This guidance describes the approach to implementing the longer term transformation described in the NHS Five Year Forward View, which was published in October 2014. The coordinated guidance includes a new support package for GPs, plans for a radical upgrade in prevention of illness, and new access and treatment standards for mental health services. Over the next year we will be incorporating this national guidance into our local plans.
Strategic report

1. Who we are and what we do

NHS Southwark CCG is the statutory body responsible for planning and commissioning high quality health services for Southwark residents. All 44 GP practices in the borough are members of the CCG and guide the organisation through the governing body. In 2014/15 we were responsible for a budget of £380 million which we used to plan, monitor and pay for hospital, community and mental-health services for people living in the borough.

More information about how we work with our membership is available in section 10.

You can read our full audited accounts in section 21 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 2014 to March 2015.

1.1. Break down of spending and who we commission from

![Pie chart: Where the money goes]

- Commissioned Services: Hospital: A&E (£14m)
- Commissioned Services: Hospital: London Ambulance Service (£11m)
- Commissioned Services: Hospital: Outpatients (£35m)
- Commissioned Services: Hospital: Emergency Admissions and Critical Care (£58m)
- Commissioned Services: Hospital: Planned Admissions (£84m)
- Commissioned Services: Hospital: Maternity (£22m)
- Commissioned Services: Hospital: Other (£51m)
- Corporate Costs (£13m)
- Commissioned Services: Client Groups (includes Mental Health and Continuing Care) (£68m)
- Commissioned Services: Community Contract and Primary Health Services (£34m)
- Prescribing (£32m)
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

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

1.3. 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.

The CCG’s three top priorities are outlined below.

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.
2. Health and wellbeing in Southwark

2.1. Health needs in Southwark

2.1.1. Southwark’s population

Southwark is a densely populated, young ethnically diverse borough with over 300 languages spoken. The resident population of 299,304 is estimated to increase by 16 percent over the next 10 years.

Southwark records comparatively high levels of internal migration, migrant national insurance number registrations, estimates of non-UK born residents and migrant GP registrations. The Black, Asian and Minority Ethnic (BAME) community account for around 47 percent of Southwark’s total population. Approximately 30 percent of people are classified as Black with a larger proportion of Black African (16 percent) and Black Caribbean (6 percent). The projections suggest BAME populations overall will increase by 23 percent.

Southwark will remain a young borough in 2024 with 23 percent of the population aged under 20 and 48 percent of the population aged 20-44.
2.1.2. What people die of

In 2013, 1,321 Southwark residents died. Cancer is the largest cause of death (30 percent) followed by circulatory disease (27 percent).
2.1.3. **Key Health Indicators**

Men can expect to live for 78 years and women for 83.1 years, significantly lower compared to England. Respiratory disease and cancer are key contributors to the life expectancy gap between Southwark and England, for men and women. More details on the key health outcomes and life expectancy can be found in the Joint Strategic Needs Assessment (JSNA) web pages (www.southwark.gov.uk/jsna).

The 2012, the under-18 conception rate for Southwark was 31.8 per 1,000 girls aged 15-17, representing an overall decline of 63.5 percent since 1998, the baseline, and a 25.5 percent reduction since 2011. This accounts for a reduction of 46 conceptions between 2011 and 2012.

The infant mortality (deaths of infants aged under one year) has dropped from 8.2 per 1,000 live births in 1995-97 to 4.3 per 1,000 live births in 2010/12, which is a reduction of 48 percent. Southwark’s rate is similar when compared to the London and England rate.

The 2010 Index of Multiple Deprivation (IMD) places Southwark as the twelfth most deprived borough in London and forty first most deprived in England.

2.1.4. **Health inequalities**

People in the poorer parts of Southwark die seven years earlier than those in the wealthier parts.

Circulatory diseases were a key contributor to this life expectancy gap between the least and most deprived areas, for males and females, as were respiratory diseases and cancer. For females, mental and behavioural disorders contributed to the life expectancy gap. Heart disease explained 40 percent of male and 65 percent of the female gap. Other conditions not specified for females contributed to 22 percent of the gap. Chronic obstructive pulmonary disease (lung disease) accounted for most of the gap for respiratory disease.

2.1.5. **Trends in premature or preventable mortality**

Over the past decade:

- there has been a 30 percent reduction in preventable deaths; and
- there is a continued need to reduce the risk factors related to ill health – smoking, high blood pressure, alcohol, obesity (diet and physical activity), and lipid control (cholesterol control) - through healthy policy as well as by targeting individual behaviour.

2.1.6. **Wider determinants of health (Marmot indicators)**

The Marmot indicators specifically measure factors outside the healthcare system which have an important impact on health and health inequalities. From 2009-2011 to 2010-12:

- healthy life expectancy in Southwark, for women improved from 60.2 to 62.5 years, but with no change for men, remaining significantly worse than the England average. Life expectancy at birth improved slightly for men (78 years) and women (83.1 years), but remained significantly lower than for the whole of England;
- on development and educational attainment, (key predictors for later income and health and wellbeing), 59.6 percent of children at the age of five have a good level of development, compared to 51.6 per cent on free school meals;
• the percentage of young people who obtained five A*-C GCSEs including English and Maths (65.2 percent) is higher than the English average (60.8 percent) for all pupils, and also for those on free school meals (Southwark: 60.1 percent, England: 38.1 percent); and

• unemployment levels in Southwark (10.4 percent) are worse than the England average of 7.4 percent. 15.4 per 1000 population are long-term unemployed, and in 2012, 6.4 percent of Southwark households were in fuel poverty, significantly fewer than the 10.4 percent average in England.


2.2. Southwark’s Health and Wellbeing Board

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

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 stories gathered by volunteers, who went into community settings around the borough, reflect the diverse needs and experiences of our communities - from staying fit and active, to preventing isolation, to dealing with long-term conditions, disabilities and mental illness. The stories shared by Southwark residents and the common themes drawn out from what we heard have been fed into the development of the Joint Health and Wellbeing Strategy, alongside evidence from the Joint Strategic Needs Assessment.

The refreshed Joint Health and Wellbeing Strategy focuses on working together to promote integration, to improve outcomes and to reduce health inequalities by:

• giving every child and young person the best start in life;
• addressing the wider socio-economic determinants of health, which we know determine our life chances: we will maximise opportunities for economic wellbeing, development, jobs and apprenticeships, and make homes safe, warm and dry;
• preventing ill health by promoting and supporting positive lifestyle changes & responsibility for own health and improving people’s wellbeing, resilience and connectedness;
• helping people with existing long-term health conditions to remain healthier and live longer lives by improving detection and management of health conditions including self-management and support;
• tackling neglect and vulnerabilities by supporting vulnerable children and young people and ensuring positive transition, ensuring choice and control for people with disabilities and supporting independent living for older people in an age friendly borough; and
• supporting integration for better health and wellbeing outcomes by integrating health and social care that is personalised and coordinated in collaboration with individuals, carers and families and by shifting away from over reliance on hospital care towards primary care and self-care.

In summer 2014, the Board carried out a review of governance in order to evaluate its ways of working and effectiveness. The review found that the Board has a good understanding of its purpose, has a clear vision and is meeting its statutory obligations. Some practical suggestions were made for improving operations, which have been implemented, such as appointing a deputy chair who is the current Chair of NHS Southwark CCG, setting up a planning sub-group to guide the forward work programme and holding informal seminar
sessions between formal board meetings to allow for more detailed discussion of key priority areas for the Board.

This year, the Board has worked towards greater integration of health and social Care and agreed the Better Care Fund plans for Southwark and this will continue to be a key area of focus as we go into 2015/16.

The CCG has reflected the Board’s priorities into its operational plan for the years from 2014/15 and 2015/16 and will continue as an active participant in the Health and Wellbeing Board to develop clear programmes of work and a refreshed monitoring framework. This will be a keystone of the CCG’s five year plan.

The Southwark Health and Wellbeing Strategy 2013/14 can be found here:

2.3. Preventing ill health

Over the last year the CCG has worked closely with partners to prevent ill health. For example, we have formed a Prevention and Resilient Communities Programme Board which brings together partners and patient representatives to identify what we need to do better to prevent people becoming ill. In many cases this is about improving the environment people live in so that housing is of a good standard, and people feel secure in their communities.

It is also about making sure we have good accessible service to help overcome the causes of illness. People with diabetes often develop other health problems. Over the last year the CCG has commissioned services to identify and work with people at risk of diabetes. We have also commissioned almost 200 self-management courses to help people learn how to look after themselves better.

We have prioritised the reduction of tobacco smoking, alcohol consumption and tackling obesity. We are talking to and working with people in our communities to better understand what will help to improve their quality of life and what we can do to help them stop smoking, drink less and lose weight. This is helping us to assess existing services and develop new approaches to help those who need it most.

This is not a quick fix. We will continue to concentrate on prevention of ill health and reducing inequality in 2015/16.
3. Working with local people

3.1. Engaging patients and the public

Local patients and residents are at the heart of what the CCG does and we have further consolidated our work to strengthen our patient engagement by building on the structures and methods that we developed in our first year.

In the last year the CCG has set up an Engagement Programme Board, chaired by Dr Jacques Mizan, the CCG’s clinical lead for engagement. The programme board reports to the Engagement and Patient Experience Committee, which is chaired by the CCG’s lay member for patient and public involvement, Diane French. The role of the engagement programme board is to work with the other newly established programme boards to plan and shape engagement in the CCG’s activity.

3.1.1. Supporting patient engagement across our pyramid structure

We continue to put a range of support and development opportunities in place to help patients across our pyramid engagement structure to build skills and knowledge to shape the NHS. As part of national Patient Participation Week in June 2014, we organised an evening workshop and had sessions on the role and objectives of patient participation groups (PPGs), having effective meetings and designing publicity and newsletters. Over 30 participants including practice staff attended and feedback was positive with nearly 90 percent of participants rating the sessions as excellent or good and two thirds stated that they felt more involved with the work of the NHS and everyone said that they would come along to another session.
This was followed up in July, February and March by dedicated training on the role of patients shaping the NHS and skills for effective meetings which was attended by 30 Southwark patients including people with learning disabilities, over 90 percent of whom rated the session as good or excellent “good training to a mixed ability group”.

The CCG funded two patient representatives from the Engagement and Patient Experience Committee to attend the annual National Association of Patient Participation conference on the theme of quality in primary care and what this means for patients. The Southwark representatives found it a 'stimulating and constructive experience' and they generated a lot of interest in the Southwark model of engagement and supporting PPGs.

You can also read about our engagement work on improving health services in Dulwich and surrounding areas in section 5.3.3.

### 3.1.2. Plans for the future

The CCG is developing its approach to engaging with our diverse communities across Southwark to reach out to those who are seldom heard. The approach involves working with partner organisations such as the Council, Healthwatch and a range of voluntary sector organisations such as the Forum for Equality and Human Rights in Southwark and Blackfriars Advice Centre.

The CCG will be reaching out to local communities from May 2015 to talk to them about the new extended primary care access service across Southwark and will be using its approach to engaging with seldom heard voices to inform this work. Moving forward, we are keen to develop a range of mechanisms to understand patient experience of the new service.

At the time of writing, the CCG is scoping out the development a digital platform to support local people to self-manage long-term conditions, to help them find the right health service for their need, and speak to a more diverse group of people to understand their views and develop services that respond to them.

### 3.2. How we support CCG staff

The CCG is committed to its staff and recognises that the organisation's aspirations can only be delivered via its workforce.

During 2014/15 the CCG received the results from its first staff survey. This was confidential, undertaken by an external company and an opportunity for employees to feedback on areas they valued, areas working well, and areas which could be improved. The CCG achieved a response rate of over 82 percent, a strong result which gave useful, credible data.
In order to respond to the survey’s feedback volunteers self-nominated to a focus group, chaired by the Head of Governance and Organisational Development. The group fed its recommendations into the governing body, and back to staff via one of the CCG’s monthly all-staff meetings.

Changes include the establishment of a Happy, Healthy Workforce Group promoting staff wellbeing, a commitment for the CCG to achieve the Mayor of London’s Workforce Wellbeing Charter, and an increased training offer for general management areas.

The CCG has regular attendance levels of about 80 percent at its staff meetings and has experienced good staff support for initiatives such as a Macmillan coffee morning, British Heart Foundation ‘Wear Red’ day, and the Prostate Cancer Movember campaign.

3.2.1. Training and development

Throughout 2014/15 the CCG continued to support its staff and governing body with training and development to ensure they had the tools to do their jobs. Objectives, appraisal and personal development plans were set for the majority of staff and governing body members. Approximately £10,000 was received from Health Education South London (HESL) for CCG staff which was allocated to support development identified within their Personal Development Plan. In addition, generic training was made available via the South East Commissioning Support Unit, and there was high compliance for the mandatory training required.

To support the organisation’s restructure a bespoke organisational development programme was commissioned which will run through to early 2015/16. An induction programme was run for new governing body members including meetings, targeted reading, and training and other governing body support included a 360 degree leadership review, skills audit, governing body effectiveness survey, development workshops, masterclasses, thinking space lunches, Chair’s email blog.

The overarching development theme through 2014/15 was to support the organisation to flex and adjust whilst ensuring it remained stable and highly functioning, especially against the contextual challenges it faced. As the CCG continues to establish itself as a high functioning organisation, flexible to the demands made upon it, training and development will continue to have an important focus.

3.2.2. Employee consultation

The CCG undertook a staff consultation on proposed changes to its structure between 17 June 2014 and 18 July 2014. The consultation included all members of the CCG management teams.

The launch of consultation followed a significant level of staff and governing body engagement with staff to discuss potential changes. The consultation period included two staff meetings, a series of directorate team meetings, opportunities for 121 discussions with senior management team members and drop-in sessions with HR colleagues on 4 and 15 July 2014.

As part of the consultation launch staff members were invited to provide feedback to the proposals either in writing (a feedback form was provided) or verbally. On 9 July 2014 members of staff were provided with a questions and answers document that captured the feedback and provided responses at that point of the consultation.

There was also a follow up consultation exercise on proposed changes to the administration function of the CCG. This resulted in one employee being made redundant.

There was also a consultation exercise with South East Commissioning Support Unit (CSU) which resulted in three finance staff being transferred to the CCG in 1 October 2014.
3.2.3. Supporting disabled staff

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>14</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>
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. 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)

Southwark Council

- Southwark Public Health Team
- Southwark Health and Wellbeing Board
- Southwark Council Health and Social Care Overview and Scrutiny Committee (OSC)

NHS organisations in London and across England

- London Ambulance Service
- Department of Health
- NHS England
- Public Health England

Other key partners

- NHS South East Commissioning Support Unit
- NHS Lambeth CCG
- NHS Lewisham CCG
- NHS Bromley CCG
- Healthwatch Southwark
5. **Our programmes for improving health outcomes**

The CCG has established four strategic ambitions, all of which contribute to an overarching ambition of establishing the effective integration of services to deliver better quality care and improved patient outcomes.

These ambitions are listed below.

1. Commission services to ensure local people can easily navigate and access appropriate care when they need it.
2. Commission services that support the prevention of ill health, the early identification of disease and focus on improving patient wellbeing.
4. Commission services that provide personalised care, empowers patients and supports people to maintain their independence through effective self-management.

To deliver these ambitions, the CCG has identified a series of transformation programmes within which we will work to deliver our key pieces of service redesign and integration. Both the structure of our transformation programme areas, and the detail of the commissioning intention or work programme within each area, is designed to intersect with the priorities included within Southwark’s Health and Wellbeing Strategy; the Better Care Fund, and also with the emerging opportunities outlined in the south east London five year strategic plan case for change.

The following part of this section outlines the CCG’s key commissioning programme delivery for 2014/15, split by transformation programme area, and priorities for 2015/16

5.1. **Integrated care**

Integrated care is health care which is joined up and more coordinated. This is especially important where services are traditionally more fragmented which makes it difficult for patients to navigate the health and social care system. We know that for some patients, particularly those with long-term conditions, it can be frustrating where different agencies involved in delivering care do not communicate well, or where multiple appointments or assessments are needed which could have been done through a single process. By integrating services we aim to improve the health outcomes and patient experience, reduce duplication and improve value, and ensure that patients are more involved in the planning of their care.

**Our progress during 2014/15**

The CCG worked with Southwark and Lambeth Integrated Care (SLIC) programme and Southwark Council to agree future commissioning plans for integrated care. Both commissioners and providers have stated their commitment to move towards ‘outcome based’ contracts, meaning better outcomes for people using services. We recognise that activity based contracts can offer perverse incentives, and do not always promote joined up care. An unintended consequence of such contracts is that they address only the patient’s immediate needs without seeking to prevent ill health or address the underlying health and social issues that the patient may be experiencing. Therefore, we want to incentivise providers to work collaboratively to redesign care pathways that prioritise health outcomes that are meaningful to patients, enhance patients experience of care and promote prevention, wellness and wellbeing in order to reduce the burden of disease and health inequalities. During the year we worked with citizens to create outcome based personalised statements reflecting what people told us they wanted to see and feel as an outcome of their care. During 2015/16 we will build on this and issue our first outcome based contracts.
We also worked with patient groups, the voluntary sector and our partner organisations across health and social care, to design Local Care Networks. These new groups will bring together all organisations across a local area to transform services in our communities. Local Care Networks will be geographically coherent, serving natural communities, and have autonomy to act for that population. They will bring services together and break down the barriers between primary, social, community and mental health services to provide more services in the community, reduce the amount of duplication and put a real emphasis on prevention, wellness and wellbeing rather than on treatment alone. We have been co-designing Local Care Networks in 2014/15 ahead of their full roll-out in 2015/16.

The CCG oversaw the extension of the ‘@home’ hospital admission avoidance programme including full roll-out of Homeward across Southwark with patients supported when discharged from hospital by integrated services through a single point of access. This has helped ensure that more patients are able to be cared for and supported in their own homes, reducing the length of time that patients need to spend in hospital, or avoiding admissions entirely.

We also worked with SLIC and other partners to deliver on key enablers of integration, including information sharing across hospital, primary care and social care, to support better care. We know that one of the barriers to better integrated services is timely access to patient notes. During 2014/15, 43 of our 44 GP practices have moved to the same IT system which will enable them to share information with partner organisations such as Guy’s and St Thomas’ Hospital and King’s College Hospital. Our hospitals have also launched a new IT system called KHP Online, which enables hospitals to share patient notes to make sure that they are able to care most appropriately for patients, leading to better outcomes and reducing the need for duplication of diagnostic tests. There is still much more we can achieve, but significant progress has now been made on an issue that has been problematic for many years.

We also continued the roll out of SLIC interventions, including holistic assessments, integrated care management and community multidisciplinary teams have also been a major step forward. These interventions aim to make sure that we are working proactively with those most at risk of falling ill or having unplanned admissions into hospital. Holistic assessments offer patients the opportunity to discuss their physical health, mental health, and social needs to enable a care plan to be put together. An Integrated Care Manager then co-ordinates all the different services that the patient needs and acts as a named contact point for any additional support that the patient requires. Community multidisciplinary teams bring together hospital, community, primary and social care staff to discuss patients with complex needs to make sure that all agencies are working together to provide the best possible care, and ensure that any system issues can be overcome as quickly as possible. Read more about the work of SLIC in section 5.1.3.

### 5.1.1. Mental health

**Our progress during 2014/15**

During 2014/15 the development of a joint mental health strategy with the local council took place responding to a local needs assessment and extensive stakeholder engagement to identify strategic intentions and priorities for the prevention and responding to mental ill health locally. The strategy is due to be approved by cabinet and the governing body in May 2015 and published in spring 2015.

**Talking therapies**

Throughout 2014/15 the review and development of talking therapies delivered across primary and community services has taken place resulting in additional investment to build capacity and reduce inequality in service delivery. In addition, following extensive stakeholder engagement further innovations in providing psychological therapies have taken place including developments of a tailored service offer for people with long-term conditions. Going forward, the retendering of the talking therapies provision provides further
opportunity to improve quality of provision and further develop innovative approaches to supporting people in Southwark with common mental disorders. Developments in 2014/15 mean that Southwark increased the number of people accessing services and made improvements to achieve better recovery rates. We achieved the national standards for Improving Access to Talking Therapies (IAPT) and were the third highest performing CCG in London.

In order to improve equality in access and quality of Talking Therapies provision and inform the development of a new talking therapy service which will be commissioned during 2015/16 the CCG developed an online patient survey. Paper copies were also provided by practice counsellors and a patient engagement event was held in April 2014 with nearly 90 percent of participants rating the event as good or excellent. There were 65 patients who took part in the survey with a further 20 attending the engagement event where the themes below were identified.

- On the whole, all services were seen to be helpful and people valued the service they received.
- Location of services in GP and other community settings was seen as positive and flexibility in terms of appointment times and location was important. 55 out of 57 people were satisfied or very satisfied with location of services which predominantly were in GP practices. 25 out of 57 people said they would prefer a GP practice and 26 said would prefer both GP practice and community settings. 50 out of 59 people were satisfied (23) or very satisfied (27) with opening hours.
- Self-referral was highlighted as being important to improve access and timeliness of services.
- Experience of therapist and language spoken were important to respondents with a shared view that a wide range of therapies should be available, including alternative, group and digital technologies.
- Interventions for people with physical health and long-term conditions are seen to be important and support for the mental health needs of carers should be considered in the delivery of the service.
- Waiting times for some services was seen as an issue and variable with a consensus that services need to be responsive to individual needs, with rapid assessment and reduced waiting times.
- Out of 59 responses to the survey, 36 were satisfied (10) or very satisfied (16) with services. Nine were neither satisfied nor dissatisfied with waiting time from referral to initial assessment. Out of 58 responses, 42 were satisfied (21) or very satisfied (21) with the time it took from initial assessment to treatment. There were 6 neither satisfied nor dissatisfied.

You can read more about patient engagement in mental health service development later in this section.

**Dementia**

Dementia diagnosis is high priority for the national and local health and social care services. In 2015/16 the NHS England national target for diagnosis is set at 66.7 percent. Dementia affects over 830,000 people in the UK. Around 23 million of the UK population has a close friend or family member with dementia. As well as the huge personal cost, dementia costs the UK economy £23 billion a year, more than cancer and heart disease combined.

South London and Maudsley NHS Foundation Trust (SLaM) have been commissioned to have a greater role in diagnosing dementia in primary care and supporting GPs to identify dementia early, and refer people for a memory assessment. The new role will also provide training to the wider primary care and community sector and will make links with social care and voluntary sector funded organisations that provide access to support for the patient and their families, enabling them to live well with dementia in the community.

It is estimated that there are around 1,115 people over the age of 65 in Southwark have dementia (figure calculated using new prevalence methodology from NHS England). In 2014/15, 250 Southwark residents were provided with a dementia diagnosis assessment. The CCG is working with local partners with the aim of increasing the number of assessments to 350 in 2015/16.
Integrated, person centred care and support

Throughout 2014/15 the integration of physical health services alongside mental health services to provide holistic support that is centred on the needs of each individual has been a priority for the CCG.

The older adult community mental health team was brought into a single service during the summer of 2014 to share resource and create equality in provision. As a result of co-locating the multidisciplinary team, support workers and nurses are working more collaboratively alongside psychology, psychotherapy input and occupational therapy provision addressing holistic needs of individuals.

The delivery of the innovative 3 Dimensions for Diabetes (3DFD) has been provided in Southwark since September 2014. It offers psychological and social support alongside physical health care for people with diabetes improving the quality of care for patients with diabetes and enabling them to manage their conditions more effectively. Delivered through the multidisciplinary approach across the King’s Health Partners and community organisations, service user feedback is showing improved satisfaction with services and an improvement in the management of blood sugar levels which improves the prognosis and outcomes of people with Diabetes.

The way social care services are being integrated with mental health care is ensuring people receive holistic support that meets their needs. This includes social care practitioners working across urgent and unplanned care, community mental health and drug and alcohol services providing more joined up care. In addition, the roll out of social care reablement services, which help people to regain skills and confidence following a period of ill health or a stay in hospital, is reducing hospital stays for people with mental ill health, helping them to be discharged earlier with their social care needs supported, and reducing readmissions to hospital.

Person centred care and support

This means someone has more say in the care and support they receive and it has been an important area of work for the CCG to improve the patient journey through services.

The introduction of the recovery and support plan CQUIN (quality initiative) for all South London and Maudsley NHS Foundation Trust (SLaM) services includes the requirement to develop and review progress against self-defined recovery goals and ensure personalised recovery, staying well and crisis prevention. This means the CCG is delivering a fundamental shift in ensuring services are responsive to the needs of individuals. In addition, the introduction of personal social care budgets for mental health service users with social care needs is giving more choice and control to individuals over the care and support they receive in their recovery journey. Currently approximately 241 mental health service users are in receipt of personal social care budgets with on-going work to expand this by a further 20 percent of SLaM service users through the introduction of a personalisation team. Recent engagement with people in receipt of personal budgets shows the extremely positive impact they are having, with people feeling more in control of their recovery journey and empowered to make decisions about their life and their future.

Delivering efficient and effective services

Throughout 2014/15 the triage of all specialist referrals through a multiagency panel arrangement across children’s, adults and older adults mental health services is helping us to work more efficiently with the resources we have. The CCG has continued to develop innovative ways to provide more responsive community based services to reduce escalation of need and demand on hospital inpatient services including the development of home treatment services for adults at risk of, or in mental health crisis, and development of older adults community services enabling more people to stay at home longer, reducing increases in the number of people who need specialist and hospital based services.
A review of residential and nursing care took place locally to provide more flexible accommodation based support options. As a result the CCG is working to make care responsive to the changing needs of the individual and support more people to recover quicker and live independently, reducing the reliance on residential based care. Three care providers locally have been deregistered from the 1 January 2015 resulting in approximately 30 placements now offering more flexible care and support options in more independent settings for people with complex mental health needs.

Urgent and unplanned care

Throughout 2014/15, King’s College Hospital, Guy’s and St Thomas’ Hospital, SLaM and Southwark Council have continued to review and develop the approach to psychiatric liaison in urgent care to ensure a high quality care for people in mental health crisis. Developments have included the increase of specialist clinicians at peak times, an improved and more integrated journey through urgent care from mental health navigators who ensure appropriate assessment, treatment, discharge and follow up for people attending A&E with mental health needs, and more robust escalation processes to reduce delays in response from partner organisations. In addition, the psychiatric liaison team is working more with patients in hospital to help with the identification of mental ill health for people with physical health issues.

Supporting people to live independently

A range of commissioning and service development activity has taken place through the year to enable more people to live independently or stay at home for longer. For example, the commissioning of an enhanced multidisciplinary Learning Disability (LD) Intervention Team, which provides specialist support to families with children and young people with LD, who have challenging behaviour, will enable more children and young people to remain at home for longer or effectively transition to independent living in the community, reducing escalation of need and demand on specialist placements. In addition the Specialist Mental Health Intervention team is supporting care homes and families to manage and support older adults with mental health needs, reducing placement breakdown and need for more specialist care. Additional work to support people with LD will be implemented via the Better Care Fund in 2015/16.

Helping communities to support one another

SLaM continue to offer a broad range of courses through the Recovery College, which aims to support individuals who are in touch with or recently discharged from SLaM services, their family, friends or carers to become expert in their own recovery and living well with their condition. Co-production is at the heart of the Recovery College model with courses co-designed and co-delivered by experts by experience alongside professional trainers. In addition during 2014/15 the commissioning of self-management courses has been expanded to for people with mental health needs supporting more people to manage their condition.

Following a successful pilot of the “Faith and Mental Health” project which trained faith leaders to promote wellbeing and raise awareness within community groups of mental ill health and engagement in mental health services, the CCG has commissioned a further two-year Mental Health Training in Pastoral and Spiritual Setting Project. This will build capacity and awareness of mental ill health within community groups, often described as hard to reach, to support one another. It is estimated 20,000 people gather to worship in around 240 different churches across Southwark each week.

In addition the CCG, in partnership with Southwark Council are undertaking a review of provision locally to ensure equality of access and sufficiency of mental health support services for Black, Asian and Minority Ethnic (BAME) and marginalised groups across the borough. The review, which includes significant stakeholder engagement, will conclude in May 2015 and will be used to support the development of commissioning intentions and service development areas going forward.
Enhanced Assessment and Liaison Service

The Enhanced Assessment and Liaison Service went live in 2014 provides a single front door to secondary care mental health services and named mental health specialist support for all GP practices to enable informed decision making and increased knowledge of mental health conditions and treatment options available across primary care. As a result of extensive GP, mental health clinicians and service user engagement the Enhanced Assessment and Liaison service now provides more specialist, therapeutic orientated mental health assessments and brief interventions earlier. This is achieved through more skilled clinicians reducing risk adverse decision making and facilitating improved access to the right help at the right time to people who need it.

Big White Wall

Following a successful funding bid to the Regional Innovation Fund, the CCG has been piloting the use of Big White Wall since July 2014. This is a safe online community of people who are anxious, down or not coping who support and help each other by sharing what’s troubling them, guided by trained professionals. The aim is to provide varied and innovative services for people affected by mental illness.

Southwark Wellbeing Hub

A new service for local people in need of support for mental ill health is opening in May 2015. The CCG has commissioned the Southwark Wellbeing Hub, which will be a space for people to access information, advice and facilitate access to services on promoting positive wellbeing, managing recovery from mental ill-health and staying well. The Hub will be open to anyone with poor mental health or a mental health condition as well as their friends, family and carers. It will offer information, advice and navigation to key services and support through a well maintained directory of local provision. It will also offer crisis open access and support which complements the health crisis support services. The Hub will be open a minimum of five days a week, with flexible opening times and will support professionals as well as service users to make sure people can find and benefit from the range of support available in Southwark.

Mental Health and Parity of Esteem Board

The creation of the Mental Health and Parity of Esteem Board, chaired by the GP lead for mental health, is providing strategic leadership to promote parity of esteem throughout Southwark CCG and its partners, as well as promoting integration and partnership working for the development and maintenance of high quality services across Mental Health, Learning Disabilities and Drug and Alcohol services across all ages.

Physical and mental health

The 2014/15 national physical health CQUIN adopted by SLaM has developed care pathways and capacity to fully implement appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia and psychosis. The CQUIN supports earlier identification and more responsive approach to addressing people’s physical ill health alongside their mental health conditions to improve outcomes and reducing premature mortality in people with serious mental illness conditions. Further work to build on with progress with improved physical health will be adopted during 2015/16 through development and promotion of integrated physical and mental health care pathways across community mental health services achieving improved parity of esteem across secondary mental health care.

Patient engagement

The CCG mental health commissioning team continue to run a diverse and active engagement programme throughout the year which directly influences decision making and the development of services and provision.
locally. Monthly engagement at the Dragon Café on key service development areas, a diverse user engagement programme ran through Southwark and Lambeth Mind and the use of experts by experience on key project and programme groups (Adult Mental Health Transformation Programme, Improving Access to Psychological Therapies (IAPT), Enhanced Assessment and Liaison) is ensuring the voice of service users is a the heart of local service delivery. Going forward improved engagement with GPs and CCG member practices will be a key priority to complement the current service user engagement programme.

Plans for the future

To continue to build on the positive work during 2014/15 the adult mental health services transformation programme has the ambitions outlined below.

- Launch the Southwark Wellbeing Hub to provide advice for people to get the most out of their personal health budgets, including using them on existing services like day centres and peer support groups as well as other support like gym membership or equipment.
- Enhance community based adult mental health services moving from monitoring and tracking to intervention and recovery through more intensive, multidisciplinary, evidence based treatment in the community
- Provide more specialist, responsive community based crisis care which intervenes earlier in the escalation of mental ill health reducing potential and severity of crisis and supporting earlier discharge from hospital through the ability to provide intensive home based care for people who would otherwise require longer lengths of stay
- Provide specialist, time limited interventions targeted at those most at risk of repeat hospital inpatient stays and emergency admissions including evidence based treatment and support for people with personality disorder and complex mental health issues.
- Build on the success of the Enhanced Assessment and Liaison Service to develop a safe and effective mental health offer across primary care which supports successful repatriation of service users between primary and secondary care, helping more people to avoid distressing trips to hospital and instead, receive the care they need close to home. In transforming the secondary care system with a focus on intervention and recovery, an enhanced primary care mental health offer will allow more people to progress through their recovery journey reducing dependency on hospital services and increasing the likelihood of recovery and staying well.

5.1.2. Southwark and Lambeth Integrated Care

In 2012, the health and social care organisations and people in Southwark and Lambeth came together so that local people can lead healthier and happier lives. Southwark and Lambeth Integrated Care (SLIC) is the partnership that brings us together. This means we can help communities and professionals to work better together to provide proactive and preventative care that gives local people control of their own health and wellbeing. For professionals, we need to make the right thing to do the easy thing to do. SLIC is a network between local GPs, the three local NHS Foundation Hospital Trusts (Guy's and St Thomas’ NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and King’s College Hospital NHS Foundation Trust), the Southwark and Lambeth Clinical Commissioning Groups, social care and people in Southwark and Lambeth, supported by Guy's and St Thomas’ Charity.

Our progress during 2014/15

Older People’s Programme

The Older People’s Programme consists of many different projects, which are categorised by:

- better proactive identification of need and intervention;
• an alternative urgent response;
• maximising independence before long-term care is finalised; and
• improved clinical pathways.

The Older People’s Programme has helped to proactively identify the needs of older people within general practice, through the creation of registers of people aged over 65 and by working with these people to complete holistic assessments. The Older People’s Programme has developed proactive interventions within general practice through the provision of Integrated Care Managers and the formation of community multidisciplinary meetings, where staff from across health and social care discuss the care of people being supported by Integrated Care Managers.

The programme has also shown that proactive identification of care needs can have a real benefit on people’s lives. It has shown that there are areas of real unmet need, such as those identified within a holistic assessment, which often go undetected until they result in emergency presentations at hospitals or care home admissions.

Through the work of the Older People’s Programme in 2014/15:

In Southwark:

• 1100 people have had a holistic assessment within general practice to generate their care plan (January 2014 – January 2015).
• 170 people have had their care co-ordinated by an Integrated Care Manager (January 2014 – January 2015).

In Lambeth:

• 2296 people have had a holistic assessment within general practice to generate their care plan (January 2014 – January 2015).
• 339 people have had their care co-ordinated by an Integrated Care Manager (January 2014 – January 2015).

Across Southwark and Lambeth:

• 1206 people have had their care supported with enhanced nursing, therapy and social care support in the community so they do not need a hospital stay (December 2013 – November 2014).
• 998 people have had their acute clinical care provided at home, through the Guy’s and St Thomas’@home service, this is care that would otherwise be carried out in hospital (December 2013 – November 2014).
• General practice and community staff have had immediate advice from a consultant in geriatric medicine 527 times (in 2014).
• 449 people have had their care discussed at a community multidisciplinary team meeting (December 2013 – November 2014).

Developing the work of the Older People’s Programme by building resilient communities and individuals

A programme of work was undertaken in 2014/15 to identify the ongoing work needed to improve the experience and clinical outcomes for people with long-term conditions and to ensure their model of care is sustainable. This work identified that further integration of services will not achieve this and instead the emphasis needs to shift to enabling and supporting people to live independently with their condition.
The aims of the SLIC Resilience Programme were established at the beginning of 2014 through four workshops involving patients, carers, health and social care professionals and voluntary sector colleagues. The objectives for the programme were agreed as follows:

- to empower adults with multiple long-term conditions to self-manage and live as independent and healthy a life as possible; and
- to ensure that when care is needed it is organised around the whole person in their whole life and supports self-management.

This early work also set out that the focus needs to be on the whole person, addressing physical and mental health and wellbeing, and not on specific clinical diagnoses. Through this work we needed to take a whole system approach and look to build on existing local capacity, skills and knowledge and connections of individuals and communities, and to develop them further.

At the conclusion of this work, five short, medium and long-term recommendations were formed, they are listed below.

1. Adapt a collaborative approach to care.
2. Develop a self-management support system.
3. Increase access to services.
4. Support the voluntary and community sector as an effective provider.
5. Support a culture of community giving and support.

The recommendations were approved by the SLIC Programme Board and this work will be amalgamated within the core programme of SLIC, rather than through a separate resilience programme. These projects are being worked up into a business case for approval in spring 2015.

Making change happen

We want to build on what works from our Older People’s Programme. That means continuing an integrated approach to multidisciplinary teams providing coordinated assessments and care; we know this can only happen at scale by system and behaviour change, from citizens and professionals. That is why the health service providers, commissioners and citizens in SLIC have come together to explore a radical transformation of how care is provided to local people. Within this programme there are three key working groups: the Provider Group, the Integrated Commissioning Group and the Finance and Payment Group. In May last year, health and social care commissioners and providers established principles for working together to transform the care system.

Health and social care commissioners issued joint commissioning intentions, these include:

- bringing together budgets across health and social care within each borough;
- shaping resources around the needs of groups of people and articulating required attributes of care;
- moving over time towards capitated contracting in order to shift resource to invest in primary, social and community care; and
- focusing on performance indicators that measure value: clinical effectiveness, citizen and staff experience and total costs.

Health service providers have worked together to welcome those intentions and to commit to:

- working together to co-design services that are characterised by the attributes of care;
- creating a genuinely joined up system through partnership working;
• working together to develop complementary models of neighbourhood working across primary, community, social and specialist care (including mental and physical health); and
• focusing on developing the infrastructure – in terms of estates, infrastructure and leadership – necessary to enable adoption of integrated working practices.

In 2014/15 the partnership has also made a commitment that by April 2016 we will:

• fully implement health management techniques with risk-based assessments, multi-disciplinary reviews and care management for people with complex needs;
• deliver the plans within our Better Care Fund;
• establish five Local Care Networks with nominated clinical directors and general management capacity;
• roll out a better information sharing system across health and social care providers, so clinicians can get the full picture they require whether they see a person in a GP surgery, community setting or hospital; and
• agree new contracts for health and social care service providers, to underpin integrated working.

5.1.3. Improving the health outcomes for clients living in care homes

Clients in care homes are one of our most vulnerable populations and are often excluded from or receive fragmented and variable services. Historically there have been concerns about the quality of care provided in the care homes in Southwark and no formal CCG commissioned model for the provision and funding of primary care services to these care homes. Therefore the CCG did not have mechanisms in place to ensure that the clinical services provided in care homes are contributing to the delivery of better outcomes for the patients who live there.

Our progress during 2014/15

The CCG, working in partnership with Southwark Council and care home providers, developed a service specification for the delivery of primary care services to the care home with nursing, which described a multi-disciplinary approach. The GP would be the lead of the multi-disciplinary team consisting of a Consultant Gerontologist, Older People’s Nurse Specialist, social workers and pharmacy support. The contracts for the four care homes was tendered and awarded to a single GP provider. The service commenced in April 2014 and is being evaluated at the time of submitting this report, and the learning will be used to inform the model of support required for residential care in Southwark.

The CCG has been working in partnership with Southwark Council and care home providers to develop a Care Home Quality Improvement Strategy. This strategy was produced within the context of wider initiatives taking place through SLIC. This has the overall aim to reduce unnecessary A&E attendances and hospital admissions and to consider the importance of the role of care homes within four key project areas: falls, infections, nutrition and dementia. SLIC are also focussing on improving way hospitals and care homes in Lambeth and Southwark work together to ensure patients are discharged with the support they need and to reduce unnecessary readmissions.

The Care Home Quality Improvement Strategy identifies five key areas for change:

• quality assurance;
• integrated working
• safeguarding;
• working together in the future; and
5.1.4. Long-term conditions self-management

Our progress during 2014/15

Over the last year, the CCG has worked with GP practices, hospital trusts, charities, Southwark Council, NHS Lambeth CCG and patients to design services which support Southwark residents with long-term health conditions to keep themselves well and increase their levels of independence.

The collaborative care planning approach has been embedded across providers in primary and secondary care. In previous years, GP practices have been incentivised to take a collaborative care planning approach with their diabetic patients. Following the significant improvements in the quality of care and health outcomes for people with diabetes over this period, incentives have now been extended so that people with hypertension and chronic obstructive pulmonary disease (COPD) are also included.

To ensure that clinicians are skilled in this approach, the CCG has commissioned further training to those primary care clinicians who did not complete the training in previous years, and has also commissioned motivational interviewing training. In the hospital trusts, there is a contractual incentive for all doctors and nurses working across the integrated respiratory team and diabetes team to be trained in collaborative care planning.

With the same goal of empowering and enabling Southwark residents with long-term health conditions to keep themselves well and increase their levels of independence, the CCG has commissioned a number of different organisations to provide self-management courses. The following is an overview of the types of courses commissioned: general courses suitable for all people with a long-term condition, courses specifically for carers, courses specifically for people with mental health conditions, courses specific to people with diabetes. The CCG is also piloting a self-management course for people identified as being at risk of diabetes.

Further self-management resources have been commissioned to provide greater access to tools which empower people to increase their independence and keep well. The CCG is part of two online self-management course pilots, being part of a ‘myhealthlocker’ pilot allowing diabetes patients to access their results online, and also providing printed copies of diabetes self-management workbooks. The initiatives below have been commissioned as part of the Better Care Fund (see section 5.5).

- Self-management for life – general self-management course, carer course, mental health course.
- Self-management UK online course.
- Living with diabetes self-management course.
- Diabetes self-management pack.

We commission the following services jointly with NHS Lambeth CCG:

- Living with diabetes self-management course
- CQUINS for acute trusts for collaborative care planning and training

Our key achievements during 2014/15 are:
• 195 self-management UK courses available to Southwark residents;
• 60 spaces on the living with diabetes courses available to Southwark residents;
• 64 places available on the online self-management UK course available to Southwark residents;
• Breathe Easy group integrated into the patient pathway for breathlessness; and
• all diabetes patients offered the DESMOND self-management course as part of the type 2 diabetes patient pathway.

Engagement

The chair of Southwark and Lambeth Diabetes UK is a member of the diabetes strategic group. This provides a clear link to patients to facilitate productive patient engagement. Clinical and management staff from the CCG frequently attend this patient group to get feedback on commissioned services and input for plans moving forward.

The CCG is part of a project involving the British Lung Foundation and the local Breathe Easy respiratory patient group to listen to patients and review how they can be more involved in developing services.

Plans for the future

Plans for 2015/16 will be informed by evaluating the impact of the services during 2014/15. The evaluation looks at shown demand for the service and their effectiveness. Additionally, gaps in self-management provision, will also be considered for funding.

Demographic and geographic data is being collected as part of the self-management online pilot to inform future commissioning decisions.

Work is planned to identify those people who do not currently access these self-management courses and to design services around them so that they can also improve their skills and knowledge of their own health, set personal goals and problem solve.

Acknowledging that support needs may not be confined to those normally supplied by traditional health services, funding may build on this by taking a community asset based approach to support individuals to feel more confident and motivated to manage their condition(s). Community and self-help groups can often provide the type of support required by people with long-term conditions.

5.1.5. Personal health budgets

Personal health budgets are being introduced by the NHS to help people manage their care in a way that suits them. A personal health budget is an amount of money to support your identified health and wellbeing needs, planned and agreed between you and the local NHS. The aim is to give people with long-term conditions and disabilities greater choice and control over the health care and support they receive.

The Government in introducing personal health budgets gradually, with some immediate requirements for CCGs. NHS Southwark CCG is compliant with national policy and has gone beyond the national requirement. We have a number of initiatives for introducing personal health budgets to different patient groups.

The CCG ratified its local personal health budgets policy in January 2015. This policy has since been revised, to take account of the Children and Families Act, NHS England planning guidance and the report Winterbourne View: Time for Change.
Our progress during 2014/15

Personal health budgets in adult continuing healthcare

Since October 2014, all adults who are eligible for NHS continuing healthcare have a right to have a personal health budget, including direct payments. In 2012, the CCG, set up a project to introduce personal health budgets in adult continuing care. The project steering group included two lay members (one from Southwark Healthwatch and a carer) and its remit was to enable Southwark to offer personal health budgets to adults eligible for NHS continuing healthcare and living in their own homes. To date we have set up personal health budgets for 15 adults. For a few people coming to the end of their life, this has meant they were able to get the care they needed to die at home, and for others, they have been able to choose the people who provide day-to-day care.

In Southwark, around 100 adults are receiving NHS continuing healthcare at any given time. Under the current ‘Choice, Cost and Equity’ policy for NHS continuing healthcare, individuals are offered care at home where the home care costs are within 10 percent of the average cost of a care home. Around half of the adults receiving NHS continuing healthcare in Southwark are in care homes. Our personal health budgets project focused on the half who remain at home for a number of reasons. First of all, the demand for personal health budgets, and direct payments in particular, came from this group; the money for personal health budgets is easy to release, as it is money that would otherwise be spent on home care. Secondly, it is because there is more scope for exercising meaningful choice and control.

The CCG is now considering how we can offer personal health budgets to everyone in this group. The next phase for work around personal health budgets in adult continuing healthcare will include:

- consultation with existing continuing healthcare patients and families to understand what, if anything, needs to change in their current care arrangements;
- undertake cost modelling to understand the impact of introducing personal health budgets for everyone eligible for NHS continuing healthcare; and
- review the Choice, Cost and Equity policy and consider how to expand the offer of personal health budgets to all continuing healthcare patients.

Personal health budgets are empowering and should open up possibilities. In addition to expanding the offer of personal health budgets to more people, the CCG is also working to ensure personal health budgets deliver better outcomes, this includes making sure that patients and families have the right information, advice and support to make best use of their personal health budgets.

Finally, we need to evaluate the impact of personal health budgets on people’s lives. All CCGs in England can use the Personal Budgets Outcomes Evaluation Tool (POET), which has been commissioned by NHS England from the University of Lancaster and ‘in Control’, the disability rights organisation. The CCG is planning how best to start using POET for the benefit of Southwark patients who have personal health budgets.

Children’s continuing care

We are also implementing personal health budgets for parents and carers of children who receive continuing care. The project team, responsible for developing how children’s personal health budgets will work, includes two parent carers, who represent the Southwark Parent Carer Council and are also involved with the Council’s Special Educational Needs and Disability programme.
The number of children with continuing care is small, a caseload of about 15 to 20 at any time, but the children have some of the most complex health needs. Therefore this project is particularly focused on supporting parents to achieve better quality of life for their families. Key areas of work for this project include:

- developing a clear, simple and robust process for personal health budgets for children, in line with Southwark’s SEND local offer;
- producing supporting documentation for this process; and
- producing information to support families to have high quality services and achieve better health outcomes.

My Life, My Home, My Choice

The aim of this major initiative across the CCG and Southwark Council is to review accommodation options for around 150 adults in mental health placements. These people are under the care of the High Support Needs Team (in the South London and Maudsley Trust), and this initiative aims to support them to live in the community with integrated health and care budgets.

5.2. Planned care

Planned care is where a patient is referred for treatment and there is a pre-determined route through which you would receive care. For example, this could be a hospital service which your GP has referred you to like physiotherapy.

5.2.1. Our priorities

Our priorities for planned care are to:

- work with providers to implement contractual requirements to support increased productivity and efficiency. These will be based on shared priorities for transformation in secondary care;
- review systems to support best practice referrals including use of referral management systems, single points of referral and decision support tools. Agree a plan following the review to move to best practice working with local GP practices;
- commission pathways for patients referred with common health conditions (e.g., diabetes; respiratory illness; gynaecology) to specialist services provided in community facilities in different locations of the borough. De-commission hospital outpatient pathways to reflect this change of provision; and
- review access policies including south east London Treatment Access Policy - consider implementation of clinical management protocols and pathways for people who smoke and require non-urgent elective admission.

5.2.2. Our progress during 2014/15

In the last year we have continued to work closely with our hospitals to make sure when people do need hospital care it is of a high standard. We have also worked with our providers to make sure there are good community services. This means people can leave hospital as soon as they are medically fit, and in some cases are able to be cared for in their own homes rather than be admitted at all. For example, the ‘@home service’ provides intensive nursing support to people throughout the day in their own home and has avoided many unnecessary admissions.

During the year our hospitals, and those throughout the country, have experienced very high demand. To avoid long waits for treatment, many patients have been offered the option of treatment in private hospitals. Health outcomes for our patients have been improved, for example, we make sure that people with
suspected cancer are seen and treated as soon as possible. Patients are directed straight to hospital speciality clinics where appropriate to avoid unnecessary delays.

We work with our hospitals to improve the performance and quality of services. During 2014/15 our clinical leads have chaired monthly meetings with hospital medical staff and managers to review what is going well and what needs to improve. Patient experience is central to driving improvement and surveys and mystery shopping provides a rich source of information. When problems have been identified, for example in referral to treatment times, action plans are agreed and rigorously managed. Overall patient experience at our main hospitals compares well.

Adult obesity

In Southwark, there are a wide range of interventions which aim to educate, provide physical activity opportunities and nutritional advice for residents. The aims are prevention and reinforcement of healthy eating and physical activity messages for all residents, irrespective of weight status. Nationally this includes public health and campaigns aimed at the public. These services are provided in partnership by health care, Southwark Council, voluntary, corporate/workplace and private sector organisations. During 2014/15 partners have been working to increase the use of these services and recent information shows this is making an impact. In addition, a hospital based service has been designed for patients who are referred for surgery and is geared towards improving the health of those patients before their surgery.

The CCG is currently working with partners to develop a proposal for a new service to identify, and appropriately treat patients who would otherwise remain unsupported. This will help people who, for a variety of reasons, do not access services. The service will be integrated with existing programmes so that support can meet individual needs rather than providing a ‘fixed’ offer. Eligible patients would have access to nurse reviews, health trainer, psychologist, and dietician appointments plus individual and group exercise and healthy cooking classes where appropriate.

Child obesity

The CCG has worked closely with Southwark Council and partners to develop Southwark multi-agency healthy weight care pathways for children. This involves providing guidance on identification, assessment, advice, signposting and highlighting the relevant local support for underweight, healthy weight, overweight and obese children. This means that it is clear to Southwark health and social care professionals what is required and available locally to achieve and maintain a healthy weight for all children 11 years old and under. It enables children, regardless of their weight status, to the chance to get the most appropriate support.

The CCG continues to work with the local authority in commissioning a range of evidence based children’s healthy weight services to support the care pathways. These include, preventive interventions which promote sustained breastfeeding, promoting healthy weight in early years and school settings, and supporting professionals to intervene where necessary. Treatment services are also being commissioned to support children who are already overweight or obese. These services are supported by social and environmental measures which promote physical activity and healthy eating.

Healthy weight service

The CCG is also planning to develop a new healthy weight service for people who struggle losing and keeping a healthy weight. This service would be an important part of wide healthy weight services and will provide an alternative for some people to having operations such as bariatric surgery. In early 2015 we spoke to people across Southwark about their experiences of trying to lose weight to become healthier and what services could help them achieve this. There were 75 people in Southwark who completed our survey to help us develop this service and you can read a report on the survey responses here:
The next phase of this project will be to use the results of the survey and talk to people who struggle with their weight in more detail through workshops we plan to host in Spring 2015.

5.3. Primary and community care

Out of hospital care is the type of care you receive outside of major hospitals, we often call this primary and community care. ‘Primary care’ is the advice and treatment you receive from your local GP. We call the health services you receive close to your home or in your home ‘community care’. For example: health visiting when you have just had a baby, physiotherapy or speech and language therapy.

5.3.1. Our priorities

Our priorities for primary and community care are outlined below.

- Implementation of the CCG primary and community care locality development plan and broader CCG Primary and Community Care Strategy.
- Commission enhanced diagnostic capacity in primary and community care settings, to support improved care management and better use of hospital care.
- Design and deliver a comprehensive primary care workforce development programme.
- Contribute to shaping Southwark Council’s approach to the commissioning of enhanced community support services (home help and domiciliary services).
- Continued implementation of the service model for the Dulwich locality and implementation of the community hub model across the borough.

5.3.2. Implementing our primary and community care strategy

Our progress during 2014/15

A core component of the Primary and Community Care Strategy 2013/14 – 2017/18 is building capability within primary care to deliver services on a population health basis. As part of this work, the CCG has supported general practice to develop geographically coherent neighbourhood GP provider organisations, where practices work collectively to improve the quality of services and outcomes for their combined registered populations. These GP provider organisations are collaborations of the 20 practices in the South (Improving Health), and 24 practices in the North (Quay Health Solutions).

The development of these organisations supports the achievement of four key objectives within the Primary and Community Care Strategy, namely:

- reducing variation in the quality of and outcomes from care;
- improving access and increasing equity;
- better integration and better care coordination; and
- increasing the range of services in community.

These GP provider organisations will form the basis of integration between primary care and other services, particularly community nursing and social care as part of the development of Local Care Networks; and will link in with community hubs being developed across the borough (eg Dulwich).
In order to increase the capacity and capability of general practice to deliver on these objectives, the CCG has initiated a range of developmental initiatives listed below.

- Neighbourhood Development Plan Scheme.
- Primary Care Development Programme.
- Challenge Fund and Extended Access.
- Workforce Development Plan.

These initiatives are in addition to the extended services (non-core) contracts that the CCG has commissioned the neighbourhood GP federations to deliver.

**Extended services**

Federations of practices are working together to deliver extended services in Southwark, and improve the quality of services and health outcomes for the registered population within their neighbourhood. These include holistic health assessments, case management of patients; stop smoking services, health checks and blood pressure monitoring as well as population health outcome targets.

During 2014/15 the federations of GP practices have started to mobilise these services so that patients can access them no matter where they are registered. They have also started working with community pharmacy colleagues to ensure there is full access to these services at a location as close to the patients home as possible and accessible during the hours that are convenient to local people.

A core component of our Primary and Community Care Strategy is building capability within primary care to deliver services based on the health needs of Southwark people and deliver on the strategy’s four key objectives.

**Neighbourhood Development Plan Scheme 2014/15**

The CCG has invested approximately £550,000 in neighbourhood service improvement and innovation via the Neighbourhood Development Plan Scheme. This scheme is about sharing and using good practice and expertise, and establishing neighbourhood infrastructures to support service improvement. For 2014/15 the GP provider neighbourhoods focused on access, dementia, childhood immunisations and flu immunisations. Both provider organisations have had good engagement from GP practices as part of this work and in 2015/16 will look to expand it to include other partners, such as community pharmacy.

**Primary Care Development Programme**

In 2014/15, Lambeth and Southwark CCGs were successful in securing £728,000 from Guy’s and St Thomas’ Charity to support primary care development across the two boroughs. This resource has enabled both CCGs to build capability within general practice to deliver new ways of integrated working that will ultimately improve outcomes for patients and reduce pressure on general practice providers.

The programme has centred on the development of 18 general practice ‘emerging leaders’. They have been leading on the development of neighbourhood working across the two boroughs, including engagement with general practice peers and wider primary care, and other health, voluntary and social care partners more broadly. As part of this work, general practice has developed and engaged on a vision for new models of primary care that aims to:

- reduce health inequalities, and provide high quality, patient centred, and coordinated services;
- empower patients and their carers to take responsibility for, and control of, their own health; including an increased focus on preventing ill health;
organise services in a way that involves general practice as a key player, and allows professionals in general practice to flourish;
facilitates close involvement with local communities; harnessing community assets and seeking input from patients and citizens into new ways of working.

**Challenge Fund and 8am-8pm, 7 day primary care access**

In 2013, the CCG undertook a review of urgent care services across Southwark, including our local walk-in centre. Analysis and engagement with residents showed the current model for accessing primary care needed to change due to:

- variation in service provision and quality;
- the system being complicated and difficult for patients to navigate leading to use of A&E and other urgent care services as default; and
- different ways in which these services are funded and commissioned leading to fragmentation, duplication and inefficient use of resources.

Following this review, the CCG agreed to commission an Extended Primary Care Access Service from the two neighbourhood GP provider organisations in then and south of the borough. The CCG agreed to invest £2.1 million to fund recurrent service costs and was one of 20 successful pilots as part of the Prime Minister’s Challenge Fund Programme. This enabled the CCG to secure an additional £975,000 to support general practice engagement, infrastructure and set-up costs.

The key elements of the new service model are:

- delivery from two fixed locations across Southwark, 8am to 8pm, 7 days a week, offering bookable appointments accessible through GP practices during core hours (8am – 6:30pm Monday to Friday) or South East London Doctors’ Co-operative (SELDOC) from 6:30pm – 8pm weekdays and 8am – 8pm weekends and bank holidays;
- patients are assessed by a senior clinician over the telephone who will provide advice, refer to another service, or book an appointment within the practice or extended access clinic as appropriate;
- access to the patient’s primary care record (with the patient’s consent) to support continuity of care and on-going management;
- patients can be referred from King’s A&E other agreed urgent care access points, and support is available for unregistered patients to register with a local practice; and
- alignment and consistent application of access policies across general practice.

The first of these clinics opened in the south of the borough at the Lister Primary Care Centre on Tuesday 11 November 2014, and replaced the walk-in centre that was based at the site. A second clinic opened in north Southwark in April 2015 and is located at the Bermondsey Spa Health Centre.

Prior to the launch of the south Southwark service, the CCG issued patient leaflets and stakeholder communications around the changes to the service at the Lister Primary Care Centre to GP practices, pharmacies and other local health providers. A broader patient and public engagement programme is expected to commence in May 2015 to build confidence in general practice, encourage people to register with a GP practice and reach seldom heard voices.

Between the November launch of the service in the south of the borough and March 2015:

- over 6000 patients have been seen by the service, over half of which were booked by their general practice;
- all 20 practices in south Southwark have now used the service, although utilisation varies;
- the number of walk-in patients remains low relative to activity levels at the walk-in centre previously based at the Lister Health Centre (a transitional policy is in place to manage walk-in centre patients). Analysis of A&E data does not suggest these patients are using emergency services; and
- patient feedback captured by the Patient Advice and Liaison Service (PALS) - who are available to facilitate patient registration and signposting on site - and through patient experience surveys has been positive.

The CCG is continuing to work with the neighbourhood groups of practices in the north and south of the borough to monitor activity, the impact on the urgent care system more widely, and to identify opportunities for service improvement. In addition, the CCG is continuing to support the two GP provider organisations to engage with patient representatives and capture patient experience information and use it to improve the service.

As a Challenge Fund pilot site, the CCG in partnership with our two neighbourhood GP providers will be participating in a national evaluation led by NHS England. In addition, the CCG will undertake a local evaluation once both services have been running for 12 months to determine the impact of the service locally.

**Workforce development plan**

A vital element to delivering on the objectives of the Primary and Community Care Strategy is workforce development; we need to ensure the workforce is appropriately skilled and more productive to maintain high quality services as demand on health care grows and we change the shape of services we commission.

To support the delivery of the strategy, the CCG has developed a comprehensive Workforce Development Plan, which over a three year period aims to deliver on the goals listed below.

- Developing primary and community care services to attract and retain a strong workforce.
- Shaping and developing the workforce to be able to deliver future models of care, including integrated care.
- Investing in learning and development to deliver high quality care and develop innovative ways of working.
- Improving productivity and flexibility of the workforce to respond to changing demands.
- Enable primary and community care providers to motivate performance through effective workforce development and support for clinical and non-clinical staff.

In 2014/15, as part of the delivery of the Workforce Development Plan, the CCG has supported a range of workforce initiatives in line with these goals, including:

- a series of neighbourhood development sessions for receptionists and administrative staff, practice managers and practice nurses;
- provision of community placements in specialist community services and community nursing services; and
- a series of workshops to engage general practice in neighbourhood working, and the establishment of joint planning and training across primary and community care.

In 2015/16, the CCG plans to support local health service providers to develop a Community Education Provider Network (CEPN) with funding from Health Education South East London (HESL). This CEPN is a key delivery arm for supporting the development of the established and future workforce both in terms of neighbourhood GP provider organisations and Local Care Networks.
The CCG is working with local partners, including Southwark Council and Southwark and Lambeth Integrated Care (SLIC) to ensure that primary care services are collectively delivered on a neighbourhood basis and that incentives between providers are aligned.

In addition, the Primary Care Programme Board, which oversees the delivery of the Strategy, has representation from Healthwatch Southwark, Local Medical Committee, Public Health, and NHS England – all of whom are well engaged in the development and delivery of key priority initiatives within the strategy.

**Developing local care networks**

During 2014/15 we have been working with patient groups, the voluntary sector and our partner organisations across health and social care, to design Local Care Networks. These new groups will bring together all organisations across a local area to transform services across our communities.

We know that we need to work differently. Patients tell us that services are fragmented, and that they find navigating the health care system confusing. Part of the problem is the way that we organise ourselves. Too often, different parts of the health and social care system operate in isolation, with patients and residents expected to arrange their lives around the needs of services, rather than services adapting to meet the needs of service users. We want to fundamentally change this approach, and move towards a system which arranges services around the patient.

We believe that Local Care Networks will be the vehicle for delivering this change. These groups will be geographically coherent, serving natural communities, and have autonomy to act for that population. They will look to bring services together and break down the barriers between primary, social, community and mental health services to provide more services in the community, reduce the amount of duplication (such as patients having to undergo multiple assessments) and put a real emphasis on prevention, wellness and wellbeing rather than on treatment alone.

The development of Local Care Networks seeks to address the three priorities set out by the CCG for 2014/15.

Local Care Networks will put an emphasis on prevention and tackling the causes of premature mortality. This will include additional action against key determinants of health including smoking, obesity and alcohol and drug misuse.

We know that there is significant variation in life expectancy across Southwark, and the Local Care Networks will work in a focused way to tackle issues within their local areas. We also recognise that health is only one part of the equation. Social isolation and mental wellbeing are key issues that we need to address, as these are important factors as to whether people are able to lead happy, healthier lives. That is why Local Care Networks seek to work across the health and social care divide, to work with patients and service users to address their needs in a more holistic way.

They will do this by ensuring that all providers work together far more closely so that there is less variation in provision, and that services are based around patient needs. Local Care Networks will also be commissioned to deliver services based on outcomes, rather than activity, as a further incentive for different organisations to work together to improve the quality of services.

Local Care Networks are being set up in all boroughs within the Our Healthier South East London Programme. We are collaborating with partners to ensure that they have similar characteristics, but are keen that these are not too prescriptive. We want each Local Care Network to be shaped around the needs of its population and to set its own priorities and work plan.
All local health service providers have been actively involved in co-designing Local Care Networks and will be key members of these forums.

Patient groups have also been actively involved in the design of Local Care Networks. The CCG ran engagement exercises, both locally and as part of the programme, and have contributed to workshops organised by Healthwatch Southwark and the Southwark and Lambeth Integrated Care (SLIC) programme.

In addition, through SLIC we have worked with patients and service users to begin to design outcome measures for services. We recognise that whilst excellent clinical outcomes are vital, so is patient experience. We have therefore been working with patient groups to understand what are the measures that service users rate as the most important, and in 2015/16 we will be tracking these so that we can measure our progress.

We will continue to build on this work locally, in full conjunction with partner organisations and patients, over the next 12 months to help deliver improved health outcomes and value.

This year has been a year of preparation ready for Local Care Networks to become established in 2015/16.

**Patient engagement**

In its first year of operation, the CCG carried out a lot of engagement on primary care development, reviewing urgent care and extending primary care access. This continued in our second year with a patient engagement meeting organised jointly between the CCG and the two new GP provider organisations for extended primary care access – Quay Health Solutions and Improving Health. This was attended by nearly 40 participants including patients and representatives from general practice; 40 percent were men.

Participants broke up into mixed groups for the north and the south to explore some elements of service design such as telephone management and appointments and explore the use of online technology as well. Feedback from patients was positive, and people felt that there was a high level of engagement from the CCG. Key points of feedback are outlined below.

- Most people were happy for telephone management to be done by either a senior nurse or GP, and felt that training and telephone manner were more important, particularly if advice was given over the phone or the person needed to be directed to the extended access clinic which was unfamiliar to them. There were a few people who felt that this should only be done by a GP.
- The majority of people preferred to have direct transfer to a senior clinician rather than be put on a call-back list; however, many recognised that this may be difficult given capacity and pressures on general practice. If there was a call-back patients felt that a one to two hour timeframe would be reasonable otherwise patients would be likely to go to A&E.
- Most people felt that access to different appointment and contact tools such as online tools would be useful, but recognised these should not replace traditional methods as not everyone is ‘tech-savvy’. It was also recognised that this could facilitate use of the service by people who have difficulty using a telephone, including those who have profound hearing impairments.

Over 90 percent of participants found the information and the event useful and informative.

The CCG undertook an outreach programme involving one-to-one interviews with 38 people in Peckham. The majority of interviewees were aged 26 – 55, all other age groups were represented apart from 16-18 year olds. Just over half were women and 30 were registered at local practices.

One objective of the interviews was to collect additional feedback to the engagement events held by the CCG. However, the primary objective was to test potential campaign messages for the new borough wide extended access service. It was recognised that it was important to test these messages with people local to the Lister...
Primary Care Centre in advance of the changes to walk-in services at the Lister site, and the start of the extended primary care access service from there.

All except one interviewee felt that it was acceptable to offer a call back from general practice and most people felt one hour was acceptable and the next largest number of respondents thought two hours. The majority of interviewees identified the benefits in the new service as more GP services in the evening, reduced waiting times, more GP services at the weekend and more appointments generally. The CCG also carried out a focus group in September 2014 with patients from south Southwark to explore the way patients would use the extended access service, the name of the service and how to communicate the changes to local people.

Updates on the services continue to take place at every locality PPG meeting by the provider including how best to capture and measure patient experience of the new service. For more information on the extended primary care services, see section 5.3.2.

Plans for the future

Ours plan for 2015/16 is to continue to build capacity and capability within our general practice neighbourhoods and neighbourhood GP provider organisations so that we have a solid foundation for the development of Local Care Networks. We also hope to start to see tangible benefits of neighbourhood working and service delivery for patients and general practice staff. This will include on-going engagement with patients to inform service development and improve patient experience.

The focus this year has been on setting up GP federations (which will be the cornerstone of Local Care Networks), and working with providers and patient groups to co-design Local Care Networks so that we can achieve a common vision of how they will work and what they will achieve.

In 2015/16 Local Care Networks will be up and running. The groups will then agree what their immediate priorities are, and start to redesign pathways and transform services.

Each Local Care Network will develop and agree its own key priority actions and initiatives that bring these commissioning aims to life, in the context of its own local population.

In addition, there will be some commonly agreed whole system priority initiatives for all Local Care Networks. The initial priorities will be those already agreed through the partnership arrangements for integrated care in Southwark and Lambeth:

- care management;
- community multidisciplinary teams;
- holistic health assessments; and
- locality-based geriatricians.

A programme of support and organisational development will be agreed with Local Care Networks to enable them to successfully take on their new role.

5.3.3. Improving health services in Dulwich and the surrounding areas

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

In 2012 we 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. A 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 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.

Based on what local people told us, we planned 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, with a focus on long term conditions.

**Progress during 2014/15**

We have refined the list of services in accordance with the results of the consultation, and calculated how many patients we need the health centre to accommodate. That has helped us to determine how big it needs to be, and how big a site it needs to be built on. These calculations were carried out using current service activity, assessments of likely future activity and projected population changes.

We have also gone through a formal process to look objectively at all the possible locations for the health centre. This included refurbishments and new builds on the Dulwich Hospital site and also looking to see if there was anywhere else in the area the health centre could sensibly be located. We analysed each option to see what the financial implications would be, and also what the non-financial benefits of each would be. Financial implications include the cost of building and the cost of maintenance over the life of the building. Non-financial benefits include things like accessibility, how easy and quick it would be to build, and whether it would easily deliver the services we need, including space for future growth.

**Recommendation to build new**

The conclusion was that a new build represents best value for public money. This would be located on the south-east corner of the Dulwich Hospital site, offering good access to both East Dulwich Grove and the bus and train links on Grove Vale.

The CCG is pleased to confirm that this work has now been approved by NHS England and NHS Property Services.

**Plans for the future**

The next step is to decide how this building is to be funded. Work is being undertaken to analyse the different options. These include using Department of Health money (a ‘capital-funded scheme’) or through our local LIFT (development) partner, which would be funded through the CCG paying annual rent on the property. We need to be sure that we are doing this in a way that is best value. Once this has been complete the design will begin. We intend this to be a process that will involve users of services - both clinicians and patients.

**Discussions about the wider site**

In the meantime Dulwich Hospital as it stands continues to be very expensive to run, so NHS Property Services as the owner of the site is seeing if it is possible to consolidate the existing services into less of the building. This would save on things like heating and lighting costs, and also on cleaning.
None of the existing services would be moved off the site until the new centre is ready for occupation.

There are ongoing discussions between NHS Property Services and the Education Funding Agency (EFA) about education facilities being located on the surplus part of the site. NHS Property Services will make sure that it retains the agreed space for a new health centre and will continue to safeguard existing services as well as seeking to accommodate the needs of the EFA.

As part of the discussions with the EFA, NHS Property Services is exploring a phased approach to the release of the surplus land. This will need CCG support, and only once the new health centre is complete and all services transferred would the final part of the site be released.

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

5.3.4. Developments in community health services and children's services

Progress during 2014/15

In 2014/15 two community services which support people to remain in their own home were implemented. These services, namely @home and Enhanced Rapid Response, focus on older people and have delivered a unified access point from December. The number of patients benefiting from the service doubled during the winter months when the both King’s College Hospital and Guy’s and St Thomas’ Trust were under significant emergency pressure.

The service provides immediate access to enhanced levels of therapy, social work and nursing support that people previously would only have received in hospital.

The unified scheme has 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.

Find out more about how patients benefited from these services in section 5.1.3.

Children and Young People’s Health Partnership

The CCG has been working closely with Southwark and Lambeth partners through the Children and Young People’s Health Partnership to develop and test new models for children and young people’s health services. The Partnership, funded by Guy’s and St Thomas’ Charity, has set out plans to improve children and young people’s services over three years working with patients, their families and carers, health and social care commissioners and providers, including voluntary organisations.

The partnership will improve children and young people’s health by:

- providing more specialist support to GP practices through joint GP and paediatric clinics to provide rapid advice and support, developing guidelines and training;

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• improving the management and mental health of children and young people with long-term conditions starting with children who have asthma and/or epilepsy;
• working with young people to review their needs and deliver services which meet these by strengthening, coordinating and providing young people’s tailored services; and
• creating a “virtual” academy to support education, training and self-management for children, young people and families with asthma and epilepsy, and education and training for specific professional groups.

The work is at an early stage but has already had a number of positive outcomes for children and young people’s services during this year including:

• joint GP and paediatrician clinics piloted in practices in Southwark and Lambeth with 90+ patients booked in, education sessions run on common conditions and very positive patient and clinician feedback;
• an assessment of the health and wellbeing needs of young people in Southwark and Lambeth, a map of local young people’s services and a conference bringing together over 70 young people, voluntary organisations, clinicians and young people’s services;
• detailed analysis on existing use of children and young people’s health services in Southwark to help identify and explore differences and possible opportunities in how services are used currently,
• a parent and carers group panel and a young people’s panel reviewing and commenting on plans and work so far; and
• working groups meeting on asthma, epilepsy, mental health and the virtual “academy”.

“Patients really valued it, very convenient. Fantastic - keep it going please” (primary care professional, Southwark)

5.3.5. Co-commissioning of primary care services

Progress during 2014/15

In October 2014 NHS England published a Five Year Forward View that makes clear that co-commissioning of primary care services will exist in some form across England by 1 April 2015. Between October 2014 and January 2015 the CCG has engaged with local residents, key partners and its member practices to explore the potential for co-commissioning in the borough and to determine the form that co-commissioning might take. By the end of January 2015 the CCG to made an expression of interest to NHS England to enter arrangements that allow for joint commissioning of primary care from 1 April 2015 and a commitment to a work programme to explore and potentially take full delegation of this responsibility from 1 April 2016.

The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically-led commissioning system, which delivers seamless, integrated out-of-hospital services that are based around the needs of local populations.

Co-commissioning could potentially lead to a range of benefits including:

• improved provision of out of hospital services for the benefit of patients and local populations;
• a more integrated healthcare system that is affordable, high quality and which better meets local needs;
• more optimal decisions to be made about how primary care resources are deployed;
• greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services; and
• a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

Importantly the development of co-commissioning arrangements on a borough basis will allow for a population focus for the commissioning of these services rather than the current single operating model for commissioning across England irrespective of local circumstance.

Although this development refers to the commissioning of primary care the opportunity for CCGs relates to general medical services or GP practices only. Community pharmacy, optical services and dentistry will remain under current commissioning arrangements.

**Integrated commissioning for local populations**

Under current NHS commissioning arrangements the commissioning of primary care services for local people is fragmented with services commissioned by up to four local or national bodies (including CCGs, Councils, Public Health England and NHS England). Whilst co-commissioning does not bring those arrangements under one commissioning body it does seek to ensure that commissioning intentions are developed in the local context - CCGs with greater influence over the commissioning of local services alongside their local council.

Commissioning for health services more generally is equally fragmented at this point in time and this does not maximise the opportunity to commission along an entire pathway of care. The establishment of co-commissioning will seek to align commissioning to address this with local decision making established across ‘upstream’ preventative measures, through to primary, secondary and tertiary care services. In addition to the co-commissioning of primary care, CCGs will also have the opportunity to play a greater role in the commissioning of specialised services with NHS England in future.

In the context of financial constraint right across the public sector - the bringing together of these budgets, in what might be termed a ‘place based budget’ also provides the opportunity to build upon local work in areas such as the Better Care Fund (see section 5.5) and create pooled or capitated budgets that reward improved population outcomes for those providers who can collaborate or integrate across health and social care to deliver them. These arrangements have the potential to allow a greater shift of resources toward primary and community based care.

**5.4. Urgent care and emergency care**

Urgent and emergency care covers the services you need when you are ill and need to be seen by a doctor or nurse straight away. Urgent care relates to less serious health problems, like a cut or sprain that can be treated by services such as an Urgent Care Centre. Emergency care is when you have a life threatening accident or illness and you have to be treated in a major hospital.

**5.4.1. Our priorities**

Our priorities for urgent care are outlines below.

• Commission effective urgent care pathways including A&E front-end; urgent care centres and walk-in centres and develop a model of care to enhance access; the quality of services; and the percentage of patients that attend the most appropriate care setting.
• Commission extended access to primary care across the borough.
• Commission for services 7-days-a-week in collaboration with Southwark Council and NHS England commissioners to support admission avoidance and to improve discharge from hospital. The scope of
7-day services will be based on urgent access and the capacity of providers to maintain safe, high quality standards over the full course of the week.

- Complete inner south east London procurement for provision of NHS 111 service from April 2015.
- Commission London Ambulance Service to safely and effectively increase the proportion of calls treated ‘on site’ to reduce A&E conveyance rates.
- With social care services, commission new services targeted at people ‘in-crisis’. This will be initially focussed on people with mental health, alcohol misuse issues and on those who are homeless.

5.4.2. Our progress during 2014/15

Over the past year our work on urgent and emergency care has focussed on the areas described below.

- Deliver the four hour A&E waiting time target of 95 percent of patients admitted, discharged or transferred within 4 hours of arrival at A&E for the King’s College Hospital, Denmark Hill site.
- Review urgent care pathway including A&E front-end, urgent care centres and walk-in centres and commission a model of care to enhance access, quality, and proportion of clinically appropriate attendances.
- Review emergency care pathway including admission from A&E to hospital. Commission a model of care, maintaining and improving the experience, quality and desirable outcomes for patients. Support the appropriate discharge of patients to self-care, GP, community services including care from virtual at home services, to care in intermediate and social care beds.

Working with local partners

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 hospital performance and ensures wider whole system actions to support admission avoidance and make sure 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:

- King’s College Hospital, Denmark Hill – action plan;
- significant increase in referrals to @home service; and
- South London Integrated Care (SLIC) simplified discharge programme

The CCG is partnering with organisations across South London to drive an improved and simplified discharge process (South London Integrated Care simplified discharge programme). Patient involvement and feedback is a fundamental aspect of the work undertaken to date and in the future

Patient feedback is also an important aspect of the development of the urgent care centre and overall emergency department, where patient response to care received from the mix of resources, facilities and wait times encountered is factored into improvement initiatives through patient feedback surveys.

Not Always A&E – winter campaign

Building on the previous year, we re-launched a communications and engagement ‘yellow man’ campaign designed to raise awareness of the range of health services in the borough and encourage people to only use emergency departments in life threatening situations. We held a launch event in Peckham and posters appeared on billboards, bus advertising and in health centres and other public buildings across the borough. They highlighted quicker and easier local alternatives to A&E where people can get expert advice and
treatment including: self-care at home, pharmacies, their GP and urgent care centres. Neighbouring CCGs also ran the campaign increasing opportunities for recognition and impact of the visuals and messages as people travel in and around local areas, as well as providing a more cost effective way to deliver the activity. An evaluation of the campaign’s impact took place in January/February 2015 involving people across south east London and parts of south west London. Findings show that:

- nearly half of residents within involved boroughs recalled advertising relating to the NHS 111 service or about not going to A&E unprompted;
- the majority of those who were able to recall that they have seen advertising relating to the NHS 111 service or to A&E and alternative sources of healthcare unprompted, also recognised the ‘Not A&E’ materials (67 percent) when prompted;
- thirty eight per cent of all of those surveyed from boroughs that were involved in the campaign recognised the ‘Not A&E’ materials when prompted;
- in Southwark, 41 percent of 140 people surveyed recognised the campaign when prompted. This is above average when compared with the other boroughs that bought-in to the campaign;
- of those that recognised the campaign, nearly half recall posters while over one third recall bus ads.
- there is evidence that the experience of campaign materials impacts on individuals’ understanding and awareness of healthcare services. Those who had seen ‘Not A&E’ materials are more likely to agree that they have a good understanding of what A&E is and isn’t for than those who have not seen the materials.
- the core messages of the campaign translate well, with the majority understanding that A&E is not always the most appropriate place to go in the event of an accident or illness.
- impacts of the campaign are also encouraging, with nearly half of responses made up of ‘Will make me think more in the future about where the right place to get care is’, ‘will mean I can advise others better on where to go when they are ill’ and ‘will make me try other health services when it is more appropriate than A&E’. The most popular answer after this was ‘no impact’, typically because the campaigns did not give any new information.

Key achievements

The target is for 95 percent of patients to be seen, treated and then admitted or discharged within four hours from arriving in an A&E department. 90 percent of A&E attendances by Southwark patients are at either King’s Denmark Hill site, St. Thomas’ A&E or Guy’s Urgent Care Centre; with a relatively equal split in activity between the two providers.

Whilst Guy’s and St Thomas’ has consistently delivered the national A&E standards in 2014/15, King’s have not. However, the performance of King’s Denmark Hill A&E department has been significantly better than performance at King’s Princess Royal University Hospital emergency department (and by virtue of that, the aggregate trust-wide performance position). Performance at Denmark Hill had improved since September 2014, with the dip in December mirroring a national trend at this time of year. At present the King’s Denmark Hill site is performing amongst the top half of A&E departments in London, although it does remain under significant pressure from high levels of activity.

The Denmark Hill site aims to improve performance through the implementation of a number of schemes within an agreed improvement plan (action plan). The action plan is reviewed at weekly emergency care board meetings, with attendance from senior members of the King’s team and the CCG. A highlight from this collaborative work is the successful implementation of Rapid Assessment and Treatment (RAT) in the majors area: where patients are now seen on arrival by a senior doctor reducing patient journey times and improving patient experience by earlier involvement in the process from a senior decision maker.

The addition of winter monies resulted in a number of schemes aimed at promoting appropriate use of services avoiding admissions and improving discharge. Some highlights from this range of schemes include:
• London Ambulance Service working with the @home service to provide effective patient care at home and avoiding unnecessary conveyance to hospital;
• A&E diversion, exceeding key performance indicators, successfully re-directing patients to more appropriate services; and
• extending the opening hours of the Medical Assessment Unit and opening the Surgical Assessment Unit, decompressing the pressure in A&E.

5.4.3. Plans for the future

The CCG has recently developed an urgent care centre service specification. This specification is in line with the London and national objective of co-locating urgent care centres within the emergency department. The plan is to implement with an initial target of 40 percent of emergency department attenders streamed to the service, increasing to 50 percent within six months.

The specification has been informed by a robust audit of A&E attendances which, demonstrated the value in increasing the number of emergency care practitioners. Guy’s and St Thomas’ have suggested that the CCG conduct a similar audit due to the benefit obtained. This process of regular collaborative audit will be maintained as we seek to improve services, patient experience and outcomes.

The CCG will continue to build on the successful promotion of alternatives to admission through the development of the virtual @home service and improved communication between GP and hospital providers of care.

The CCG will continue to be closely involved in the development of the specification for the 111 service.

The rigorous monitoring of the key performance indicators for this year’s winter monies will inform the decisions around which of the schemes offer most value beyond the 2014/15 winter. This objective assessment will inform the CCG in developing innovative and effective improvement schemes beyond March 2015.

5.5. Better Care Fund

The Better Care Fund is a national initiative to promote the integration of health and social care services. In Southwark it involves the CCG and Southwark Council agreeing plans for a joint budget of £22 million to strengthen and improve community based health and care services.

The joint budget comes into being on 1st April 2015. During 2014/15 we have been engaged in developing detailed plans to ensure it operates effectively and meets national assurance and local governance requirements. In November it was announced that Southwark was one of just six boroughs nationally to be given full unqualified approval for its Better Care Fund plan, indicating that the national team are confident that our plans are good, and we can deliver on them.

5.5.1. Our progress during 2014/15

In 2014/15 we have also been managing the transitional changes, including seed funding 2015/16 investment in key areas.

The budget covers a range of existing and new services including those listed below.

• Reablement, intermediate care, hospital discharge and other services previously funded by NHS transfers to the council.
• @home and Enhanced Rapid Response (intensive community health and care as an alternative to hospital).
• Joint carers strategy roll out.
• Telecare and assistive technology (equipment such as monitors and alarms that help people live safely at home).
• Home care, helping fund a significant increase in the quality and effectiveness of home base social care support.
• Self-management for people with long term conditions.
• Seven day working for primary care and social care to assist weekend discharge from hospital.
• Mental health reablement and community teams.
• End of life care co-ordination.
• Care Act implementation costs.
• Enhanced community support for people with learning disabilities.
• Voluntary sector community based support services.

To help make sure these services operate in an effective integrated way a co-ordinated multi-disciplinary approach to assessment and case management will be developed around the emerging Local Care Network model.

To underpin the development of the Better Care Fund plan a vision for integrated services was developed in agreement with partners - Better Care, Better Quality of Life in Southwark. Our vision 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 wellbeing, 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.

The objectives of the Better Care Fund are to improve health and wellbeing outcomes for older people and people with long term conditions through the activity outlined below.

• Shifting the balance of care away from hospitals and care homes towards better, integrated community based health and care services that focus on meeting individual needs in a co-ordinated and preventative way.
• Developing integrated working such as joint assessment, case management, community multi-disciplinary teams and care co-ordination – all underpinned by strong data sharing.
• Protecting the most vital social services for health in the face of funding cuts.
• Helping the whole health and social care system achieve financial balance. Our case for change in the Better Care Fund plan illustrates that without radical change the overall funding gap is projected to become unsustainable due to demographic pressures and real terms funding reductions especially for social care. Integration can contribute to increased effectiveness and therefore create savings;
• Preventing the need for admission to hospital - we have a key Better Care Fund target reduction of 3.5 percent for 2015.
• Reducing care home admissions, maintaining delayed transfers of care at a low level, and achieving good outcomes from reablement to reduce re-admissions;
• The Better Care Fund plan was agreed by the local Health and Wellbeing Board, which represents all key local public services. The Board has a responsibility to ensure an integrated approach is taken to health and care related services. The Board will also monitor progress on the plan during 2015/16.
• The detailed joint budget will be agreed by the CCG and Southwark Council, and overseen at a detailed level under joint governance arrangements. Southwark Council and CCG will both commission services from the budget on an aligned basis and hold each other to account to deliver these services on a more integrated and cost effective basis.
Provider services including social care, community health, primary care and hospital trusts are working together through Southwark and Lambeth Integrated Care (SLIC) to develop more integrated ways of working to deliver agreed outcomes, for example in developing better discharge support arrangements.

The plan is underpinned by a vision for improving services in the community through better integrated working that has been developed over several years and shaped by a range of engagement activity.

SLIC, which has developed much of the thinking behind our approach, has actively engaged with the public through its Citizen’s Forum over the past two years. For example, an engagement event with residents on what outcomes they want from integration led to the selection of our local Better Care Fund target (people feeling supported to manage their long-term conditions).

Individual Better Care Fund schemes have been subject to separate consultation processes, for example the joint carers strategy was subject to extensive consultation, and is now due to receive around £1 million in total from the fund, for a service model strongly informed by the consultation.

The key achievements in 2014/15 were:

- agreeing with partners a strong joint approach to the Better Care Fund that provides a firm foundation for strengthening community based services;
- obtaining unconditional government approval for the £22m joint budget plan in November, one of only six areas nationally to achieve this;
- agreeing the approach to governance arrangements;
- investing transitional resources to seed fund priority schemes, including seven day working and high needs homecare; and
- strong early progress made on the key target to reduce care home admissions.

5.5.2. Plans for the future

Priorities for 15/16 are outlined below.

- To implement the Better Care Fund plan agreed across the CCG and Southwark Council and deliver its targets.
- To agree further areas where a joint budget approach may be beneficial to promote integrated approaches to service delivery, including more integrated approaches to commissioning.
- Align Better Care Fund services with emerging Local Care Networks to ensure maximum value added from investment.
- Develop new contractual mechanisms for integrated services that incentivise key health outcomes for the people of Southwark.

5.6. Our Healthier South East London

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 developing a five year commissioning strategy together in October 2013. Since October 2014, this has been known as Our Healthier South East London.

The strategy aims to improve health, reduce health inequalities and to ensure the provision of health services across south east London that consistently meet high standards of safety and quality and are sustainable in the longer term. It focuses on issues for people across south east London which need collective action to address them successfully or where there is clear added value from the commissioners working together.
The priority areas are community based care, urgent and emergency care, planned care, children and young people, maternity services and cancer, with mental health care being integral to each area.

The commissioners are working in partnership with local councils, health service providers, including hospitals, hospices, community services, mental health services, and patients, carers and local people. 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.

The programme has undertaken a range of engagement with patients and the public. During the year, over 30 people have been recruited to bring patient and public voices into all the Clinical Leadership Groups and governance groups. They also meet every six weeks as a single body – the south east London Patient and Public Advisory Group (PPAG) – advising the programme on all aspects of public engagement and involvement. PPAG set up a reading panel in August 2014 which supports the programme by ensuring that all published materials are understandable, jargon free and in plain English. The chair of the PPAG is a Southwark patient who also sits on our Engagement and Patient Experience Committee.

Further, wider engagement on the draft case for change and the emerging thinking has been undertaken locally. To complement this, a market research survey was commissioned in summer 2014 and wider engagement events across south east London with voluntary and stakeholder organisations, patients and local people have taken place. Two deliberative events for voluntary organisations and other stakeholders took place on 3 June and 18 June 2014. Further events were held for Lambeth and Southwark on 3 December and Bromley on 9 December 2014. The feedback from these events (and other feedback from local people) is published in ‘you said, we did’ reports, the first of which was published in November 2014.

We have continued to make good progress on the strategy during 2014-15 and in June 2014, submitted a draft strategy to NHS England for review. This was a national milestone and enabled NHS England to give the CCGs feedback on the strategy and progress on it. Work has been continuing since and an update on the programme, including an outline whole system model, was presented to governing bodies in public during January 2015. This is available online in January Governing Body papers. An updated case for change will be published by April 2015.

The whole system model (Fig 1 and 2 below), which describes how models of care in the six priorities will fit together, is being refined. Clinical models describing how care might be delivered in the priority areas are also being refined and checked for outcomes and impacts as well as for compatibility with CCGs’ operational plans. Plans for future development have been drafted for 2015/16 and beyond. These will be subject to further wide engagement, working closely with CCG engagement leads.

Further information on the strategy, including a plain English summary, the case for change, ‘you said, we did’ documents and updates are available on the programme website www.ourhealthiersel.nhs.uk.
Southwark Clinical Commissioning Group

The best possible health outcomes for Southwark people

Chair: Dr Jonty Heaversedge
Chief Officer: Andrew Bland
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6. Putting quality at the heart of the CCG

NHS Southwark CCG committed this year to working in partnership with Southwark Council, providers, stakeholders, and NHS England to develop a shared vision of high quality, safe, and patient centred care.

The CCG outlined its aspirations and goals in its Quality Framework which was approved by the Governing Body in May 2014. This responded to national reports including Francis, Keogh and Berwick\(^1\) which all set out the central role of quality in commissioning organisations. It also drew on the assessed needs of the local population set out in the Joint Strategic Needs Assessment (JSNA), and the voice of local people gathered through engagement events.

Over the year the Quality Framework set the strategic direction for monitoring and promoting the quality and safety of commissioned services and placing patients’ own experience at the centre of this. Progress against this framework will continue to be evaluated and place increasing emphasis on the use of patient and stakeholder feedback. It is this dynamic and real time use of such feedback which is seen to be the hallmark of a learning organisation with quality at its heart.

6.1. System drivers for quality

During 2014 the CCG supported its quality aspirations through use of a number of tools including the Commissioning for Quality and Innovation (CQUIN) Payments, input to Foundation Trust’s Quality Accounts, tracking the Friends and Family (FFT) and other audits, and working in collaboration with commissioning partners.

Key quality indicators were negotiated with providers within the local element of the contract, using feedback from stakeholders and relevant national guidance. These have been robustly monitored using information supplied by providers through outcome related audit and performance data, and also clinical discussion throughout the year in Clinical Quality Review Group meetings. CCG clinicians are able to question and review the detail of the quality of care provided against these indicators, and also reference to national guidance, research and best practice.

In addition, improvements in the quality of care received by patients in the following areas have been incentivised through the CQUIN dimension of contracting.

6.1.1. In hospital and community

CQUINS focus on a reduction in falls and pressure ulcers; improvement in the detection and improvement in care of people suffering from dementia; improved coordination and delivery of care of people suffering long-term conditions; improvement in the care of chronic obstructive pulmonary disease; improved communication between primary and secondary care leading to less duplication and delays for patients, focussing on preventing ill health by targeting smoking and alcohol use by patients; improving care in emergency departments for local people; and improved take up of the National Early Warning System (NEWS) on adult inpatient wards.


6.1.2. In mental health

CQUINs focus on improving physical healthcare of people with severe mental illness through improved physical health checks in order to reduce premature mortality; a reduction in the amount of time spent in inpatient beds by providing enhanced care in people’s homes; improved communication with patients’ GPs, particularly those on the enhanced care programme approach; improved rates of recovery orientated care plans co-produced with patients; and improving the discharge process from secondary mental health in adult mental health, child and adolescent mental health, mental health assertive outreach and community forensics, through effective post discharge communication with GPs within seven days.

6.2. Quality and innovation

The CCG has focussed on the following issues over the course of the last year to improve the quality of patient care delivered by providers of the NHS services we commission:

- In partnership with Southwark Council the CCG established a Winterbourne View Steering Group. This oversees the action plan which monitors care for all current residential placements for people with learning disabilities. The steering group reports into the CCG’s Quality and Safety sub-committee, and the CCG is assured that plans in place are appropriate.

- Further work has taken place on the quality alerts system that looks at quality issues originating in hospitals, raised on behalf of patients by GPs - the system is being developed to have more impact with member practices, to be able to capture feedback from secondary care providers as well as GPs, and integrate with patient experience feedback systems that actively look at emerging issues.

- Working alongside Healthwatch Southwark, NHS Lambeth CCG, and providers, the CCG has created a clinical site visit framework within which a structured programme of hospital visits has been planned. This will triangulate performance data and soft intelligence such as patient and staff feedback in a way that will guide lines of enquiry to be reviewed during a visit. Gaining patient and staff feedback directly while on-site is a key facet of this approach.

  It is anticipated that providers and commissioners will collectively identify any constraints to service delivery and quality as well as identifying areas of good practice. It also provides the opportunity to respond quickly and decisively to concerns or incidents surrounding quality of services.

- The CCG ran comprehensive reviews into topics including patient experience and health inequalities in 2014/15. The reviews provided assurance to the CCG governing body that areas of interest are being addressed adequately.

  These reviews also propose specific recommendations to resolve any issues identified. The CCG’s wider strategic goal to assess variation in quality and outcomes for Southwark patients using general practice services across the borough, has been targeted this year through a workshop ran by public health and the membership and engagement team, and wider CCG to enable equitable planning for next year. The Quality and Safety sub-committee also contributed to this.

- The Mental Health and Parity of Esteem Programme Board worked with Lambeth, Southwark, Lewisham and Croydon commissioners in incentivising improvements to mental health services. A four borough project to review the key performance indicators (quality and information schedule) provided as part of the South London and Maudsley (SLaM) contract has been agreed. The project will review the information currently provided against what is needed to better understand impact and outcomes of clinical activity. This project engages a range of stakeholders and will result in a core set of performance indicators and outcome measures being adopted.
- Following the NHS Quality Observatory’s initial consultation and scoping with organisations that will contribute to and use the insight dashboard, the CCG, has signed up to participate in the use and development of this. The dashboard will be available at a London wide, provider and CCG level. Initial proposed areas to cover include feeds from NHS Choices, Patient Opinion, Friends and Family test, NHS Safety Thermometer, inpatient and outpatient survey, serious incident data, Patient Reported Outcome Measures (PROMs), CQC data, Healthwatch data. This is expected to start in 2015/16.

- A primary care quality scorecard has been created this year which will be used by localities in the development of primary care neighbourhood models of service delivery with the aim of improving quality and access and reducing inter-practice variation. The scorecard supports the operational and strategic work of many CCG areas including the Primary Care Strategy Group, Integrated Care Neighbourhood Working Programme Board, the Mental Health Transformation Programme Board and the Quality and Safety Directorate.

- The CCG has joined a new south east London serious incident advisory panel whose membership includes NHS Bexley CCG, NHS Bromley CCG, NHS Lambeth CCG, NHS Lewisham CCG, NHS Southwark CCG and NHS Greenwich CCG. The panel shares good practice in the review and management of serious incident investigations and dissemination of learning. It is also reviewing draft new national guidance on management of serious incidents to enable a joined up approach across south east London to strengthen commissioner oversight of the process when it launches.

6.3. Developing Quality in the Organisation:

In order to support and realise its quality vision, as part of the organisational restructure a Quality and Safety directorate was created. The objective for the directorate is to provide a focus and lead for the CCG’s quality aspiration to ensure quality sits at the heart of everything the CCG does. Also, in September 2014 the CCG established the Quality and Safety Sub-Committee (QSSC)² as a forum for championing. This has strengthened quality and safety by having a dedicated platform with senior representation to focus on the detail of monitoring and developing quality in strategic commissioning, in delivery by providers, and in ensuring equality and human rights is integral to its work.

² reports to the Integrated Governance and Performance Committee (IGP)
The Quality and Safety sub-committee has provided a more robust assurance and escalation process for reviewing the services we commission and monitoring how care is delivered. The CCG has strengthened its systems to assure quality and patient outcomes through Clinical Quality Review groups alongside each main provider.

Serious incident investigations are also rigorously monitored and issues are escalated to the Quality and Safety sub-committee with representatives from Clinical Leads, Service Redesign, Safeguarding, Public Health, Mental Health, Healthwatch and Medicines Optimisation.

The quality team manage and escalate any quality or safety risks as they arise, supported by clinicians, providers and CCG directors. Issues captured in the CCG’s quarterly quality report which has been further refined and is reported up to the governing body.

6.4. Using feedback to improve quality

A comprehensive review of the use of patient experience in detecting early warnings relating to the quality of services has taken place in the CCG. This looked at all strands of soft intelligence or patient experience that relates to the process of receiving care for the patient, their family, or carers. This included structured
surveys, Friends and Family test in clinical areas, complaints and serious incidents, social media feedback, quality alerts via patients’ GPs, and provider specific initiatives.

A wider review has been undertaken with partner agencies including the Health Innovation Network at assessing research models of analysing narrative from patients in creating more tangible patient experience metrics.

This review has produced a more robust use of feedback from patients own experience within the CCG’s quality assurance process and will be reported back to the governing body through the quarterly report.

6.4.1. Complaints and PALs

CCGs are responsible for managing any complaints about local healthcare services they commission directly. Providers are responsible for managing complaints they receive about their own services, and the CCG monitors those themes and systems. The CCG has oversight of these systems at their regular provider meetings and challenges partners to ensure learning is acted upon.

NHS Southwark CCG purchases a service from the South East Commissioning Support Unit (CSU) to manage both complaints and PALS (Patients Advice and Liaison Service) on our behalf. Feedback is welcomed, both positive and negative, so that improvements can be made based on the concerns of patients and the public. The CCG regularly analyse the number of complaints and PALS queries to identify any patterns, themes and trends which both informs current service provision as well as ensuring that fairness and transparency is exercised.

Information regarding the number of queries and complaints redirected to NHS England by the CSU is provided in monthly, quarterly and annual reports to the CCG. All complaints relating to services commissioned by the CCG undergo investigation by the CCG’s commissioning manager, appropriate to the nature of the complaint. Information regarding complaints is provided to the Integrated Governance and Performance Committee, a committee of the governing body, for review and to ensure they are sighted on any themes.

Complaints 2014/15

During 2014/15, there were 26 formal complaints, compared with 19 in 2013/14. Of these 26 complaints 12 related to CCG directly commissioned services, compared with 4 in 2013/14.

Of the 12 complaints, 5 related to access and eligibility, 5 to commissioning decisions and 2 to policy and process.

1. Complaint received from a local MP on behalf of constituent asking that the CCG consider a retrospective application for overseas funding for his treatment of Lyme’s disease. A response was sought from the Head of Centre of Excellence (Specialist Services) at the South East CSU; the application was rejected following investigation.

2. Patient complaint was made via their MP on behalf of a child to reconsider the decision to transfer care from nurses to trained carers. Following appeal this case was closed.

3. Complaint was received from a law firm on behalf of their client (deceased patient’s family member) concerning payments for Continuing Care. Complaint was partially upheld and a full retrospective review was undertaken.

4. Complaint was received from son of deceased patient concerning management of the patient’s finances and entitlement of personal monies. A review of the assessments was undertaken and the complaint was not upheld.
5. Complaint was received concerning the withdrawal of funding for body contouring. This was investigated by the Independent Funding Review team and related to particular ‘phrasing’ used in communication. Full funding was provided. Case closed.

6. Complaint was received concerning IVF funding and responded to in line with guidance from the Independent Funding Review team.

7. Complaint was received concerning continued provision of neuro-rehabilitation services for a patient. This was managed jointly between the CCG and Southwark Council, resulting in confirmation that the service would be provided by the Community Health Services and Southwark Council. Case closed.

8. Complaint received concerning an application for fertility treatment which had been rejected previously.

9. Complaint received from patient asking the CCG to instruct a commissioned service to provide more comprehensive information on the nature of some procedures carried out as part of the service.

10. Communication email from social services complaints team regarding a complaint they received from a patient which they feel is CCG and not the Southwark Council. The complaint is regarding the funding for the provision of the Crossways Centre in Peckham.

11. Concerns about the closure of Crossways centre and asking for a permanent place to reconvene meetings with fully trained mental health advisors.

12. A complaint was received via a local MP concerning Crossways day Centre in Peckham.

The themes of the other 14 complaints received by the CCG which did not relate to services directly commissioned by the organisation are listed below. No specific trends have been identified.

- Treatment
- Access
- Case Update Request
- Communication
- Complaint Handling
- Estates/Facilities/Premises
- Other (Local Authority/Police)
- Policy and Process
- Prescribing/Medicines Management
- Staff Attitude

MP Enquiries 2014/15

During 2014/15 the CCG received 13 enquiries from MPs. Of this number, 7 were received in March 2015. Of the 13, 4 MP enquiries were CCG direct complaints, 1 was a non CCG direct complaint, 4 were CCG direct PALS queries, 1 was a non CCG direct PALS query and the remaining 3 were MP enquires. The nature of MP enquires received covered a range of topics including Assessment and eligibility, Communication, Contact information, Policy and Process and Treatment.

Patient Advice and Liaison Service 2014/15

The Patient Advice and Liaison Service (PALS) provides information and advice to patients, carers, the public and staff to ensure quick resolution of enquiries and questions raised about services provided by or commissioned by the CCG.

84 PALS enquiries were received in 2014/15. Of these, 22 related directly to the CCG. PALS enquiries can cover a range of topics including information and advice on access, communication, and contact information,
The CSU’s PALS office works closely with the CCG to ensure that concerns are dealt with promptly and services are improved.

**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; and
- seek continuous improvement.

The CCG has continued 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 Southwark residents.

A key principle 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.

**6.5. Safeguarding Adults and Children**

Integrated multi-agency working is the key to our robust joint approach to key safeguarding issues and 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. As a commissioning organisation, the CCG is required to ensure that all health providers from whom it commissions services (both public and independent sector) have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect vulnerable adults from abuse or the risk of abuse. 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 adults and children is part of the CCG’s business plan and operating plan objectives and key areas of delivery to improve the quality and safety of local services. More widely the CCG participates in the South London Quality Surveillance Group which looks more broadly at quality issues across the regional CCG and provider landscape and includes relevant safeguarding issues.

**6.5.1. Safeguarding Adults**

This year we have been working closely with the partners of the Safeguarding Adults Partnership Board to ensure readiness for the statutory requirements for safeguarding adults outlined in the Care Act 2015. The CCG has participated in the review of the Safeguarding Adults Board and the Head of Continuing Care and Safeguarding has been appointed as Chair of the Quality and Performance sub-group of the board. They are charged with ensuring the effectiveness of the Board and to provide assurance that provider organisation in Southwark are providing discharging their duties with regards adult safeguarding in a robust manner. The
CCG has been working with Board partners to develop the Safeguarding Adult Board Strategy and business plan. We have a CCG clinical lead and governing body member who has responsibility for adult safeguarding.

We have been working with primary care to raise awareness of the Mental Capacity Act and the roles and responsibilities of GPs regarding adult safeguarding. We have completed a safeguarding adults audit in primary care in order to establish a baseline upon which to further develop safeguarding adult systems and processes.

We continue to work closely with both our social care and mental health colleagues to ensure that the requirements of the Winterbourne Concordant are implemented in Southwark. We also continue to work with social care colleagues and care home providers to ensure the quality of care delivered within commissioned care homes. This work has include the commissioning of a GP contract for the provision of primary care services to care homes with nursing and the development of a multi-disciplinary team including a Consultant Gerontologist, specialist older people’s nurses and dedicated social workers to support this contract and improve the health outcomes for this vulnerable 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, eg. clients with learning disability and complex needs, including end of life.

6.5.2.  Safeguarding Children

Leadership and responsibility for safeguarding at the governing body level is achieved through the CCG Accountable Officer. The CCG also has a clinical lead and a director responsible for safeguarding children who provide clinical expertise in partnership with the designated doctor, named GP and designated nurse. In addition there are commissioned designated professionals in respect of looked after children and designated paediatrician. NHS Southwark CCG is fully compliant with the current statutory guidance ‘Working Together to Safeguard Children 2013’ and ‘Children Act 1989 and 2004’.

During 2013/14 the CCG has worked together with partner agencies to prevent children suffering harm and to promote their welfare by providing services they require to address identified needs and safeguarding children who are vulnerable.

The CCG host a bi-monthly health sub-group of the Southwark Safeguarding Children Board which has membership from all relevant health partners including health providers, looked after children designates, public health and Southwark Council. The purpose of the sub-group is to build and maintain an accurate picture of the quality and effectiveness of safeguarding arrangements, areas of strength and good practice and areas of risk and vulnerability across the health sector in Southwark. The sub-group takes the lead in instigating developments designed to improve safeguarding arrangements and improved outcomes for looked after children, which have cross sector or inter-agency relevance.

A learning event is held annually for GP practices. The 2013/4 event GP focussed particularly on child neglect, female genital mutilation (FGM), Southwark services – Multi-Agency Safeguarding Hub, Children’s Social Care Early Help, Solace (domestic violence organisation) and Common Assessment Frameworks (CAFs). The event was led by the clinical lead and named GP and included table top discussions on scenarios relating to domestic abuse and a Bubble Theatre Company presentation on neglect. The event was extremely well evaluated and received.

During 2013/14 the CCG implemented a safeguarding children’s audit in primary care to assure safe practice in respect of safeguarding and to identify areas for further training and development. This audit was based on The Royal College of GPs (RCGP) Safeguarding Children and Young People’s toolkit for 2011 and 82 percent of GP practices responded. Following analysis of the results a number of themes and areas for

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland

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The best possible health outcomes for Southwark people
development have been identified and have formed part of the CCG safeguarding action plan and future primary are audit development.

The CCG has worked in partnership with Southwark Safeguarding Children Board and partner agencies to ensure robust safeguarding arrangements are in place within the organisation and within commissioned services provided by health organisations in the CCG footprint.

6.6. Medicines optimisation

Medicines optimisation is an important part of the CCG’s work. Medicines optimisation is an approach to the quality use of medicines that aims to produce the best possible outcomes. Our primary goal is maximising value of medicines. That is the value a patient gets from their medicines and the value that the whole population experiences from NHS investment in medicines. Optimal medicines use is a crucial step in improving quality of care and balancing the costs of healthcare. Successful implementation of medicines optimisation initiatives have the potential to improve patient health outcomes, prevent medication related patient harm and improve service efficiency.

Our team, led by the Chief Pharmacist, comprises of highly professional and trusted pharmacists who work closely with local GPs and local health service providers to support high quality, cost effective prescribing. We provide pharmaceutical advice and support medicines optimisation related strategy and policy development. The CCG Medicines Management Committee oversees medicines optimisation strategy across Southwark and is responsible for monitoring the primary care practice prescribing budget, local enhanced services for medicines optimisation and any Southwark specific initiatives related to the use of medicines. The Committee is chaired by the CCG GP lead for prescribing and has representation from clinicians and general practice staff, medicines optimisation team members, finance and commissioning manageress.

Our progress during 2014/2015

General practice support

GP practices were supported to manage medicines optimisation issues, including advice on decision making at point of patient care and developing written material such as flyers. They worked to compare, analyse and interpret prescribing data for practices. The medicines optimisation team carried out face-to-face annual prescribing reviews with practices. They also worked as an intermediary to help resolve medicines optimisation issues with health service providers.

Finance and quality

The team worked with finance colleagues to set and monitor practice prescribing budgets – the overall prescribing budget for the CCG is £30 million. They developed and implemented the savings plan to ensure prescribing is cost effective and evidence based. They gained approval of a rebate scheme for new oral anticoagulants to ensure the best use of NHS resources for the local population.

Governance

To support the organisations robust governance procedures, they supported the quality team in managing quality alerts and incidents relating to medicines, and developed a risk register for medicines optimisation across the CCG. Working alongside local hospitals the team developed a local policy for commissioning high cost drugs and set up key performance indicators to be monitored as part of the hospital contracts.
Collaborative working

As part of the south east London Area Prescribing Committee, the medicines optimisation team took on the lead role for liaising with King’s College Hospital for development of an epilepsy treatment pathway and working with Evelina Children’s Hospital on shared care guidance for attention deficit hyperactivity disorder (ADHD) treatments.

The team also worked collaboratively with the London Borough of Southwark on public health related medicines optimisation issues, such as antibiotic prescribing and sexual health. They led on implementation of NICE lipid and AF guidance within Southwark, but also across South London.

Patient Involvement

Our consultant pharmacist for cardiovascular disease has direct patient contact in Southwark and trains other healthcare professionals to improve care for this group of patients. She has led several innovative projects this includes:

- Development and implementation of guidance to support the introduction of new oral anticoagulant drugs to improve reduce the risk of stroke in people with Atrial Fibrillation.
- Implementation of revised hypertension detection, management and monitoring guidance.
- Worked with selected practices to ensure maximum implementation of national cholesterol guidance to ensure the most effective cholesterol lowering option is prescribed, tailored to the patients need.
- Education of GPs and nurses on optimal care of patients with cardiovascular issues.
- Working with public health to support the delivery of the NHS Health Check programme across the borough.
- Supported the implementation of 24 hour ambulatory blood pressure monitoring across the borough to improve the diagnosis of hypertension.
- Working with local providers to implement community based services, such as the pharmacist led hypertension and hyperlipidaemia service.

In addition, we have successfully just employed a care homes pharmacist to support the use of medication within this setting and improve patient care.

Plans for the future

In addition to building on the positive work in 2014/15, the medicines optimisation team aim to:

- Support a campaign across the borough to reduce medicines waste.
- Review and improve the use of medication in care homes through the new pharmacist post.
- Support the work of the south east London Area Prescribing Committee with a planned work programme to review medication pathways in agreed key areas.
- Use specialist anticoagulant pharmacists to review all patients on practice atrial fibrillation registers in Southwark who are not currently anti-coagulated to assess suitability for anticoagulation.
- Implement a project of atrial fibrillation detection in people having blood pressure checks in community pharmacies.
- Support public health with improved access to medication in sexual health for patients using the online site, SH24.
• Support the integrated care agenda across Lambeth and Southwark through innovative ways of working, learning from new projects in south east London where there is improved discharge and transfer of care and through the exploration of establishing two new consultant pharmacist posts in diabetes and respiratory across the two boroughs.
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 the 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 2014/15 NHS Southwark CCG has achieved or exceeded the requisite level of performance in a number of key areas.

7.1. Biggest achievements

7.1.1. Improving access to psychological therapies

Improving Access to Psychological Therapies (IAPT) is a national programme to increase the availability of talking therapies. IAPT is primarily for people who have mild to moderate mental health problems, such as depression, anxiety, phobias and post-traumatic stress disorder.

The CCG invested in additional resource to increase access to the service, which resulted in a significant increase in people entering treatment and achievement of the 2014/15 target of 15 percent of adult patients who might benefit from appropriate psychological therapies accessing treatment.

7.1.2. Dementia diagnosis

There has been a national drive to increase dementia diagnosis so that at least two-thirds of people with dementia are identified by the end of 2014/15. In Southwark, over two thirds of residents expected to have dementia were identified in 2014/15, ensuring they can access the treatment and services they need to improve their quality of life as they live with the condition.

7.1.3. Cancer waiting time standards

All cancer waiting time targets were achieved for Southwark patients.

7.1.4. Care programme approach follow up in seven days

There is a requirement for service users discharged from mental health inpatient services who are receiving care under the care programme approach (CPA) process to be followed up within 7 days of discharge. Southwark maintained a high level of performance in 2014/15 and has achieved the performance target (95 percent) in 2014/15.
7.2. Challenges addressed

7.2.1. A&E 4 hour wait standard

The target is for 95 percent of patients to be seen, treated and then admitted or discharged within four hours from arriving in an A&E department. Meeting this requirement has been a challenge both nationally and in Southwark. King’s College Hospital’s Emergency Department at Denmark Hill did not meet the A&E four hour standard in any quarter of the last year. Despite this, the number of Southwark people attending A&E or admitted as non-elective patients has stabilised for the first time in years. This achievement can, in significant part, be attributed to the investment the CCG has made in out-of-hospital services.

The CCG will work closely with local A&E departments to improve performance throughout 2015/16.

7.2.2. Ambulance response times

Ambulance response times targets for 8 minutes red 1 and 2 response and 19 minutes response were not achieved in 2014/15. The London Ambulance Service has undertaken a series of actions to address performance to ensure that targets are achieved.

7.2.3. Referral to Treatment Times

The CCG maintained a strong performance on non-admitted and incomplete referral-to-treatment (RTT) performance, consistently achieving these performance targets in 2014/15.

The admitted RTT target was not achieved in 2014/15, however the CCG has worked with local hospitals to reduce the number of long waiting patients, which has reduced from thirteen 52 week waiters in March 2014 to three 52 week waiters in March 2015. The CCG is working with partners to ensure that admitted RTT performance improves in 2015/16.

7.2.4. Healthcare acquired infections

Incidence of C.difficile were higher than last year and over target for 2014/15. There was one MRSA infection assigned to the CCG in 2014/15. Post infection reviews are completed whenever an MRSA case is reported to ensure learning is embedded and incidence remain minimal.

7.3. Performance on NHS National Standards 2014/15

The table below shows NHS Southwark CCG performance against the national performance measures included in the operating framework for the NHS in England 2014/15. The below performance reflect the CCG’s position against the indicators.
<table>
<thead>
<tr>
<th>National priorities</th>
<th>Year end position 13/14</th>
<th>Target 14/15</th>
<th>M12 14/15</th>
<th>Traffic light</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 weeks RTT admitted</td>
<td>87.5%</td>
<td>90%</td>
<td>82.1%</td>
<td></td>
</tr>
<tr>
<td>18 weeks RTT non-admitted</td>
<td>97.2%</td>
<td>95%</td>
<td>96.2%</td>
<td></td>
</tr>
<tr>
<td>18 weeks RTT incomplete pathway (most recent)</td>
<td>93.1%</td>
<td>92%</td>
<td>93.7%</td>
<td></td>
</tr>
<tr>
<td>Diagnostic waits &lt; 6 weeks</td>
<td>96.2%</td>
<td>99%</td>
<td>96.4%</td>
<td></td>
</tr>
<tr>
<td>A&amp;E waits</td>
<td>93.4%</td>
<td>96%</td>
<td>91.5%</td>
<td></td>
</tr>
<tr>
<td>Cancer 2 weeks (GP referral)</td>
<td>96.0%</td>
<td>93%</td>
<td>96.5%</td>
<td></td>
</tr>
<tr>
<td>Cancer 2 weeks (breast symptoms)</td>
<td>96.2%</td>
<td>93%</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 days (first definitive)</td>
<td>97.1%</td>
<td>96%</td>
<td>97.3%</td>
<td></td>
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<tr>
<td>Cancer 31 days (subsequent treatment - surgery)</td>
<td>97.6%</td>
<td>94%</td>
<td>95.8%</td>
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<tr>
<td>Cancer 31 days (subsequent treatment - drug)</td>
<td>98.9%</td>
<td>98%</td>
<td>99.7%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31 days (subsequent treatment - radiotherapy)</td>
<td>95.5%</td>
<td>94%</td>
<td>95.9%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 days (GP referral)</td>
<td>87.0%</td>
<td>85%</td>
<td>89.7%</td>
<td></td>
</tr>
<tr>
<td>Cancer 62 days (referral NHS screening)</td>
<td>91.7%</td>
<td>90%</td>
<td>95.7%</td>
<td></td>
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<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>77.4%</td>
<td>75%</td>
<td>67.2%</td>
<td></td>
</tr>
<tr>
<td>Cat. A (Red 2) calls response within 8 mins</td>
<td>75.3%</td>
<td>75%</td>
<td>59.7%</td>
<td></td>
</tr>
<tr>
<td>Cat. A response within 19 mins</td>
<td>97.9%</td>
<td>95%</td>
<td>92.0%</td>
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<tr>
<td>Mixed-sex accommodation (total breaches)</td>
<td>132</td>
<td>0</td>
<td>11</td>
<td></td>
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<tr>
<td>52 weeks waiters (incomplete pathways)</td>
<td>13</td>
<td>0</td>
<td>3</td>
<td></td>
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<tr>
<td>Clostridium difficile (C. diff.) cases</td>
<td>36</td>
<td>42</td>
<td>51</td>
<td></td>
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<tr>
<td>MRSA bacteraemia (assigned to the CCG)</td>
<td>3</td>
<td>0</td>
<td>1</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>98.4%</td>
<td>95%</td>
<td>98.1%</td>
<td></td>
</tr>
<tr>
<td>Dementia diagnosis rate</td>
<td>57.6%</td>
<td>87%</td>
<td>67.7%</td>
<td></td>
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<tr>
<td>IAPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of people with depression accessing treatment (YTD)</td>
<td>10.8%</td>
<td>15.0%</td>
<td>16.0%</td>
<td></td>
</tr>
<tr>
<td>Proportion who complete therapy who are moving to recovery</td>
<td>40.1%</td>
<td>50%</td>
<td>37.3%</td>
<td></td>
</tr>
</tbody>
</table>
8. Sustainability report

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. As a local employer and organisation whose activities impact the local economy, environment and community, we acknowledge our responsibility to our patients, local communities and the environment to ensure our actions consider issues of sustainability and work hard to minimise our footprint.

We recognise sustainability goes beyond carbon emissions and environmental sustainability and have incorporated financial and social sustainability into our definition: Sustainability is defined as ‘meeting the needs of today without compromising the needs of tomorrow’. In commissioning terms, sustainability is defined as follows:

“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 is about striking the right balance between the three key areas of financial, social and environmental sustainability when making commissioning decisions. Commissioning for Sustainable Development saves money; saves resources; benefits staff and patients."³

In Autumn 2014 we reviewed sustainability within the organisation and set out our future plans in the Sustainable Development Strategy and Management Plan (SDMP), approved by Integrated Governance and Performance Committee through delegated powers from the governing body. The SDMP sets out the aims of the CCG’s sustainability agenda, our commitments to sustainable working and describes further actions to meet those aims and commitments. The plan also describes the actions we will take to support the NHS Carbon Reduction Strategy and contribute to ensure the NHS meets its duties under the Climate Change Act (2008).

8.1. Statement of commitment

NHS Southwark CCG is committed to commissioning services in a way that supports the NHS sustainable development agenda and contributes to environmental improvements, regeneration and reducing health inequalities.

Within our organisation this means minimising energy use and waste production, promoting sustainable travel for staff, developing employment opportunities for local people, and engaging local suppliers in procurement.

In our commissioning processes, this means designing services with sustainability in mind- and acting to ensure that commissioned providers abide by principles of sustainability (environmental, economic and social) in their activities. Practically this means the CCG should make sure we do the following:

- plan services which are efficient and effective;
- procure services which provide highest quality at best value and which have the least impact on the environment; offer positive sustainable employment; and deliver value for money; and

monitor services to ensure that sustainability is considered in providers’ day-to-day activities.

In addition, the CCG works to develop sustainable healthcare in Southwark by relieving some of the growing pressure on all health services. It seeks to be proactive and provide care which supports people to maintain their independence. This includes self-management and prevention as well as implementing processes to manage demand, particularly secondary care services.

In particular relation to the environment, the CCG will review its carbon footprint. The NHS target on carbon reduction, in line with the amendment (May 2009) to the Climate Change Act, is to achieve the following reductions on a 1990 baseline:

- 10 percent reduction by 2015
- 34 percent reduction by 2020
- 80 percent reduction by 2050.

8.2. Sustainability in commissioning

The CCG focusses on two key ways to support sustainability. The first is to look at sustainability within our own organisation and the second is to act to secure sustainability through our procurement and contracting processes and in our work with commissioned providers.

As a commissioning organisation our biggest impact is through procurement and contracting. In 2014/5 we have comprehensively reviewed and updated the procurement policy to fully reflect environmental, social and financial sustainability. We are working with our major providers to review their sustainability plans and annual carbon emissions as set out in the NHS policy framework.

This year, one key achievement in social sustainability supports our shared commitment with Southwark Council to ensure high quality support for people who live at home, the CCG has followed the recommendations of UNISON’s Ethical Care Charter (2012) in its re-tendering of its contract for the provision of care at home for people receiving NHS Continuing Healthcare. Care staff working on this contract are paid the London Living Wage and receive payment for travel time between visits, ensuring they are paid fairly for the important work that they do.

8.3. Sustainability within our organisation

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

The CCG participates in Southwark Council’s Green Buildings programme. The project works to reduce environmental impact and costs by improving efficiency in a number of areas: energy, water, waste and recycling, use of paper and transport.

One of the targets for the Green Buildings programme is to reduce paper usage to seven reams per person per year. The CCG has invested in new technology to significantly reduce the quantity of paper consumed. Committee papers are now accessed electronically for the governing body and its sub-committees using mobile devices. Not only does this impact on the environment but also improves use of CCG resources.
9. Equality report

9.1. Our commitment to Southwark people

Human rights and equality are inexorably linked to the quality of healthcare and patient outcomes. Therefore, we are committed to an inclusive NHS that provides equal access to quality and compassionate care for all Southwark people. Human rights can be seen as the overall umbrella of cradle to grave rights and freedoms enjoyed by every citizen in the UK, for example, a right to life and a right not to be treated in an inhuman or degrading way. Equality sits below focusing on preventing unlawful discrimination and promoting fairness and diversity on the basis of staff and patients’ nine ‘protected characteristics’ as defined by the Equality Act 2010, which are:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership/marriage;
- pregnancy and maternity;
- race;
- religion or belief;
- sex; and
- sexual orientation.

We also know that some groups and communities may have differential experience in accessing health services, and that socioeconomic determinants can exacerbate health inequalities. In this respect, protecting or enhancing human rights and promoting equality and inclusion are integral to our core business and reflected throughout everything that we do. Our operating plan, for example, is underpinned by the human rights principles of Fairness, Respect, Equality, Dignity and Autonomy (the FREDA Principles). In practice, this means that as a commissioning organisation, one of our core aims is to provide care that is personalised and supports people to maintain their independence regardless of their background.

9.2. Achievements during 2014/15

The challenges to make local NHS services inclusive, both culturally and person-centred for our diverse, transient and growing population cannot be underestimated, particularly under the present financial constraints on health and social care expenditure. In 2014, we took further internal initiatives to improve our focus on underpinning equality and human rights in all our functions. This included moving the ‘equalities’ work to sit with the membership and engagement team, the establishing of the Equality and Human Rights Steering Group reporting to the Quality and Safety sub-committee, which has a comprehensive oversight of our equalities work.

9.2.1. Equality objectives

Our four year equality objectives are locally driven to reflect local equality priorities for Southwark people. We have made good progress on all of our five equality objectives over the past year and of particular note is the work on:
Equality Objective 1 - Engagement and Patient Experience
For information on our engagement work please see section 3. Quality and compassionate care for patients is one of our key objectives, therefore, we conducted a comprehensive analysis of patient experience section 6.4. This resulted in a number of recommendations on how we can improve our ‘quality and safety assurance’ framework.

Equality Objective 2 - Learning Disability
Care outcomes for people with learning disabilities (LD) in Southwark are improving, but further improvements need to be made. Last year we rolled out personal health budgets for NHS fully funded healthcare clients with LD. In addition, there are joint health and social care reviews of our out of borough placements for clients with LD. We also have quarterly reporting on status of all patients with LD in inpatient beds. In response to the Winterbourne View Concordant, a Strategic Local Area Plan has been developed, which sets out the range of integrated working initiatives to provide appropriate community based support of children and adults whose behaviour challenges services and to meet the requirements of the Concordant.

Equality Objective 3 - Mental Health
Over the past year, working with our partners, we have developed a joint mental health strategy for Southwark. This includes specific strategic objectives to ensure equality of access and improved outcomes for vulnerable and at risk groups locally. We have also started to map marginalised groups in relation to the mental health needs of the Black, Asian and Minority Ethnic (BAME) communities. In addition, following a successful pilot project, we have commissioned further mental health training in spiritual and pastoral care setting across Southwark’s faith organisations. This project is making good inroads in mental health awareness among the faith communities fostering a culture of prevention, early intervention and signposting to services where appropriate.

Equality Objective 4 - Provider Contracts
Both mid Staffordshire and Winterbourne View raised fundamental issues about human dignity and compassionate care. We are keen to build on our quarterly provider quality reports and also focusing on some of the more ‘soft’ human factors as identified by Francis and Winterbourne. Therefore, we are developing a ‘quality site-visit framework’, so that as commissioners we can be assured that our hospitals and community care services are safe and of high quality and that concerns or incidents can be responded to quickly and decisively.

Equality Objective 5 – Care Homes in Southwark
We have developed a joint vision for care homes with the council to raise the bar in care standards across all care homes in Southwark. This includes improving access to nursing for those living with dementia in in care homes. Working with providers and other agencies, a pilot project “My Home Life Southwark” has been implemented. The aim of the project is to create a ‘gold standard’ in terms of compassionate care, promote care homes as a career pathway together with leadership development by attracting and retaining the best talent possible.

The 2014 report on the progress that we have made on our equality objectives can be found by following this link: http://www.southwarkccg.nhs.uk/about-us/equality-and-diversity/Pages/default.aspx

9.3. Going forward
Over the next year our aim is to consolidate on our internal initiatives to ensure that equality and human rights is central in everything that we do. In particular, we have started to implement the Equality Delivery
System (EDS2), which is the NHS’ equalities reporting framework. Working with local community organisations, including Healthwatch Southwark and the Forum for Equality and Human Rights in Southwark, EDS2 will help us to identify what we are doing well, what we need to improve on, and the equality gaps/risks that we need close or mitigate. It is a comprehensive analysis focusing on four goals (better health outcomes, improved patient access and experience, a representative and supported workforce, and inclusive leadership) measured against eighteen equality and health inequalities outcomes.

Equal opportunities for all

The CCG is an inclusive organisation for patients, staff and members. We are fully committed to ensure better health outcomes, improved patient access and experience, a representative and supported workforce and inclusive leadership. In this respect, we pay due regard to the rights, duties and pledges that underpin inclusion, namely, the Human Rights Act 1998, Equality Act 2010, Health & Social Care Act 2012 and the NHS Constitution.
Members’ Report

Southwark has a strong history of clinical involvement in commissioning. GPs in Southwark came together as the NHS 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 44 GP practices in Southwark and bound by an agreed constitution. The 44 member practices work together in two localities: north Southwark 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 all practices and chaired by GP with a nurse practitioner as deputy chair. 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 three times during the year two additional membership engagement meetings were organised to enable members to debate and discuss the proposals for taking forward co-commissioning of primary care locally. 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 2015 prior to them being submitted to NHS England. It also agreed constitutional changes in March 2015 to enable the setting up of governance structures to enable joint decision making with NHS England of primary care. You can find more information about our governance structure in the governance statement in section 20.

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 member’s 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.

As part of our 360º stakeholder survey one GP from each of our 44 member practices was surveyed by Ipsos-Mori on behalf of NHS England and the CCG achieved an 89 percent response rate from member practices. 90 percent of member practices who participated felt that they have been engaged a great deal or a fair amount. “[The] CCG is going through challenging times … but they endeavour to do their best to engage with practices who are inundated with work and struggle to effectively engage.”

However, a lower number or practices were satisfied with the way that the CCG had engaged with them. “I think they do try and engage through locality meetings, council of members meetings and update in our protected learning time”. As a result the CCG engaged in a short piece of co-design work with an independent organisation called Live Work who undertook a series of focus groups with member practices, practice visits and presentation at a development event to understand the constraints of engagement for GPs
and practice staff and to recommend ways forward. Practices enlisted as knowing who is who and who is working on specific projects as being particularly important to them and also ensuring the visibility of process. The CCG is exploring how we can use the member’s zone to address these areas. In addition, the CCG is looking into developing a smart phone app for member practices to use as a means of communicating with each other.
10. **Our member practices**

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

The governing body of NHS Southwark CCG is clinically led. It consists of eight elected GPs from member practices, three Lay Members, a secondary care consultant, two nurse members (one from secondary care and one practice nurse), the Chief Officer, the Chief Financial Officer, a Public Health representative and a Healthwatch representative. These members are all voting.

In addition, the governing body has a number of non-voting members: Director of Quality and Safety, Director of Integrated Commissioning, a representative from Southwark Council, a representative from the Local Medical Committee (LMC), and a representative from King’s Health Partners.

Total membership of the Governing Body is 23 of which 14 are clinical – 12 of the clinical members hold voting rights. The CCG Chair is Dr Jonty Heaversedge.

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

Andrew Bland has been the Chief Officer 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. These are outlined below.

- 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 section 20. Profiles of our governing body are available in the remuneration report in section 16.
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 Quality, Innovation, Productivity, Prevention (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.

On 30 June 2014, four GP members of the CCG governing body stepped down from their positions, having come to the end of their two year tenure. A selection/election process was undertaken to appoint replacements and the four new members (elect) were welcomed ahead of taking up their positions on 1 July 2014.

- Total no. of applications received = 8
- No. of candidates selected for interview = 8
- No. of candidates for election = 5
- No. of candidates elected = 4

The newly elected members of the governing body are:

Dr Roe, Dr Ezeji, Dr Baxter and Dr Mizan

The outgoing members of the governing body were:

Dr Zeineldine (Chair), Dr Fradd, Dr Holden and Dr Durston

14.1. New Chair of the CCG

Having completed the process of appointment of GP Clinical Leads, the CCG then began the process of Chair appointment.

The CCG’s Constitution states that the Chair of the CCG’s governing body should be a GP member of its Governing Body; should have demonstrated the requisite competencies of the role (as nationally and locally defined); and should be elected to that position by the eight GP leads on the governing body. Against that process Dr Jonty Heaversedge stood for the position of Chair, having successfully completed the national assessment centre process for CCG Chairs in March 2014. Dr Heaversedge was been unanimously supported by the GP members of the governing body and appointed as Chair of the governing body.
15. Managing our risks

The CCG recognises the importance of good risk management and board assurance as an integral part of its approach. Risk is an inevitable part of managing healthcare but it must be managed in such a way that the impacts of commissioning decisions can be understood as fully as possible before they are made. This reflects the way members, in their clinical roles, make judgements about good patient care day in day out.

We adopt a balanced and proportionate approach to risk management that is substantively robust whilst not unnecessarily bureaucratic. Such an approach seeks to balance our obligations to exercise our functions safely, effectively, efficiently and economically, with our duties to drive improvements in services, promote innovation, and reduce inequalities.

Our Board Assurance Framework captures strategic risks to our corporate objectives and provides assurance to the governing body that the organisation is effectively managing or has plans in place to manage risks which may threaten achievement of the organisational annual objectives.

Full details of our approach to risk management can be found in the annual governance statement in section 20.

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 21.5.4.5 Accounting Policies in the Annual Accounts. For details of senior manager's pension entitlements please see the CCG’s Remuneration Report on page 86.

15.2. Sickness absence data

Sickness absence data is provided in the Financial Statements.

15.3. External audit

NHS Southwark CCG’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 2014-15 is £84,800 +VAT. NHS Southwark CCG received no further assurance or non-audit services from Grant Thornton UK LLP during 2014/15.

15.4. Disclosure of Serious Incidents

The responsibilities of many facets of the NHS changed substantially in 2014. CCGs are not direct providers of care and have negligible access to patient data. Consequently the possibility for adverse incidents and serious incidents involving data breaches is considerably reduced. The CCG takes data security very seriously. All staff are required to complete mandatory information governance training. 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 East 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.
The CCG’s Quality and Safety team manages the assurance process of serious incidents and lessons learnt via meetings held with each provider. Lead clinicians and relevant directors are also in attendance. During 2014/15 the CCG reviewed and refined its serious incidents management systems and updated the Integrated Governance and Performance Committee on a monthly basis in addition to the quality and safety sub-committee. The CCG takes responsibility to ensure that the organisation and its providers conform to the national serious incident framework, never events frameworks and duty of candour regulations.

During 2014/15, there were nine serious incidents were logged by the CCG. These occurred across a range of individual services commissioned by the CCG or jointly with Southwark Council. Each serious incident undergoes a thorough review and interrogation of actions identified and lessons learnt to ensure that the risk of it happening again is minimised. The CCG endeavours to encourage openness and transparency and has encouraged the reporting of all incidents whether serious or not. We continue working towards creating a blame free culture in 2015/16 where emphasis is on improving patient safety and learning lessons.

You can find details of incidents involving data loss or confidentiality breaches in the governance statement in section 20.

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.

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 in section 6.4.1
15.7. Employee consultation

You can find information about how we engage and consult with staff in section 3.2.2.

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 information about how we support CCG staff in section 3.2.

15.9. Emergency preparedness

Under the Health & Social Care Act 2012, CCGs are designated Category 2 responders with a duty to cooperate with and support the NHS England (London) as the Category 1 responder under the Civil Contingencies Act 2004. As the lead commissioner of acute care, CCGs are required to have a system in place to manage surge capacity and provide a 24/7 point of contact for providers to escalate any potential or actual service failure. CCGs are additionally required to cooperate and share information with the NHS England (London). These arrangements will be covered under a memorandum of understanding between the CCGs and the NHS England (London).

In accordance with statute, the CCG has an Accountable Emergency Officer (AEO) 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 (EPRR) Network, London Health Resilience Partnership and the Southwark local resilience forum, which includes all the emergency services.

The CCG has a pandemic flu plan in place which has been developed by the joint public health team for Southwark and Lambeth and has an approved EPRR policy which demonstrates CCG commitment towards emergency preparedness.

The CCG is part of South East London (SEL) Directors-on-call rota for handling surge capacity management with the requirement that the director-on-call will support the NHS England (London) in a major incident through the management of the impact of the incident. The six CCGs in this arrangement are NHS Bexley CCG, NHS Bromley CCG, NHS Greenwich CCG, NHS Lambeth CCG, NHS Lewisham CCG and NHS Southwark CCG.

In 2014-15, the CCG received significant assurance from NHS England on its EPRR plans and policies. The CCG is working towards updating its Business Continuity Plan to reflect NHS England’s expectations.

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.
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

16. Remuneration committee report

The Remuneration Committee comprises of five members – three lay members and two clinical leads. 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>3</td>
</tr>
<tr>
<td>Richard Gibbs</td>
<td>Lay Member</td>
<td>April 2013</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Robert Park</td>
<td>Lay Member</td>
<td>April 2013</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Dr. Pat Holden</td>
<td>GP Clinical lead</td>
<td>April 2013</td>
<td>30th June 2014</td>
<td>1</td>
</tr>
<tr>
<td>Dr. Jonty Heaversedge</td>
<td>GP Clinical lead</td>
<td>April 2014</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Dr. Tushar Sharma</td>
<td>GP Clinical lead</td>
<td>July 2014</td>
<td>31st Jan 2015</td>
<td>2</td>
</tr>
<tr>
<td>Dr. Nancy Kuchemann</td>
<td>GP Clinical lead</td>
<td>Feb 2015</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Linda Drake</td>
<td>Practice Nurse Clinical Lead</td>
<td>Oct 2014</td>
<td></td>
<td>1</td>
</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.

<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>Gwen Kennedy</td>
<td>Director of Quality and Safety</td>
<td>CCG</td>
</tr>
<tr>
<td>Alison Rayner</td>
<td>HR Consultant</td>
<td>HR advice</td>
</tr>
</tbody>
</table>

The committee met four times during the financial year, was quorate on each occasion and discussed issues such as extension of lay member contracts, employment tribunal issues, CCG re-structure proposals and recruitment for secondary doctor.

16.1. 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.
16.2. Senior managers’ performance related pay

The CCG does not have a policy of paying performance related pay for senior managers. 2014/15 was the second year of the CCG, and it has been announced, by the Department of Health, that there will be a zero pay increase for those on very senior manager terms, for the year.

16.3. 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 contracts were extended by the Remuneration Committee to 30 Sept 2016. GP Clinical leads are subject to a two year fixed term, which for four leads ends in June 2015. 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 2015.

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

16.4. Payments to Past Senior Managers

There have been no payments in respect of past senior managers.
## 16.5. Senior managers’ salaries and allowances

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary &amp; Fees (bands of £5,000)</th>
<th>Taxable Benefits (£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. Jonty Heaversedge Clinical Chair (from Jul 2014)</td>
<td>90-95 (45-50)</td>
<td>90-95 (45-50)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Amr Zeineldine Clinical Chair (until Jul 2014)</td>
<td>20-25 (55-60)</td>
<td>20-25 (55-60)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Andrew Bland - Chief Officer</td>
<td>120-125 (120-125)</td>
<td>0.0-2.5 (17.5-20)</td>
<td>2.5-5.0 (132.5-135)</td>
<td>125-130 (255-260)</td>
<td>110-115 (130-135)</td>
<td></td>
</tr>
<tr>
<td>Mr. Malcolm Hines - Chief Financial Officer/ Deputy CO</td>
<td>110-115 (110-115)</td>
<td>175-180 (NIL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Paul Jenkins - Director of Integrated Commissioning (interim) (from Jul 2014)</td>
<td>35-40 (90-95)</td>
<td>10.0-12.5 (37.5-40)</td>
<td>125-130 (145-150)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Tamsin Hooton - Director of Service Redesign (until Aug 2014)</td>
<td>35-40 (95-100)</td>
<td>27.5-30.0 (50-52.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Gwen Kennedy - Director of Quality &amp; Safety</td>
<td>100-105 (95-100)</td>
<td>25-30 (35-40)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dr. Adam Bradford - GP clinical lead</td>
<td>25-30 (35-40)</td>
<td>25-30 (35-40)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Sian Howell - GP clinical lead</td>
<td>35-40 (35-40)</td>
<td>35-40 (35-40)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Jacques Mizan - GP clinical lead (from Jul 2014)</td>
<td>25-30 (NIL)</td>
<td>25-30 (NIL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Noel Baxter - GP clinical lead (from Jul 2014)</td>
<td>30-35 (NIL)</td>
<td>30-35 (NIL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Obi Ezeji - GP clinical lead (from Jul 2014)</td>
<td>25-30 (NIL)</td>
<td>25-30 (NIL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Yvonneke Roe - GP clinical lead (from Jul 2014)</td>
<td>25-30 (NIL)</td>
<td>25-30 (NIL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name and title</td>
<td>Salary &amp; Fees (bands of £5,000)</td>
<td>Taxable Benefits (rounded to the nearest £00)</td>
<td>Annual Performance Related Bonuses (bands of £5,000)</td>
<td>Long-term Performance Related bonuses (bands of £5,000)</td>
<td>All Pension Related Benefits (bands of £2,500)</td>
<td>TOTAL (bands of £5,000)</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>Ms. Linda Drake - practice nurse</td>
<td>35-40 (35-40)</td>
<td></td>
<td></td>
<td></td>
<td>30.0-32.5 (202.5-205)</td>
<td>65-70 (240-245)</td>
</tr>
<tr>
<td>Ms. Diane French - lay member</td>
<td>5-10 (5-10)</td>
<td></td>
<td></td>
<td></td>
<td>5-10 (5-10)</td>
<td>10-15 (10-15)</td>
</tr>
<tr>
<td>Mr. Robert Park - lay member</td>
<td>5-10 (5-10)</td>
<td></td>
<td></td>
<td></td>
<td>5-10 (5-10)</td>
<td>10-15 (10-15)</td>
</tr>
<tr>
<td>Dr. Roger Durston - GP clinical lead (until June 2014)</td>
<td>5-10 (35-40)</td>
<td></td>
<td></td>
<td></td>
<td>5-10 (35-40)</td>
<td>10-15 (10-15)</td>
</tr>
<tr>
<td>Dr. Simon Fradd - GP clinical lead (until June 2014)</td>
<td>5-10 (35-40)</td>
<td></td>
<td></td>
<td></td>
<td>5-10 (35-40)</td>
<td>10-15 (10-15)</td>
</tr>
<tr>
<td>Dr. Tan Vandal - secondary care Dr. (until March 2015)</td>
<td>10-15 (0-5)</td>
<td></td>
<td></td>
<td></td>
<td>10-15 (0-5)</td>
<td>10-15 (10-15)</td>
</tr>
<tr>
<td>Dr. Ruth Wallis - Director of Public Health</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
<td></td>
<td>NIL (NIL)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Ms. Alvin Kinch – Healthwatch (until May 2014)</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
<td></td>
<td>NIL (NIL)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Mr. David Cooper – Healthwatch (from June 2014)</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
<td></td>
<td>NIL (NIL)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Prof. John Moxham - clinical lead for Kings Health Partners</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
<td></td>
<td>NIL (NIL)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Ms. Sarah McClinton - Director of Social Services LBS (until Aug 2014)</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
<td></td>
<td>NIL (NIL)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Mr. Jay Strickland – Director of Social Services LBS (from Dec 2014)</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
<td></td>
<td>NIL (NIL)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Dr. Jane Cliffe - LMC representative</td>
<td>NIL (NIL)</td>
<td></td>
<td></td>
<td></td>
<td>NIL (NIL)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Dr. Kathy McAdam</td>
<td>NIL</td>
<td></td>
<td></td>
<td></td>
<td>NIL</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>
Figures in brackets and italics in the above table are prior year comparators. The prior year figures were calculated using a different methodology. The current year figures are based on actual payments made.

No taxable benefits were paid in 2014-15.

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 GP’s 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 2014-15.
### 16.6. Senior Managers’ Pension Benefits

*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 age 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2015</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Cash Equivalent Transfer Value at 31 March 2014</th>
<th>Employer's contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Andrew Bland Chief Officer</td>
<td>0.0-2.5</td>
<td>2.5-5.0</td>
<td>20-25</td>
<td>65-70</td>
<td>266</td>
<td>18</td>
<td>241</td>
<td></td>
</tr>
<tr>
<td>Mr. Malcolm Hines Chief Finance Officer/Deputy CO</td>
<td>0.0-2.5</td>
<td>0.0-2.5</td>
<td>50-55</td>
<td>150-155</td>
<td>1,116</td>
<td>34</td>
<td>1,054</td>
<td></td>
</tr>
<tr>
<td>Ms. Tamsin Hooton Director of Service Redesign</td>
<td>0.0-2.5</td>
<td>0.0-2.5</td>
<td>20-25</td>
<td>65-70</td>
<td>339</td>
<td>8</td>
<td>312</td>
<td></td>
</tr>
<tr>
<td>Ms. Gwen Kennedy Director of Quality &amp; Safety</td>
<td>0.0-2.5</td>
<td>5.0-7.5</td>
<td>30-35</td>
<td>100-105</td>
<td>727</td>
<td>58</td>
<td>652</td>
<td></td>
</tr>
<tr>
<td>Ms. Linda Drake Practice Nurse, Clinical Lead for Primary Care Development and Integrate</td>
<td>0.0-2.5</td>
<td>2.5-5.0</td>
<td>15-20</td>
<td>45-50</td>
<td>352</td>
<td>47</td>
<td>297</td>
<td></td>
</tr>
</tbody>
</table>

### 16.7. 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 (or other allowable beneficiary’s) pension payable from the scheme.
CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer values) Regulations 2008.

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.

16.8. **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.

16.9. **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 2014/15 was £177,500 (2013-14, £122,500).

This was 3.82 (2013-14, 2.53) times the median remuneration of the workforce, which was £46,423 (2013-14, £48,387).

In 2014/15 no employees (2013-14, 0) received remuneration in excess of the highest paid member of the Membership Body/Governing Body. Remuneration ranged from £7,094 to £122,850 (2013-14, £7,882 to £111,250).

Total Remuneration includes salary, non-consolidated performance related pay, and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

There has been a change with regard to the highest paid individual in the CCG in 2014-15, with this now being the Director of Integrated Commissioning (Interim) post.

The remuneration range (excluding the highest paid individual) has increased due to the inclusion of the previous highest paid individual within this range.

The median remuneration of the workforce has reduced in 2013-14 due to an average increase in the number of staff employed and the type of roles that were filled by the additional staff members.
16.10. Off-payroll engagements

Off-payroll engagements as of 31 March 2015, 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 2015 | 5 |

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 2014 and 31 March 2015. | 1 |
| Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations. | 3 |
| Number for who assurance has been requested. | 5 |
| Of which, the number: | |
| For whom assurance has been received. | 5 |
| For whom assurance has not been received. | 0 |
| That has been terminated as a result of assurance not being received. | 0 |

| 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 | 1 |
| 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) | 31 |
### 17. Governing body profiles

<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 Jonty Heaversedge</td>
<td>CCG Chair CCG chair, clinical lead for integration and supports quality and engagement</td>
<td>Jonty is the CCG Chair and 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. Jonty is the clinical lead for integration and plays a role in clinical leadership for quality and engagement. He takes a leading role in engagement – both with CCG member practices and the public. 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. In addition to his roles in the CCG Jonty is currently providing clinical leadership on the Community Based Care Workstream for the South East London Community Based Care Programme and he sits on the Clinical Board for Primary Care Transformation in London. He is Vice Chair of the Southwark Health and Wellbeing Board and is a member of the Early Action Commission, Chaired by Margaret Hodge MP, looking at the benefits of intervening earlier to improve the health and wellbeing of Southwark residents.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Experience and Qualifications</td>
<td></td>
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<tr>
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</tr>
<tr>
<td>Dr Sian Howell</td>
<td>Clinical lead for primary care development and has a leading role in prevention. Governing body link for safeguarding</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>
<tr>
<td>Dr Adam Bradford</td>
<td>Clinical lead for the Clinical Quality Review Group, engagement and quality. Governing body link for cancer</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 Obi Ezeji</td>
<td>Clinical lead for information management and technology, supports integration and engagement</td>
<td>Obi has been a GP in Southwark for over 11 years and works at Grange Road Practice and has first-hand experience and understanding of the health needs of local residents. He has actively collaborated with colleagues in GP locality commissioning that have helped to shape the development of Southwark CCG. He also has experience as a medical appraiser for the NHS South London Area Team. Obi is the clinical lead for Information Management and Technology as well as taking a leading role in integration and engagement.</td>
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</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Description</td>
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<td>------------------------</td>
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<td></td>
</tr>
<tr>
<td>Dr Yvonneke Roe</td>
<td>Clinical lead for prevention and supports on the Health and Wellbeing board. Governing body link for inequality</td>
<td>Yvonneke has been working in Southwark for almost 30 years and has been a GP in Southwark for over 24 years working from the Nunhead Surgery. She completed her clinical training at St Thomas's hospital and spent a year working as an out of hours GP in Queensland Australia. Yvonneke is the clinical lead for Prevention and sits on the Health and Wellbeing Board. She has a keen interest in health promotion and the management of chronic diseases. She is also the Governing Body link for inequality. She has extensive experience and previously held roles as the Clinical Governance Lead for south Southwark Primary Care Group, and GP advisor on the Dulwich hospital redevelopment project.</td>
<td></td>
</tr>
<tr>
<td>Dr Noel Baxter</td>
<td>Clinical lead for quality and the Clinical Quality Review Group and supports integration</td>
<td>Noel has been a GP in Southwark for 11 years. He trained as an undergraduate in South London, graduating from St George’s medical school in 1992. Though new to the Governing Body in 2014, Noel has already been involved in CCG respiratory service plans as a GP member. His experience as co-Lead of the London Respiratory Team as part of the Department of Health’s three year respiratory improvement programme meant he had key insights to share. He is the clinical lead for the Quality Review Group and has a leading role in quality and integration. He is passionate about joining up services which historically haven’t been and works closely with health professionals across the patient journey. He wants patients to feel...</td>
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</tbody>
</table>
confident that the people looking after them are talking to each other. Living and working in south east London, Noel has personal experience of the benefits derived from a diverse population, but is also very aware that not all people in Southwark benefit equally from the health knowledge and skill available in our borough. It is his aim to help redress this imbalance.

<table>
<thead>
<tr>
<th>Dr Jacques Mizan</th>
<th>Clinical lead for engagement and leading role in prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacques has been a GP in Southwark for two years and has worked in the NHS in London for over 20 years. As well as being a GP, he is the clinical lead for engagement and has a leading role in prevention. Jacques is also interested in academia and research to design buildings and neighbourhood spaces for health care. In previous roles he has worked extensively with the voluntary sector, charities and not-for-profit organisations and recognises their key role in delivering health services. Jacques feels it is important to drive innovation in the NHS to develop services which are people centre and sustainable. He believes that the NHS must address why people get ill, rather than just treating them when they are.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Dr Nancy Kuchemann</th>
<th>Clinical Lead mental health and parity of esteem, leading role in quality and the Clinical Quality Review Group</th>
</tr>
</thead>
<tbody>
<tr>
<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. She leads on mental health and parity of esteem as well as having a leading role in the Clinical Quality Review Group. Her clinical interests include the care of people with substance misuse, the</td>
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</tbody>
</table>
patient experience and health-related behaviour, medically unexplained symptoms and health promotion. She lives in Peckham and uses the local health and other community services regularly. As a result, she cares about the quality of our local health service and the way it functions, how it treats patients and how its professionals perform and develop.

Dr Tushar Sharma

Clinical Lead for Medicines Management and supports mental health and parity of esteem. Governing body link for dementia (until 31 January 2015)

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.

Linda Drake

Practice Nurse. Leading role in primary care development and integration. Governing body link for children services

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 and supports Primary Care Development in Southwark, as well as taking a leading role in integration. She is also the governing
<table>
<thead>
<tr>
<th><strong>Chair:</strong> Dr Jonty Heaversedge</th>
<th><strong>Chief Officer:</strong> Andrew Bland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professor Ami David MBE</strong></td>
<td><strong>Registered Nurse. Supports primary care development. Governing body link for maternity</strong></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Dr Richard Gibbs</strong></td>
<td><strong>Lay Member leading on audit, remuneration and governance</strong></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Robert Park</strong></td>
<td><strong>Lay Member leading on quality of commissioned services</strong></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Diane French</td>
<td>Lay Member leading on patient and public engagement</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<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. Diane is the lead for patient and public involvement, and has an interest in mental health and parity of esteem, as well as engagement. 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>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Andrew Bland</th>
<th>Chief Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>
can bring about real sustainable change and make NHS services in Southwark the best they can be.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malcolm Hines</td>
<td>Chief Financial Officer and Deputy Chief Officer</td>
<td>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 23 years’ experience as a NHS Finance Director.</td>
</tr>
<tr>
<td>Gwen Kennedy</td>
<td>Director of Quality and Safety</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>
</tr>
<tr>
<td>John Moxham</td>
<td>Co-opted Member, Director of Clinical Strategy for King’s Health Partners</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</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dr Ruth Wallis</td>
<td>Director of Public Health</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 doctor and supports integration</td>
<td>Tan has been a Consultant Urological Surgeon since 1988. Initially at Greenwich District Hospital, he moved to Barking, Havering and Redbridge University Hospitals NHS Trust where he retired as Associate Medical Director. He appointed Consultant member of the CCG’s governing body in February 2014 and serves on several other CCG Governing Bodies. In Southwark he has a leading role in integration. He began his surgical career in 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 a consultant he held successive clinical leadership roles in secondary care, including Director of Surgical Division &amp; Associate Medical Director. As Associate Medical Director his portfolio included CCG liaison, 7-day quality care, internal professional standards, consultant job planning and appraisal.</td>
</tr>
<tr>
<td>Alvin Kinch</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</td>
</tr>
</tbody>
</table>
### Local Authority Accountability

Local authority and is accountable to them.

| NHS | Dr Jane Cliffe | Local Medical Council representative | 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. |
| Dr Amr Zeineldine | CCG Chair Clinical Lead for Integration of Care (until 30 June 2014) | 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. |
| Dr Patrick Holden | GP Lead for Unplanned Care and 111 and Planned Care (until 30 June 2014) | 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. |
| Dr Roger Durston | GP Lead for Mental Health and SLAM Quality and Dulwich Programme (until 30 June 2014) | 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Simon Fradd</td>
<td>GP Lead for Continuing Care (until 30 June 2014)</td>
<td>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. He is also a locality chair so makes sure the views of GP members in South Southwark are used to develop CCG plans.</td>
</tr>
<tr>
<td>Tamsin Hooton</td>
<td>Director of Service Redesign (until August 2014)</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>
</tr>
<tr>
<td>Paul Jenkins</td>
<td>Director of Integrated Commissioning (interim) (from August 2014)</td>
<td>Paul has worked in the NHS at Board level for 19 years holding director roles in primary care, service development &amp; transformation, deputy chief executive of Westminster PCT and recently in an acute trust as director of performance and partnerships. As managing director in North West London he set up the largest acute commissioning vehicle in London across 8 primary care trusts. Paul’s portfolio with Southwark CCG includes commissioning services across all sectors, maximising potential of</td>
</tr>
</tbody>
</table>
integrated care, oversight and delivery of key enablers such as the Better Care Fund, and delivering increased access to primary care taking advantage of the Prime Minister’s Challenge Fund and the new models of care commissioned from GP Federations.

<table>
<thead>
<tr>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Alex Laidler</td>
<td>Acting Director of Adult Social Care (acting from March 2014)</td>
</tr>
<tr>
<td>Jay Strickland</td>
<td>Director of Social Care (from Dec 2014)</td>
</tr>
</tbody>
</table>
18. Register of interests

**Register of Interests**
March 2015

NHS Southwark CCG’s Register of Interests and 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](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](mailto: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](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)⁴ who are not members of the committee in question.

⁴ All attendees at CCG meetings will be asked to indicate any change to the available register of interests and where attendees are CCG or SLCSU employees they will be asked to declare any interests relating to the agenda.
<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>Aflatt Melanie</td>
<td>Counter Fraud Management Specialist, TIAA Ltd.</td>
<td>• Employed by TIAA which provides following services to NHS clients: Counter Fraud, Security Management, Internal Audit, Information Governance, ICT Audit, Governance and Risk Management, CQC Advice, No other interests to declare</td>
<td>√</td>
<td>18 Dec 14</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 of “At One”- alternative medicine and personal development - unlikely to do business with CCG in field of alternative medicine/ personal development.  
• Ex-PA to Clinical Director (Interventional Radiology), employed by KCL but based at St. Thomas' Hospital.  
• Currently, temporary PA for NHS Confederation and Institute of Directors, in process of commencing temporary PA work with central government department. | √ | 14 July 14 |
<table>
<thead>
<tr>
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</thead>
</table>
| Dr Baxter Noel      | Clinical Lead, Governing Body | • GP Partner at Surrey Docks Health Centre which is a member practice of Quay Health Solutions Ltd, a Community Interest Company (CIC).  
• Respiratory Lead GP Southwark. Practice funded 1 session per week  
• Working on NHS England project titled ‘Tobacco in health services: making every contact count in London’ for which the practice is reimbursed 1 session per week.  
• Voluntary role with Primary Care Respiratory Society-UK.  
• Voluntary work for Asthma UK and British Lung Foundation periodically. | Governing body   
Audit       
Remuneration   
Integrated Governance & Performance   
Commissioning Strategy   
Engagement & Patient Experience   
Senior Management Team   
Dulwich Programme Board | 12.03.15 |
| Bland Andrew       | Chief Officer | • Employed by NHS Southwark CCG  
• Partner employed at NHS England as a primary care contracts manager for North West London.  
• Stakeholder Governor at South London and Maudsley NHS Foundation Trust. | Governing body   
Audit       
Remuneration   
Integrated Governance & Performance   
Commissioning Strategy   
Engagement & Patient Experience   
Senior Management Team   
Dulwich Programme Board | 12.03.15 |
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<th>Membership</th>
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</tr>
</thead>
</table>
| Dr. Bradford Adam  | Clinical lead, Governing body | • GP Partner at East Street GP Practice  
• LMC member  
• SELODC GP member  
• Quay Health Solutions, a not-for-profit Community Interest Company (CIC), practice is a shareholder. | Governing body | 19 Sept 14 |
| Chappell Andrew    | Internal Auditor | • KPMG Internal Auditor  
• None | Audit | 18 Dec 14 |
| Dr. Cliffe Jane    | LMC Representative | • GP with Special Interest – Dermatology  
• SELODC GP member  
• Ex Director of Improving Health Ltd – South Southwark provider | Remuneration | 12.03.15 |
| Cooper David       | HealthWatch Southwark representative | • Chair of Healthwatch Southwark - Healthwatch Southwark may have some supporters who are contracted by the NHS to deliver services.  
• Southwark Carers is on the Healthwatch Southwark Board and has been commissioned by the CCG during 2013/14 | Integrated Governance & Performance | 22.01.15 |
| Crichlow Nadia     | EPEC Member | • Member of Locality PPG  
• Member of Practice-based PPG | Engagement & Patient Experience | 20 Nov 14 |
<table>
<thead>
<tr>
<th>Name (Last / First)</th>
<th>Position Held</th>
<th>Declaration of Interest</th>
<th>Membership membership</th>
<th>Date Reviewed</th>
</tr>
</thead>
</table>
| Prof. David Ami MBE | 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. | Governing body, Audit, Remuneration & Governance, Performance, Commissioning Strategy, Engagement & Patient Experience, Senior Management Team, Dulwich Programme Board | 5.03.15        |
<p>| Dawe Angela        | Dulwich Programme Board Member | - Director of Operations, Guy’s and St. Thomas’ Trust Community Services                                                                                                                                                                                                                                                                                       | Audit                  | 25 July 14   |</p>
<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>
| Drake Linda         | Practice nurse member of governing body | • Practice nurse at Elm Lodge Surgery - salaried 15 hours and sister is practice manager at the same surgery  
• Employed by Practice which is a member of Improving Health South Southwark providers.  
• Management Group member South Southwark GP Commissioning Group  
• Husband is Consultant Paediatric Surgeon at GSTT (Evelina Children’s Hospital) | Governing body | 12.03.15 |
| Duford-Swirles Delia | EPEC member | • Patient representative – Dulwich and Nunhead Locality  
• None | Engagement & Patient Experience | 16 Jan 15 |
| Dr. Durston Roger   | Clinical Lead, Dulwich Programme Board | • Principal GP in Camberwell Green General Practice -14% profit share.  
• Practice is a member of Improving Health Ltd.  
• SELDOC GP member  
• Forensic Medical Examiner.  
• Patient at a Lambeth GP practice | Audit | 27 Nov 14 |
<table>
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<tr>
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<th>Membership</th>
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</thead>
</table>
| Dr Ezeji Obinna     | Clinical Lead, Governing Body | - GP Partner, Grange Road Practice which is also a part of Quay Health Solutions Ltd. - a Community Interest Company  
- Director of Grange Family Services Limited  
- Grange Family Services now part of Municipal Health Limited | √ √ √ √ | 12.03.15 |
| Fernandez Sharon    | Dulwich Programme Board Member | South London Area Team, NHS England representative | √ | 5 Dec 14 |
| Jacque Foster       | Head of Quality and OD | - Employed by NHS Southwark CCG  
- None | √ √ √ | 5 Feb 15 |
<table>
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<tr>
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</thead>
</table>
| French Diane        | Lay member    | • Executive Director of Richmond Fellowship (not-for-profit provider of mental health services)  
|                    | Governing body| • Board member of 2Care (subsidiary organisation)  
|                    |               | • Board member of new subsidiary “Croftlands” a mental health provider in Cumbria.  
|                    |               | • Board member (NED) of County of Northampton Council on Addiction (CAN), which provides drug, alcohol and homelessness services is now a subsidiary of Richmond Fellowship.  
|                    |               | • SLaM psychiatrist has recently joined Richmond Fellowship Board.  
|                    |               | • From 1 April 2015, Richmond Fellowship will add a further subsidiary, Aquarius based in Birmingham. | Governing body | 12.03.15 |
| Furey Alison        | Deputy to Director of Public Health - Lambeth and Southwark | • Employed by Southwark Council  
|                    |               | • KPMG Associate  
<p>|                    |               | • Sole trader Public Health Resources | | 12.03.15 |</p>
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<tr>
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<th>Membership</th>
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<tbody>
<tr>
<td>Gandesha Aarti</td>
<td>HealthWatch Southwark</td>
<td>* None</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</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), no involvement with PHAST work in SE London.  
* Freelance management consultant in field of healthcare information and analysis | √ | √ | √ | √ | 12.03.15 |
| Dr. Heaversedge Jonty | Clinical lead, Governing body | * Locum GP at Walworth Partnership - which is part of Quay Health Solutions Ltd  
* GP at Crowndale Medical Centre in Lambeth  
* Director Vitality Ltd. - specialists in Health Communications  
* Work in the media both broadcast and print - related to work as a medical practitioner and not a health care commissioner or SCCG representative.  
* Contribute to campaigns and conferences on an ad hoc basis which may be sponsored by pharmaceutical companies. | √ | √ | √ | √ | 12.03.15 |
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<tr>
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<th>Membership</th>
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</thead>
<tbody>
<tr>
<td>Hines Malcolm</td>
<td>Chief Finance Officer &amp; Deputy Chief Officer</td>
<td>• Employed by NHS Southwark CCG</td>
<td>√ √ √ √ √ √</td>
<td>12.03.15</td>
</tr>
<tr>
<td>Dr. Howell Sian</td>
<td>Clinical lead, Governing body</td>
<td>• Salaried GP at Bermondsey &amp; Lansdowne Medical Mission</td>
<td>√ √ √</td>
<td>12.03.15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Practice is a member of Quay Health Solutions Ltd, a Community Interest Company (CIC)</td>
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<tr>
<td></td>
<td></td>
<td>• Husband is lay, unpaid chair of social enterprise providing IAPT in East London.</td>
<td></td>
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</tr>
<tr>
<td>Hughes Rhiannon</td>
<td>Voluntary Sector member</td>
<td>• Blackfriars Advice Centre</td>
<td>√</td>
<td>16 Jan 15</td>
</tr>
<tr>
<td>Jenkins Paul</td>
<td>Interim Director of Integrated Commissioning</td>
<td>• Director Mandatum Ltd. Consultancy Company</td>
<td>√ √ √ √</td>
<td>12.03.15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trustee Terrence Higgins Trust</td>
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<tr>
<td>Name (Last / First)</td>
<td>Position Held</td>
<td>Declaration of Interest</td>
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</tbody>
</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. | √ | 12.03.15 |
| King John           | EPEC & Dulwich Programme Board Member | • Chair of Hambleden Patient Participation Group and delegate to South Southwark Locality Patient Participation Group.  
• Chair SEL Strategy Patient Participation Group  
• Board Member NHS England (London) – 1) Adult Screening Unit, 2) Cancer Screening. Also member of Reading Group  
• Member of SEL Clinical Leadership Group | √ | 5.03.15 |
<table>
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<tr>
<th>Name (Last / First)</th>
<th>Position Held</th>
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<th>Membership</th>
<th>Date Reviewed</th>
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</thead>
</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 is a member of Quay Health Solutions Ltd.  
● 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 variable. | Governing body | √ | √ | √ | 12.03.15 |
<p>| Kwasny-Spechko Ela  | EPEC member | Patient Participation Group member - Camberwell Green Surgery | | | | 16 Jan 15 |
| Laidler Alexandra  | Dulwich Programme Board Member | ● Interim Director – Adult Social Care – London Borough of Southwark | | | | 13 Mar 14 |</p>
<table>
<thead>
<tr>
<th>Name (Last / First)</th>
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<th>Membership</th>
<th>Date Reviewed</th>
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</thead>
<tbody>
<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 14</td>
</tr>
</tbody>
</table>
| Dr. Lloyd Claire    | LMC representative                    | • LMC Joint Chair for Southwark  
• Partner Evolution Health providing headache service  
• SELDOC GP member                                                                                                                                                                        |            |               |
| Dr McAdam - Freud Kathy | LMC Representative | • LMC Joint Chair for Southwark  
• Practice is part of Quay Health Solutions CIC – a GP federation for north Southwark general practices  
• GPwSI Diabetes, GP lead in Diabetes for the Southwark Diabetes Community team (1.5 sessions/ wk)  
• Support to practices as GP lead for diabetes Southwark Community Team                                                                                                                  | √ | 5 Feb 15     |
<table>
<thead>
<tr>
<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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</thead>
</table>
| Dr. Mizan Jacques   | Clinical Lead | • Salaried GP, (AT Medics) Queen’s Road Surgery  
• Practice is a member of Improving Health Ltd. | Governing body | 12.03.15 |
| 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 | Governing body | 12.03.15 |
| Offord Peter        | EPEC Member    | • Chair Acorn Patient Participation Group  
• Patient representative - Peckham and Camberwell Locality | Governing body | 16 Jan 15 |
<table>
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</thead>
</table>
| Dr. Osonuga Olufemi | GP Lead- Dulwich Programme Board Member | ● GP partner Manor Close Surgery and Sir John Kirk Close Surgery  
● Practice is part of Quay Health Solutions | √ | 12 Feb 15 |
| Park Robert         | Lay member Governing Body | ● None | √ | 12.03.15 |
| Prinsloo Eugène     | Dulwich Programme Board member | ● Head of Infrastructure Development at Community Health Partnership (CHP), a DH Property company.  
● CHP may be head tenant in Dulwich project if brought forward by LIFTCo. CHP would also invest in the project if done through LIFT.  
● Owner of 2 private companies | √ | 23.10.14 |
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<tr>
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</tr>
</thead>
</table>
| Puddicombe Abi      | EPEC Member   | • Patient Participation Group Chair for Aylesbury Partnership  
                      • Member of Locality for Borough and Walworth | √          | 16 Jan 15    |
| 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  
                      • Labour Party member  
                      • Chair of Southwark Disability Forum.  
                      • Member Forum for Equality and Human Rights in Southwark | √          | 19 Mar 14    |
| Dr. Roe Yvonneke    | Clinical Lead, Governing Body | • Principal GP at Nunhead Surgery which is a member of Improving Health Limited – a federation of GP practices in south Southwark  
                      • Named shareholder of Improving Health Ltd. | √ √ √ √ | 18 Mar 15    |

Chair: Dr Jonty Heaversedge  
Chief Officer: Andrew Bland  
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<thead>
<tr>
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<tbody>
<tr>
<td>Saunders Martin</td>
<td>EPEC Member</td>
<td>• Member of Southwark HealthWatch</td>
<td>Governing body</td>
<td>27 Nov 14</td>
</tr>
</tbody>
</table>
| Scott Rebecca      | Director for Dulwich Programme Board | • Owner of Rebecca Scott Associates providing consultancy/contractor services to NHS organisations  
• Partner is GP in Camden | Remuneration, Integrated Governance & Performance, Commissioning Strategy, Engagement & Patient Experience, Senior Management Team, Dulwich Programme Board | 27 Nov 14 |
| 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)  
• Member of NHS England’s Urgent Care System Evaluation Group (NHS 111 Service), Primary Care Transformation Board, Primary Care Transformation Patient Board. | Audit, Integrated Governance & Performance, Commissioning Strategy, Engagement & Patient Experience | 20 Nov 14 |
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<th>Membership</th>
<th>Date Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith David</td>
<td>Head of Transformation Integration</td>
<td>• Owner of Health Management Consultancy Ltd. through which contracted to NHS Southwark CCG</td>
<td>Audit</td>
<td>√</td>
</tr>
<tr>
<td>Smith Nigel</td>
<td>Head of Pathway Commissioning (Maternity cover)</td>
<td>• Employed by NHS Southwark CCG</td>
<td>Audit</td>
<td>√</td>
</tr>
<tr>
<td>Solly Jill</td>
<td>Dulwich Programme Board Member</td>
<td>• Head of Primary and Secondary care interface at King’s College Hospital</td>
<td>Audit</td>
<td>√</td>
</tr>
<tr>
<td>Sturgeon David</td>
<td>Dulwich Programme Board Member</td>
<td>• Head of Primary Care, South London NHS England</td>
<td>Audit</td>
<td>√</td>
</tr>
<tr>
<td>Swann Kieran</td>
<td>Head of Planning and Performance</td>
<td>• Employed by NHS Southwark CCG</td>
<td>Audit</td>
<td>√</td>
</tr>
<tr>
<td>Thomas Neil</td>
<td>Internal Auditor</td>
<td>• Head of Internal Audit, KPMG</td>
<td>Audit</td>
<td>√</td>
</tr>
<tr>
<td>Name</td>
<td>Position Held</td>
<td>Declaration of Interest</td>
<td>Membership</td>
<td>Date Reviewed</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>---------------</td>
</tr>
</tbody>
</table>
| 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 Hartswood Hospital, Brentwood Essex CM13 3LE | Governing body, Remuneration, Integrated Governance & Performance, Commissioning Strategy, Engagement & Patient Experience, Senior Management Team, Dulwich Programme Board | 11 Sept 14 |
| Vohra Neetu             | Dulwich Programme Board member                          | • Site Manager for Dulwich Community Hospital  
• Employed by GSTT                                                                                                                                                                                                     | √                                  | 22.05.14      |
| Dr. Wallis Ruth         | Director of Public Health, Lambeth and Southwark        | • Employed by Southwark Council  
• None                                                                                                                                                                                                                | √                                  | 22 Jan 15     |
| Watts Rosemary          | Head of Membership and Engagement                       | • Employed by NHS Southwark CCG  
• None                                                                                                                                                                                                                | √                                  | 5.03.15       |
<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>
| Westcott Julian     | Head of Finance and Business | • Employed by Southwark CCG  
• Partner is Assistant General Manager for Women’s Services at GSTT | | √ | |
| Young Jean          | Head of Primary Care and Community Development | • Employed by NHS Southwark CCG  
• None | | √ | 5.03.15 |
# EX-MEMBERS OF THE CCG

<table>
<thead>
<tr>
<th>Name (Last / First)</th>
<th>Position Held while at the CCG</th>
<th>Declaration of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrea Baldwin</td>
<td>Dulwich Programme Board Member</td>
<td>Representative of NHS England – South London Area Team</td>
</tr>
<tr>
<td>Hill Emily</td>
<td>External Auditor</td>
<td>Audit Engagement Lead, Grant Thornton UK LLP, None</td>
</tr>
<tr>
<td>Bowden Andy</td>
<td>EPEC member</td>
<td>Employee of Community Action Southwark, an umbrella organisation for voluntary organisations.</td>
</tr>
<tr>
<td>Dr. Lloyd Claire</td>
<td>LMC representative</td>
<td>LMC Joint Chair for Southwark, Partner Evolution Health providing headache service, SELDOC GP member</td>
</tr>
<tr>
<td>Cooper Pam</td>
<td>Patient Representative, Dulwich Project Board</td>
<td>Patient at Elm Lodge Surgery and member of practice (Patient Participation Group)</td>
</tr>
<tr>
<td>McClinton Sarah</td>
<td>Director of Adult Social Care, Southwark Council</td>
<td>None, Employed by Southwark Council</td>
</tr>
<tr>
<td>Suttar Dadoo</td>
<td>EPEC member</td>
<td>Peckham and Camberwell Locality Patient Participation Group member</td>
</tr>
<tr>
<td>O’Hanlon Mairead</td>
<td>EPEC Member</td>
<td>Chair MGP Director - Cushmore Consultancy Ltd.</td>
</tr>
</tbody>
</table>
## EX-MEMBERS OF THE CCG

<table>
<thead>
<tr>
<th>Name (Last / First)</th>
<th>Position Held while at the CCG</th>
<th>Declaration of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrea Baldwin</td>
<td>Dulwich Programme Board Member</td>
<td>• Representative of NHS England – South London Area Team</td>
</tr>
<tr>
<td>Dr. Sharma Tushar</td>
<td>Clinical Lead, Governing body</td>
<td>• Salaried GP – Spa Medical Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice is a member of Quay Health Solutions Ltd, a Community Interest Company (CIC)</td>
</tr>
<tr>
<td>Alexander Julian</td>
<td>Dulwich Programme Board Member</td>
<td>• Senior Estates Manager - Lambeth, Southwark, Lewisham - NHS Property Services</td>
</tr>
<tr>
<td>Dr. Zeineldine Amr</td>
<td>GP Chair and Clinical Lead, Governing body</td>
<td>• GP partner Aylesbury Partnership [PMS]-17.25% share</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Director Aylesbury Medical Services providing Community Dermatology in Southwark – 17.25% share</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• SELDOC GP member</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quay Health Solutions, a not-for-profit Community Interest Company (CIC), Practice is a shareholder.</td>
</tr>
<tr>
<td>Kinch Alvin</td>
<td>HealthWatch Southwark Interim representative</td>
<td>• Member of senior management team of Community Action Southwark - 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Southwark Carers is on the Healthwatch Southwark Board and has been commissioned by the CCG during 2013/14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient at Sternhall Lane Surgery, Peckham Guy’s Hospital and Kings College Hospital</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Information</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Dr. Fradd Simon    | Clinical lead, Governing Body | - Non 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 |
| 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 (CIO). Practice is a shareholder in – I am the nominated shareholder but neither I nor my partners hold any office in the organisation. |
| Hooton Tamsin      | Director of Service Redesign  | - Employed by Southwark CCG  
- Health Foundation & Generation Q Award – Value £5K |
19. **Statement of Accountable Officer's Responsibilities**

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

28 May 2015
Annual Governance Statement

Introduction and context

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

As at 1 April 2014, the clinical commissioning group continued being approved without conditions.

NHS Southwark Clinical Commissioning Group is a membership organisation made up of 44 Southwark GP practices, as in March 2015. We are responsible for commissioning healthcare services for the people of Southwark. Our Constitution sets out the way we operate.

As a member organisation we work through the Council of Members and Governing Body to ensure health services are commissioned effectively and meet the needs of local people. We do this in line with our agreed mission, vision and values. The CCG is made up of two localities, North Southwark and South Southwark, together comprising all of our 44 member practices.

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

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

Scope of Responsibility

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

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

Compliance with the 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 Corporate Governance Code we consider to be relevant to the CCG and best practice.
For the financial year ended 31 March 2015, 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:

1. Selflessness
2. Integrity
3. Objectivity
4. Accountability
5. Openness
6. Honesty
7. 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:

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

19.1. 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.

Governance Framework of the CCG

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

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

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

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 three times during the year to approve commissioning plan and budgets. Representatives of the Council of Members attended the Audit Committee for signing off the draft and final Annual Accounts and Annual Report.

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).

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.

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 Integrated Commissioning and
- CCG Director of Quality and Safety,
- 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.

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:

1. Audit Committee: The Audit Committee met five times during the year including two meetings for signing off draft and final accounts and Annual Report. All meetings were well-attended by Lay Members and Clinical Leads. The committee is chaired by the Lay Member leading on governance. Some of the significant issues that the committee considered and reviewed were Risks to the CCG and CCG Board Assurance Framework, internal audit reviews, external audit updates, risk management arrangements in the CCG, appointment of auditors counter fraud service providers.

   The Audit Committee will complete a self-assessment of its effectiveness in August 2015.

2. Remuneration Committee: The Remuneration Committee met four times during the year including to discuss extension to lay member contracts and revision to CCG staff internal structure proposal. Human Resources partners from the South East Commissioning Support Unit provided professional advice where required. The Committee is chaired by a Lay member of the Southwark CCG Governing Body and its members are 3 Lay Members and 2 Clinical Leads. Where conflicted, members from neighbouring CCGs are invited to attend.

3. Integrated Governance and Performance Committee: This committee met every month of the year 2014/15. Every meeting held met quoracy requirements and regular agenda items included finance
reports, integrated performance reports and governance updates. The agenda also included deep dives on quality and safety issues as well as updates on strategic performance and clinical risk areas such as Referral to Treatment Time (RTT) and A&E 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 and the new Quality and Safety Programme Board.

4. Commissioning Strategy Committee: The Commissioning Strategy Committee met every month of the financial year 2014/15. 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 the new Programme Boards v.i.z. Mental Health and Parity of Esteem Programme Board, Building Resilient Communities and Prevention and Programme Board, Integrated Care and Neighbourhood Working Programme Board, Primary and Community Care Delivery Programme Board. In addition, the local Southwark Medicines Optimisation Group reports in to the committee on prescribing issues.

Conflict of Interest Panel: Commissioning and procurement decisions that cannot be taken by any of the committees of the Governing Body due to conflicts of interest issues are referred to the Conflict of Interest Panel. The panel's recommendations are considered and approved by the Governing Body. The panel can also be asked to audit the process by which a GB committee reaches a recommendation and to give assurance that it has not been influenced by a conflicted interest. This panel is chaired by the CCG’s Lay Member for governance. It includes the Director of Public Health, Chief Officer/Chief Financial Officer, Secondary Care Consultant and Registered Nurse on the Governing Body for increased clinical input.

5. Engagement and Patient Experience Committee: The Engagement and Patient Experience Committee provided oversight of the development of patient engagement structures to the Governing Body. The committee has representation from Locality Patient Participation Groups that enable the patient voice to be fed in to the CCG’s commissioning activities. The committee is chaired by the lay member for engagement and has representation from Healthwatch Southwark, Community Action Southwark and Forum for Equality and Human Rights in Southwark. The Engagement Programme Board and Equalities and Human Rights Steering Group inform the activities of the Committee. Every meeting held during the year met quoracy requirements and was well attended by locality leads and patient participation group representatives.

6. 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 the Project Initiation Document for the programme, which was approved by NHS England in May 2014. Following that, a comprehensive Site Options Appraisal was developed, which received approval by NHS England in December 2014. This confirmed that the future Dulwich Health Centre will be a new build on the SE corner of the existing Dulwich Hospital site. The Department of Health confirmed in February 2015 that the procurement of this health centre will be a Land Retained Agreement delivered through LIFT. This was confirmed through an analysis of the value of different LIFT developments against a Public Sector Comparator.

All of the committees set out above are accountable to the Governing Body. The terms of reference of all committees were reviewed following internal structure changes to reporting in to them. The Governing Body
Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland

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has approved and keeps under review the terms of reference for the committees, which includes information on the membership of the committees.

**Joint Committees**

1. **South East London Joint and Area Prescribing Committees**: The South East London Area Prescribing Committee was established in 2013 and is a partnership committee which discusses and makes recommendations on medicines issues. Southwark also participates in the South East London Area Prescribing Committee (APC) that takes a strategic view on prescribing issues across the wider south east London sector.

2. **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 builds 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.

3. **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.

4. **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.

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

6. **Southwark and Lambeth Integrated Care Programme (SLIC)**: Southwark and Lambeth Integrated Care is a partnership between local GPs, the three local NHS Foundation Hospital Trusts Southwark and Lambeth Clinical Commissioning Groups, social care and people in Southwark and Lambeth, supported by Guy’s and St Thomas Charity, with a vision is to increase the value of care provided for the people of Southwark and Lambeth, so they can lead healthier and happier lives.

   SLIC Sponsor Board defines the strategic direction of integrated care in Southwark and Lambeth. The programme consists of many different projects, which aim to deliver our vision. These projects report to the Provider Group and Integrated Commissioning Group, which contain staff from across the partnership. In 2014-15, its main work included the Older People’s Programme as detailed in section 5.

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

Attendance Record for Governing Body meetings

Figure 2 – Attendance record for GB meetings

<table>
<thead>
<tr>
<th>Name (alphabetical order)</th>
<th>Governing Body Member type</th>
<th>GB meeting attendance in 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Noel Baxter</td>
<td>GP Clinical Lead</td>
<td>2/4</td>
</tr>
<tr>
<td>Mr. Andrew Bland</td>
<td>Chief Officer</td>
<td>6/6</td>
</tr>
<tr>
<td>Dr. Adam Bradford</td>
<td>GP Clinical Lead</td>
<td>3/6 (sick leave)</td>
</tr>
<tr>
<td>Dr. Jane Cliffe/ Dr Kathy McAdam Freud</td>
<td>Local Medical Committee representative</td>
<td>6/6</td>
</tr>
<tr>
<td>Prof. Ami David</td>
<td>Nurse Member (Community)</td>
<td>5/6</td>
</tr>
<tr>
<td>Mrs. Linda Drake</td>
<td>Nurse Member (General Practice)</td>
<td>5/6</td>
</tr>
<tr>
<td>Dr. Obinna Ezeji</td>
<td>GP Clinical Lead</td>
<td>4/4</td>
</tr>
<tr>
<td>Ms. Diane French</td>
<td>Lay Member</td>
<td>5/6</td>
</tr>
<tr>
<td>Dr. Richard Gibbs</td>
<td>Lay Member</td>
<td>6/6</td>
</tr>
<tr>
<td>Dr. Jonty Heaversedge</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>Mr. Malcolm Hines</td>
<td>Chief Financial Officer</td>
<td>6/6</td>
</tr>
<tr>
<td>Dr. Sian Howell</td>
<td>GP Clinical Lead</td>
<td>5/6</td>
</tr>
<tr>
<td>Mr. Paul Jenkins</td>
<td>CCG Director for Integrated Commissioning</td>
<td>4/4</td>
</tr>
<tr>
<td>Mrs. Gwen Kennedy</td>
<td>CCG Director for Quality and Safety</td>
<td>6/6</td>
</tr>
<tr>
<td>Ms. Alvin Kinch / Mr. David Cooper</td>
<td>Healthwatch Representative</td>
<td>6/6</td>
</tr>
<tr>
<td>Dr. Nancy Kuchemann</td>
<td>GP Clinical Lead (part-time)</td>
<td>6/6</td>
</tr>
<tr>
<td>Dr. Jacques Mizan</td>
<td>GP Clinical Lead</td>
<td>3/4</td>
</tr>
<tr>
<td>Prof. John Moxham</td>
<td>Clinical Lead (Co-opted member), Director of Clinical Strategy, Kings Health Partners</td>
<td>4/6</td>
</tr>
<tr>
<td>Mr. Robert Park</td>
<td>Lay Member</td>
<td>6/6</td>
</tr>
<tr>
<td>Dr. Yvonneke Roe</td>
<td>GP Clinical Lead</td>
<td>3/4</td>
</tr>
<tr>
<td>Jay Strickland</td>
<td>Director of Adult Social Care, Southwark Council</td>
<td>0/3</td>
</tr>
<tr>
<td>Dr. Ruth Wallis/ Deputy</td>
<td>Public Health Consultant</td>
<td>4/6</td>
</tr>
</tbody>
</table>
Ex-Governing Body Members

<table>
<thead>
<tr>
<th>Name (alphabetical order)</th>
<th>Governing Body Member type</th>
<th>GB meeting attendance in 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Patrick Holden</td>
<td>GP Clinical Lead</td>
<td>2/2</td>
</tr>
<tr>
<td>Dr. Roger Durston</td>
<td>GP Clinical Lead</td>
<td>2/2</td>
</tr>
<tr>
<td>Dr. Simon Fradd</td>
<td>GP Clinical Lead</td>
<td>2/2</td>
</tr>
<tr>
<td>Dr. Amr Zeineldine</td>
<td>GP Clinical Lead (Chair)</td>
<td>2/2</td>
</tr>
<tr>
<td>Dr. Tushar Sharma</td>
<td>GP Clinical Lead (part-time)</td>
<td>5/5</td>
</tr>
<tr>
<td>Mrs. Tamsin Hooton</td>
<td>CCG Director for Service Redesign</td>
<td>2/2</td>
</tr>
<tr>
<td>Ms. Alexandra Laidler</td>
<td>Interim Director of Adult Social Care, Southwark Council</td>
<td>1/3</td>
</tr>
<tr>
<td>Mr. Tan Vandal</td>
<td>Secondary Care Specialist Doctor</td>
<td>4/6</td>
</tr>
</tbody>
</table>

Governing Body Performance and Self-assessment of its Effectiveness

A survey of the CCG’s Governing Body members was carried out during February 2015 to individually assess how effective it viewed the Body had been over the past year. The survey achieved a response rate of nearly 90%.

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.

93% of respondents agreed that the body ensure effective financial planning, control and value for money. Over 80% respondents felt the Governing Body worked as an effective team and encourages critical challenge to ensure the best decision is made in the interests of Southwark’s residents.

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 reviewed as part of the CCG’s Organisational Development plan for 2015-16.

Development for Governing Body members has been carried out both collectively and individually during 2014/18. Collectively, Governing Body members attended Away Days and workshop seminars. 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 and undertook a 360 Leadership assessment and a Skills Audit to better enable them to do their job.
19.2. 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 recognised 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 last reviewed in March 2015. It lays down risk management duties and responsibilities for staff at different levels in the organisation as well as Governing Body members including clinical leads. It presents a framework for CCG policies designed for proactive and reactive risk management to the CCG’s objectives.

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

The CCG leadership team employs effective techniques for risk management, supported by good information systems, discusses and shares risk information amongst themselves and trains and supports all their staff to an appropriate level of expertise. Southwark CCG also requires that the organisations and people it commissions to provide health services operate demonstrably effective risk management systems. NHS Southwark CCG is committed to the application and embedding of best practice principles across all services and actively communicating these principles with NHS stakeholders in an effort to share best practice risk management activities.

Risk Appetite

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

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 7 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.

**Risk Scoring**

A risk score is achieved by multiplying an individual likelihood (probability) score with an individual severity (impact) score: Likelihood X Impact = 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.

**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.

**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. 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.
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 for greater visibility and requirement of assurance.

The CCG BAF is reviewed by Governing Body members on a bi-monthly basis, a monthly basis through the Integrated Governance and Performance Committee reporting while the Directorate Risk Registers are produced fortnightly for inspection and monitoring to the Senior Management Team meetings.

The wording of all risk controls and assurances was comprehensively reviewed in November 2014 by each CCG director; the Head of Planning and CCG Assurance; and the Corporate Governance Manager. The focus of the review was to ensure the risk controls and assurances are clearly and accurately described for the diverse audiences of the risk registers and to ensure the risk controls are properly distinguished from risk assurances. Assurances were strengthened so that they accurately demonstrate the way in which the CCG monitors the effectiveness of the controls in place to manage risk.

Committees reviewing BAF and Risk Registers

The Audit Committee, Integrated Governance and Performance Committee and Senior Management Team support the effective management of risk within the CCG through providing scrutiny and discussion of risks on the CCG BAF and Risk Registers. In 2014/15 the Senior Management Team review and scrutiny of risks was greatly strengthened: SMT now completes fortnightly reviews of risks by Directorate including reviewing new risks and deciding the most appropriate risk register for each identified risk.

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 is also presented to Governing Body meetings. The risk report includes a Heat Map to ensure the CCG has easy oversight of its highest risks.

Policies supporting Risk Management

A number of policies support risk management within the CCG. The main ones are listed below:

- Conflict of Interests Policy updated December 2014 in line with NHS England guidance
- Integrated Risk Management Framework updated March 2015
- Gifts and Hospitality Policy
- Anti-Bribery Policy
- Fraud Policy and Response Plan
- Complaints Policy
- Freedom of Information Policy

Chair: Dr Jonty Heaversedge

The best possible health outcomes for Southwark people
- Information Governance Framework and suite of policies including Information quality and Information security,
- Joint Working with Pharmaceutical Industry Policy,
- Human resources suite of policies including Organisational change, Individual Grievance procedure, Bullying and Harassment, Capability, Sickness absence, Annual and special leave, Maternity, paternity and adoption,
- Incident/accident reporting policy
- Safeguarding children and adults
- Personal Health Budgets
- Procurement policy
- Policy on management of violence and aggression
- Security policy
- Training and development policy

Training

The following training/workshops were conducted for the CCG during the year:

- Risk management and Board Assurance Framework training and development at Directorate meetings
- Conflict of Interest workshop for Governing Body members
- Counter-Fraud and Security Management training as part of mandatory training for all CCG staff
- Individual training and one-to-one support for Designated Officers as they took up their new roles of operational management for risks.

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

Embedding of Risk Management

Staff engagement

A new process including formal accountability for operational risk leads was introduced in 2014/15. Risks are assigned a Designated Officer, usually a Head of Service or other Manager, who is responsible for leading actions to mitigate risks and ensure suitable assurance. Implementation of the new process has included CCG-wide engagement, training and informal support to those identified as Designated Officers.

As mentioned above, various workshops and training sessions for CCG staff were conducted in the year in an effort to boost embedding the new enhanced process of risk management.

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. Further engagement has been completed in 2014/15 to improve agenda planning and participation in risk discussions at directorate team meetings.
Incident Reporting

The CCG has two Incident Reporting Policies; one focuses on the reporting and managing of CCG incidents/accidents and one for working with main providers in their management of incidents and never events through contract management. Both policies are available to the CCG staff via the staff extranet.

Equality Impact Assessments

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

Stakeholder involvement

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

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

19.3. 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.

Governing Body meetings in public receives board assurance framework and risk report quarterly. Directors review their risks on a monthly basis.

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.

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.
IT Security: The CCG has purchased IT services from the South East Commissioning Support Unit (SECSU). An IT Steering Group having representation from SECSU, GP practices and the CCG meets regularly. A suite of IT policies is in place to support the IT function.

Information Governance: The CCG has purchased specialist Information Governance services from the South East Commissioning Support Unit (SECSU) to ensure its compliance to statutory duties. 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 for information governance, information risk management, incident management.

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 also has an appointed Caldicott Guardian and Senior Information Risk Owner.

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 and above incidents to the Information Commissioner (ICO). An incident reporting system is operational in the CCG with the support of the governance team and expert IG support from the South East Commissioning Support Unit.

Freedom of Information (FoI) Requests: The SECSU provides the FoI service for Southwark CCG. The CCG complies with its statutory duty to respond to requests for information. During the year, the CCG received 249 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 one Subject Access Request (SARs) under the Data Protection Act 1998, which was dealt with within the required timeframe.

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.

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

The CCG has satisfied the IG Toolkit requirements applicable to CCGs. We have achieved Level 2 assurance in 9 requirements and Level 3 assurance in 18 requirements. At the end of the year, the CCG had an overall satisfactory position of 90% for the IG Toolkit submission.

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.

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland
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, quality management etc.

**Principal Risks**

At the end of the year 2014-15, Southwark CCG’s Board Assurance Framework has 35 strategic risks. The risk profile for the CCG at the end of the financial year is as follows:

- 3 rated Extreme/ Red
- 20 rated High/ Amber
- 11 rated Moderate/ Yellow
- 1 rated Low/ Green

These risks have been presented to the various committees and Governing Body as detailed before.
The best possible health outcomes for Southwark people
19.4. New risks to Governance, Risk Management and Internal Control identified during 2014-15

1. Co-Commissioning Primary Care

In October 2014 the NHS Leadership in England published a Five Year Forward View that makes clear that co-commissioning of primary care services will exist in some form across England by 1 April 2015. Southwark CCG will jointly commission primary care from 1 April 2015, at level 2. The risks include Governance, Conflicts of Interest, Financial and engaging with member practices.

The CCG has a Governance structure in place where decisions will be made through a joint committee with NHS England and South East London CCGs. The CCG and NHS England will remain accountable for meeting their own statutory duties. The CCG Constitution has been updated to reflect this.

CCG members, partners and local residents are fully engaged with proposals and a SWOT analysis. Members are supportive of the CCG to adopt joint commissioning arrangements for primary care. These include full support from the Council of Members and EPEC.

The CCG has a robust Conflicts of Interest policy and procedure in place with non-executive Guardian and panel in place. The register of Interests with declarations from staff, Governing Body members and members of committees and sub-committees are all in place and consistently used.

The CCG will implement a new structure to deliver co-commissioning of primary care and will work with NHS England and partner CCG’s to establish the joint committee.

2. Implementation of Primary and Community Care Strategy

Southwark was successful in bidding for the Prime Minister’s Challenge Fund and has been working with local practices to establish two GP Federations. The Federations have been successful in tendering for extended access services. These services have only started recently and there is a significant developmental agenda with both Federations.

3. Commissioning Children’s services for Southwark

During 2014/15 the CCG identified a new approach for children’s commissioning. As a result a new structure has been established, which includes dedicated children’s commissioning resource. The CCG has senior leadership input into the South East London Children and Young People programme. Southwark CCG and Southwark Council presented their joint commissioning intentions to the Joint Children’s Board in March 2015.

The Governing Body has approved the Children and Young People’s Health Partnership proposal for integrated models of care. The CCG is in the process of developing the mental and physical children’s health strategy.

4. Review of and implementation of CCG management structure

A new CCG structure was implemented to ensure the CCG was ‘fit for purpose’ and the directorate structure was best aligned for anticipated future joint working with the local authority. The Directorate structures were also reviewed in light of national changes in year, such as Co-commissioning primary care. The structural changes led to a risk of destabilising the workforce which would impact on the delivery of CCG business. The
risk was mitigated successfully by staff meetings and a formal consultation even though it wasn't legally required. The Organisational Change Policy was also updated. Recruitment to a number of positions are completed and recruitment to two substantive Director positions are underway.

19.5. Major In-Year Risks to Governance, Risk Management and Internal Control

Nationally, the NHS is faced with a huge challenge to close the gap between the rising costs of healthcare and available funding. NHS Southwark CCG is working to reduce costs and increase efficiencies by not only working with providers through quality and contract monitoring but importantly, re-designing pathways of care to decrease costs and improve patient experience. Risks are inherent in any change to the way care is organised and we fully risk assess all initiatives as part of planning and implementation stages.

1. Delivery of financial savings to achieve financial balance

The CCG is in a strong financial position with regular reports to IGP and Governing Body.

2. Achievement of targets for A&E and Referral to Treatment (RTT)

As lead commissioners for Kings College Hospital, we have been involved in a comprehensive approach to performance management with partner organisations led by a Tripartite panel to improve A&E performance and reduce the backlog of RTT patients.

We have agreed additional funding along with other CCGs to support increased hospital capacity including winter resilience funding.

The CCG is working with NHS England, as the commissioners of specialised services, to ensure that appropriate levels of activity are purchased and resources made available for all Southwark residents to be treated within these targets.

The CCG is working with our partners across the health and social care spectrum in south east London, to achieve improved quality and safety of care, and assist in delivering a sustainable balanced economy in south east London.

3. Achievement of Improving Access to Psychological Therapies (IAPT) targets

The CCG has acknowledged the challenges with achieving IAPT targets for the year, however a new trajectory is agreed with providers and they are on track to deliver this. The CCG has funded additional low and high intensity workers throughout 2014/15 and into 2015/16.

The CCG has evaluated the impact on the risk of retendering services and agreed a strategy to address this. The tender process will start in April 2015 to start in February 2016.

The risk is no longer scored extreme but remains 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.


The CCG is fully engaged with the London-wide Strategic Commissioning Board and NHS England in addressing the contractual breach of London Ambulance Service not meeting performance standards for
response rates or hospital handover. CCG’s in London have committed to invest in LAS to support an agreed recovery plan, including recruitment of 250 additional paramedics.

**Significant challenges during 2014/15**

1. **South East London Commissioning Strategy Programme**

In its second year, there has been significant clinical engagement in six Clinical Leadership Groups and engagement of external consultations, which has taken forward areas for improved productivity and efficiency.

19.6. **Review of Economy, Efficiency & 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 CCG Audit Committee at its various meetings.

**Review of the Effectiveness of Governance, Risk Management & Internal Control**

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

**Capacity to Handle Risk**

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 and Risk Register.
- 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 Quality and Safety

- Is the CCG’s Caldicott Guardian.
- Is responsible for risks related to Continuing Care, Infection Prevention and Control Safeguarding of Children and Adults across acute and community services.
- Is responsible for quality assurance from providers on clinical governance, including complaints and serious untoward incidents.

iii) Director of Integrated Commissioning

- Is responsible for risk management in the areas of acute commissioning, mental health, 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.

v) 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.

vi) Head of Planning and CCG Assurance

- The Head of Planning and CCG Assurance is responsible for the CCG’s approach to identifying and managing risk, 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.

vii) Corporate Governance Manager

- The Corporate Governance Manager is responsible for assisting the Head of Planning and Assurance in developing and promoting a risk aware culture across Southwark CCG, 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.

viii) All CCG employees

- All CCG employees are encouraged to report all risks as well as 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.

ix) South East Commissioning Support Unit
- Responsibilities for risk relating to provision of services purchased from the South East 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. During 2014/15 the contract was renegotiated and a new contract agreed until March 2016.

x) 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. A new lease was agreed until August 2017.

Review of Effectiveness

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

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and risk/clinical governance/quality 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 2014-15. There were no serious incidents relating to data security breaches that were reported during the year.

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.

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:

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

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

- Information Governance
- Budget setting
- Risk Management
During the year the Internal Audit issued the following audit reports with a conclusion of ‘significant assurance with minor improvement opportunities’:

- Mental Health Contract Management
- Collaborative and Partnership Governance
- QIPP Delivery
- Governance Effectiveness

There were no audits with ‘nil assurance’.

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

The Macpherson Report on the review of quality assurance (QA) of Government Analytical Models set out the components of best practice in QA making eight key recommendations. NHS Southwark CCG recognises the importance of this and has been working with partners to ensure appropriate QA processes are in place across its analytical work.

With other CCGs in South East London, the CCG has undertaken a wide ranging review of the current Business Intelligence services provided by the South East Commissioning Support unit. The result of this are revised service specifications and performance indicators to ensure the quality of information received. The CCG will continue to work with the SECSU in the further development of the models, ensuring compliance with the standards set out in the Macpherson report.

In 2014/15, work has also continued on the development the financial model to support the South East London Five Year Strategy. The model brings together wide-ranging expertise from all stakeholder organisations in South East London. This includes drawing upon clinical input from the clinical leadership groups covering the key priority areas set out in the strategy.

This is overseen by the Senior Responsible Officer and supported by clear governance structure. This includes the finance leads group attended by the lead finance officers from all commissioner and provider organisations across South East London, as well as Local Authorities. 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.

Data Security

The Information Governance Toolkit has been provided by the Health and Social Care Information Centre (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 90% 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 2014/15.
Discharge of Statutory Functions

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

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

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

Conclusion

I believe that as stated 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

28 May 2015
HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL FOR THE YEAR ENDED 31 MARCH 2015

Basis of opinion for the period 1 April 2014 to 31 March 2015

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

Roles and responsibilities

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

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

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

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

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

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

A further component will be the assurances provided on the operation of the systems of internal control the service organisations which provide financial services on behalf of the CCG during 2014/15 as follows:

- NHS South East Commissioning Support Unit;
- NHS Shared Business Service; and
- McKesson: NHS Electronic Staff Records.

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

Our opinion is set out as follows: basis for the opinion; overall opinion; and commentary.
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 assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

Our opinion based for the period 1 April 2014 to 31 March 2015 is that:

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

Commentary

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

Our opinion covers the period 1 April 2014 to 31 March 2015 inclusive, and is based on the seven audits that we completed to date in 2014/15.

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 provides appropriate assurance to the Governing Body.

The Assurance Framework reflects the organisation’s key objectives and risks and is reviewed on a regular basis by the Governing Body.

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

We only issued ‘significant assurance’ and ‘significant assurance with minor improvement opportunities’ ratings in 2014/15. As such there are no findings that prevent us from issuing a ‘significant with minor improvements’ assurance opinion in respect of the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control. Management has either implemented or is implementing the recommendations raised our reports. We are satisfied that these do not materially adversely effect the CCG’s control environment to impact on our ability to provide a Head of Internal Audit Opinion.

KPMG LLP
31 March 2015
## Annual Accounts

### 20. The Primary Statements


<table>
<thead>
<tr>
<th>Note</th>
<th>2014-15 £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits</td>
<td>4.1.1</td>
<td>3,994</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>5</td>
<td>389,201</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
<td>(20,646)</td>
</tr>
<tr>
<td><strong>Net operating expenditure before interest</strong></td>
<td></td>
<td>372,549</td>
</tr>
<tr>
<td>Investment Revenue</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Other (gains)/losses</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Finance costs</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>Net operating expenditure for the financial year</strong></td>
<td></td>
<td>372,549</td>
</tr>
<tr>
<td>Net (gain)/loss on transfers by absorption</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td></td>
<td>372,549</td>
</tr>
<tr>
<td>Of which: Administration Income and Expenditure</td>
<td></td>
<td></td>
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<tr>
<td>Employee benefits</td>
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<tr>
<td>Operating Expenses</td>
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<td>4,028</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
<td>(114)</td>
</tr>
<tr>
<td><strong>Net administration costs before interest</strong></td>
<td></td>
<td>6,811</td>
</tr>
<tr>
<td>Programme Income and Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits</td>
<td>4.1.1</td>
<td>1,097</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>5</td>
<td>385,173</td>
</tr>
<tr>
<td>Other operating revenue</td>
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<td>(20,532)</td>
</tr>
<tr>
<td><strong>Net programme expenditure before interest</strong></td>
<td></td>
<td>365,738</td>
</tr>
<tr>
<td>Other Comprehensive Net Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant &amp; equipment</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangibles</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Description</td>
<td>Amount 1</td>
<td>Amount 2</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Net gain/(loss) on available for sale financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on assets held for sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net actuarial gain/(loss) on pension schemes</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Share of (profit)/loss of associates and joint ventures</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassification Adjustments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>On disposal of available for sale financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total comprehensive net expenditure for the year</strong></td>
<td><strong>372,549</strong></td>
<td><strong>360,936</strong></td>
</tr>
</tbody>
</table>
20.2. Statement of Financial Position as at 31st March 2015

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Non-current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Investment property</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>17</td>
<td>6,298</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>18</td>
<td>0</td>
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<tr>
<td>Other current assets</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td><strong>6,325</strong></td>
<td><strong>6,904</strong></td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td><strong>6,325</strong></td>
<td><strong>6,904</strong></td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td><strong>6,325</strong></td>
<td><strong>6,904</strong></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
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<tr>
<td>Trade and other payables</td>
<td>23</td>
<td>(28,644)</td>
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<tr>
<td>Other financial liabilities</td>
<td>24</td>
<td>0</td>
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<tr>
<td>Other liabilities</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Borrowings</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>30</td>
<td>(439)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td><strong>(29,083)</strong></td>
<td><strong>(28,519)</strong></td>
</tr>
<tr>
<td>Non-Current Assets plus/less Net Current Assets/Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(22,758)</strong></td>
<td><strong>(21,615)</strong></td>
<td></td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Borrowings</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td><strong>0</strong></td>
<td><strong>(814)</strong></td>
</tr>
<tr>
<td>Assets less Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(22,758)</strong></td>
<td><strong>(22,429)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Financed by Taxpayers’ Equity

General fund | (22,758) | (22,429)
<table>
<thead>
<tr>
<th>Revaluation reserve</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other reserves</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Charitable Reserves</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total taxpayers' equity:</strong></td>
<td><strong>(22,758)</strong></td>
<td><strong>(22,429)</strong></td>
</tr>
</tbody>
</table>

The notes on pages 5 to 28 form part of this statement.

The financial statements on pages 1 to 28 were approved by the Governing Body on 28 May 2015 and signed on its behalf by:

**Chief Accountable Officer**
Andrew Bland

**Chief Financial Officer**
Malcolm Hines
### 20.3. Statement of Changes in Taxpayers’ Equity for the year ended 31st March 2015

<table>
<thead>
<tr>
<th></th>
<th>General fund £000</th>
<th>Revaluation reserve £000</th>
<th>Other reserves £000</th>
<th>Total reserves £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in taxpayers’ equity for 2014-15</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Balance at 1 April 2014</strong></td>
<td>(22,429)</td>
<td>0</td>
<td>0</td>
<td>(22,429)</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 1 April 2014</td>
<td>(22,429)</td>
<td>0</td>
<td>0</td>
<td>(22,429)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2014-15</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(372,549)</td>
<td>(372,549)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant and equipment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total revaluations against revaluation reserve</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain (loss) on available for sale financial assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain (loss) on revaluation of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net actuarial gain (loss) on pensions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Release of reserves to the Statement of Comprehensive Net Expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassification adjustment on disposal of available for sale financial assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfers by absorption to (from) other bodies</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reserves eliminated on dissolution</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
**Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year**

<table>
<thead>
<tr>
<th>Description</th>
<th>General fund £000</th>
<th>Revaluation reserve £000</th>
<th>Other reserves £000</th>
<th>Total reserves £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net funding</td>
<td>(372,549)</td>
<td>0</td>
<td>0</td>
<td>(372,549)</td>
</tr>
<tr>
<td>Balance at 31 March 2015</td>
<td>372,219</td>
<td>0</td>
<td>0</td>
<td>372,219</td>
</tr>
</tbody>
</table>

**Changes in taxpayers’ equity for 2013-14**

**Balance at 1 April 2013**

Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition

**Adjusted NHS Commissioning Board balance at 1 April 2013**

0 0 0 0

**Changes in NHS Commissioning Board taxpayers’ equity for 2013-14**

**Net operating costs for the financial year**

(360,936) (360,936)

**Net gain/(loss) on revaluation of property, plant and equipment**

0 0 0 0

**Net gain/(loss) on revaluation of intangible assets**

0 0 0 0

**Net gain/(loss) on revaluation of financial assets**

0 0 0 0

**Total revaluations against revaluation reserve**

0 0 0 0

**Net gain (loss) on available for sale financial assets**

0 0 0 0

**Net gain (loss) on revaluation of assets held for sale**

0 0 0 0

**Impairments and reversals**

0 0 0 0

**Net actuarial gain (loss) on pensions**

0 0 0 0

**Movements in other reserves**

0 0 0 0

---

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people
<table>
<thead>
<tr>
<th>Description</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<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>Reserves eliminated on dissolution</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Commissioning Board Expenditure for the Financial Year</strong></td>
<td>(360,936)</td>
<td>0</td>
<td>0</td>
<td>(360,936)</td>
</tr>
<tr>
<td>Net funding</td>
<td>338,507</td>
<td>0</td>
<td>0</td>
<td>338,507</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>(22,429)</td>
<td>0</td>
<td>0</td>
<td>(22,429)</td>
</tr>
</tbody>
</table>

The notes on pages 5 to 28 from part of this statement.

<table>
<thead>
<tr>
<th>Cash Flows from Operating Activities</th>
<th>2014-15 £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(372,549)</td>
<td>(360,936)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals</td>
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<td>0</td>
</tr>
<tr>
<td>Movement due to transfer by Modified Absorption</td>
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<td>0</td>
</tr>
<tr>
<td>Other gains (losses) on foreign exchange</td>
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<td>0</td>
</tr>
<tr>
<td>Donated assets received credited to revenue but non-cash</td>
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<td>0</td>
</tr>
<tr>
<td>Government granted assets received credited to revenue but non-cash</td>
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<td>0</td>
</tr>
<tr>
<td>Interest paid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Release of PFI deferred credit</td>
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<td>0</td>
</tr>
<tr>
<td>Other Gains &amp; Losses</td>
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<td>0</td>
</tr>
<tr>
<td>Finance Costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unwinding of Discounts</td>
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<td>0</td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>17</td>
<td>599</td>
</tr>
<tr>
<td>(Increase)/decrease in other current assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>23</td>
<td>763</td>
</tr>
<tr>
<td>Increase/(decrease) in other current liabilities</td>
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<td>0</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>30</td>
<td>(692)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>30</td>
<td>(321)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td>(372,201)</td>
<td>(338,499)</td>
</tr>
</tbody>
</table>

Cash Flows from Investing Activities

<table>
<thead>
<tr>
<th></th>
<th>2014-15 £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest received</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Payments) for property, plant and equipment</td>
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<td>0</td>
</tr>
<tr>
<td>(Payments) for intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Payments) for investments with the Department of Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Payments) for other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
(Payments) for financial assets (LIFT) 0 0
Proceeds from disposal of assets held for sale: property, plant and equipment 0 0
Proceeds from disposal of assets held for sale: intangible assets 0 0
Proceeds from disposal of investments with the Department of Health 0 0
Proceeds from disposal of other financial assets 0 0
Proceeds from disposal of financial assets (LIFT) 0 0
Loans made in respect of LIFT 0 0
Loans repaid in respect of LIFT 0 0
Rental revenue 0 0
**Net Cash Inflow (Outflow) from Investing Activities** 0 0

**Net Cash Inflow (Outflow) before Financing**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount 1</th>
<th>Amount 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parliamentary Funding received</td>
<td>372,219</td>
<td>338,507</td>
</tr>
<tr>
<td>Other loans received</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other loans repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital grants and other capital receipts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital receipts surrendered</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Net Cash Inflow (Outflow) from Financing Activities** 372,219 338,507

**Net Increase (Decrease) in Cash & Cash Equivalents** 20 19 8

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</td>
<td>8</td>
</tr>
<tr>
<td>Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies</td>
<td>0</td>
</tr>
</tbody>
</table>

**Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** 27 8

The notes on pages 5 to 28 form part of this statement
20.5. Notes to the accounts

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 2014-15 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 are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

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

1.5.1 Critical Judgements in Applying Accounting Policies

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

- NHS Southwark CCG exercised critical judgement in respect of prescribing accruals

1.5.2 Key Sources of Estimation Uncertainty

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

- NHS Southwark CCG had no material key sources of estimation uncertainty during 2014-15.

1.6 Revenue

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

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

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

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

1.7.2 Retirement Benefit Costs

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.8 Other Expenses

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

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

1.9 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 the clinical commissioning group’s cash management.

1.10 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.11 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.
1.12 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.

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

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

Financial assets are classified into the following categories:

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

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

1.15.1 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.

1.17 Value Added Tax

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

1.18 Foreign Currencies

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

1.19 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 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
IFRS 15: Revenue for Contract with Customers
The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.
## 20.5.2. Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Recoveries in respect of employee benefits</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Patient transport services</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prescription fees and charges</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Dental fees and charges</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education, training and research</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Charitable and other contributions to revenue expenditure: NHS</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
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<td>0</td>
<td>19</td>
<td>45</td>
</tr>
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<td>Receipt of donations for capital acquisitions: NHS Charity</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receipt of Government grants for capital acquisitions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>16,700</td>
<td>29</td>
<td>16,671</td>
<td>20,316</td>
</tr>
<tr>
<td>Income generation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rental revenue from finance leases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other revenue</td>
<td>3,927</td>
<td>85</td>
<td>3,842</td>
<td>408</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>20,646</strong></td>
<td><strong>114</strong></td>
<td><strong>20,532</strong></td>
<td><strong>20,769</strong></td>
</tr>
</tbody>
</table>

Other Operating Revenue includes income from lead commissioner arrangements with the London Borough of Southwark, income from other CCGs where NHS Southwark CCG acted as the host organisation for Southeast London and income for the Prime Minister’s Challenge Fund.
20.5.3. Revenue

<table>
<thead>
<tr>
<th></th>
<th>2014-15 Total £000</th>
<th>2014-15 Admin £000</th>
<th>2014-15 Programme £000</th>
<th>2013-14 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>From rendering of services</td>
<td>20,646</td>
<td>114</td>
<td>20,532</td>
<td>20,769</td>
</tr>
<tr>
<td>From sale of goods</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,646</strong></td>
<td><strong>114</strong></td>
<td><strong>20,532</strong></td>
<td><strong>20,769</strong></td>
</tr>
</tbody>
</table>
## 20.5.4. Employee benefits and staff numbers

### 4.1.1 Employee benefits

<table>
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<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th></th>
<th>2013-14</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
<td>Total</td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>3,436</td>
<td>2,505</td>
<td>931</td>
<td>2,448</td>
<td>2,017</td>
<td>431</td>
</tr>
<tr>
<td>Social security costs</td>
<td>255</td>
<td>255</td>
<td>0</td>
<td>208</td>
<td>208</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>303</td>
<td>303</td>
<td>0</td>
<td>241</td>
<td>241</td>
<td>0</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>3,994</td>
<td>3,063</td>
<td>931</td>
<td>2,897</td>
<td>2,466</td>
<td>431</td>
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<tr>
<td>Less: recoveries in respect of employee benefits (note 4.1.2)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>3,994</td>
<td>3,063</td>
<td>931</td>
<td>2,897</td>
<td>2,466</td>
<td>431</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>3,994</td>
<td>3,063</td>
<td>931</td>
<td>2,897</td>
<td>2,466</td>
<td>431</td>
</tr>
</tbody>
</table>

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Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people
### 4.1.2 Recoveries in respect of employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th>2013-14</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent Employees</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Employee Benefits - Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employer contributions to the NHS Pension Scheme</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td><strong>Total recoveries in respect of employee benefits</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

### 20.5.4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th>2013-14</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanently employed</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>67</td>
<td>43</td>
<td>24</td>
<td>52</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>74</td>
<td>50</td>
<td>24</td>
<td>61</td>
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</tbody>
</table>

Of the above:

**Number of whole time equivalent people engaged on capital projects**

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th></th>
<th>2013-14</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
20.5.4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2014-15 Number</th>
<th>2013-14 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>280</td>
<td>369</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>50</td>
<td>48</td>
</tr>
<tr>
<td><strong>Average working Days Lost</strong></td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Number of persons retired early on ill health grounds</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total additional Pensions liabilities accrued in the year</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

*Ill health retirement costs are met by the NHS Pension Scheme*
### 20.5.4.4 Exit packages agreed in the financial year

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<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
<td>Number</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>1</td>
<td>9,471</td>
<td>0</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£25,001 to £50,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£100,001 to £150,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£150,001 to £200,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over £200,001</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>9,471</strong></td>
<td><strong>0</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Compulsory redundancies</th>
<th>2013-14 Other agreed departures</th>
<th>2013-14 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>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>0</td>
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<tr>
<td>£25,001 to £50,000</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>1</td>
<td>34,000</td>
<td>0</td>
</tr>
<tr>
<td>£100,001 to £150,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£150,001 to £200,000</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Over £200,001</td>
<td>0</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>34,000</strong></td>
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</table>

### Departures where special payments have been made

<table>
<thead>
<tr>
<th></th>
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<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
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<tr>
<td>Less than £10,000</td>
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<td>0</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
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</tr>
<tr>
<td>£25,001 to £50,000</td>
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</tbody>
</table>

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland
<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
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<th>2013-14</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
<td>Number</td>
</tr>
<tr>
<td>Voluntary</td>
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</tr>
<tr>
<td>redundancies</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>including</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>early retirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contractual costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>agreed</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>resignations</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(MARS) contractual</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early retirements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in the efficiency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contractual costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contractual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payments in lieu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of notice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exit payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>following</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribunals or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>court orders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-contractual</td>
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<tr>
<td>payments</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>requiring HMT</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>approval*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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.
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:

4.5.1 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 2012.

The Scheme Regulations 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.

4.5.2 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 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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.

4.5.3 Scheme Provisions

The NHS Pension Scheme provides 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 HM Revenue & Customs 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 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>2014-15 Total £000</th>
<th>2014-15 Admin £000</th>
<th>2014-15 Programme £000</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>2,976</td>
<td>1,879</td>
<td>1,097</td>
<td>2,820</td>
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<tr>
<td>Executive governing body members</td>
<td>1,018</td>
<td>1,018</td>
<td>0</td>
<td>675</td>
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<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>3,994</td>
<td>2,897</td>
<td>1,097</td>
<td>3,495</td>
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<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>3,922</td>
<td>2,147</td>
<td>1,775</td>
<td>3,990</td>
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<tr>
<td>Services from foundation trusts</td>
<td>269,899</td>
<td>0</td>
<td>269,899</td>
<td>272,947</td>
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<tr>
<td>Services from other NHS trusts</td>
<td>23,917</td>
<td>2</td>
<td>23,915</td>
<td>20,683</td>
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<tr>
<td>Services from other NHS bodies</td>
<td>(10)</td>
<td>2</td>
<td>(12)</td>
<td>610</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>27,015</td>
<td>0</td>
<td>27,015</td>
<td>35,634</td>
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<td>Chair and Non Executive Members</td>
<td>95</td>
<td>95</td>
<td>0</td>
<td>67</td>
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<tr>
<td>Supplies and services – clinical</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Supplies and services – general</td>
<td>527</td>
<td>69</td>
<td>458</td>
<td>291</td>
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<td>Consultancy services</td>
<td>1,655</td>
<td>111</td>
<td>1,544</td>
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<td>Establishment</td>
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<td>1,101</td>
<td>1,061</td>
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<td>Transport</td>
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<td>3</td>
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<td>Premises</td>
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<td>3,958</td>
<td>4,510</td>
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<td>Impairments and reversals of receivables</td>
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<tr>
<td>Inventories written down</td>
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<td>Depreciation</td>
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<td>Amortisation</td>
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<tr>
<td>Impairments and reversals of property, plant and equipment</td>
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<td>Impairments and reversals of intangible assets</td>
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<tr>
<td>Impairments and reversals of financial assets</td>
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</tr>
<tr>
<td>· Assets carried at amortised cost</td>
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<td>0</td>
</tr>
<tr>
<td>· Assets carried at cost</td>
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<tr>
<td>· Available for sale financial assets</td>
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<tr>
<td>Impairments and reversals of non-current assets held for sale</td>
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<td>Impairments and reversals of investment properties</td>
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<td>· Internal audit services</td>
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<td>0</td>
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<td>· Other services</td>
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<td>(3)</td>
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<tr>
<td>General dental services and personal dental services</td>
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<td>General ophthalmic services</td>
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<tr>
<td>Clinical negligence</td>
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<tr>
<td>Research and development (excluding staff costs)</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Education and training</td>
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<td>437</td>
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<td>Provisions</td>
<td>(321)</td>
<td>10</td>
<td>(331)</td>
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<td>GHC Risk Pool contributions</td>
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<td>528</td>
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<td>Other expenditure</td>
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<td>240</td>
<td>1,624</td>
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<tr>
<td><strong>Total other costs</strong></td>
<td>389,201</td>
<td>4,028</td>
<td>385,173</td>
<td>378,210</td>
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<tr>
<td><strong>Total operating expenses</strong></td>
<td>393,195</td>
<td>6,926</td>
<td>386,270</td>
<td>381,705</td>
</tr>
</tbody>
</table>

Included within Services from other CCGs and NHS England, Services from Foundation Trusts and Purchase of Healthcare from non-NHS bodies, are payments relating to Referral to Treatment and Winter Resilience Funding. The additional funding made available to CCGs for these programmes was non-patient specific and payments were made on a lead commissioner basis.

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people
20.5.6. Better Payment Practice Code

6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000</td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td>Non-NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>7,839</td>
<td>46,030</td>
<td>6,822</td>
<td>39,272</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>7,466</td>
<td>41,757</td>
<td>6,259</td>
<td>32,983</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>95.24%</td>
<td>90.72%</td>
<td>91.75%</td>
<td>83.99%</td>
</tr>
<tr>
<td>NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>3,227</td>
<td>318,731</td>
<td>2,048</td>
<td>291,275</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>3,162</td>
<td>317,345</td>
<td>1,926</td>
<td>289,348</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>97.99%</td>
<td>99.57%</td>
<td>94.04%</td>
<td>99.34%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Amounts included in finance costs from claims made under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compensation paid to cover debt recovery costs under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</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

The clinical commissioning group had no investment revenue as at 31 March 2015.

20.5.9. Other gains and losses

The clinical commissioning group had no other gains or losses as at 31 March 2015.

20.5.10. Finance costs

The clinical commissioning group had no finance costs as at 31 March 2015.

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

NHS Southwark CCG had no gains or losses on transfer by absorption during 2014-15.
20.5.12. **Operating Leases**

Under the NHS Act 2012, all leases were transferred to NHS Property Services (NPSPS) or Guy's and St Thomas' NHS Foundation Trust.

NHS Southwark CCG is recharged by NHSPS for the costs of its staff accommodation at 160 Tooley Street and running costs of Dulwich.

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 2015.

20.5.14. **Intangible non-current assets**

NHS Southwark CCG had no intangible assets as at 31 March 2015.

20.5.15. **Investment property**

The clinical commissioning group had no investment property as at 31 March 2015.

20.5.16. **Inventories**

The clinical commissioning group had no inventories as at 31 March 2015.
### Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>NHS receivables: Revenue</td>
<td>3,953</td>
<td>0</td>
<td>1,349</td>
<td>0</td>
</tr>
<tr>
<td>NHS receivables: Capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>1,696</td>
<td>0</td>
<td>2,429</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>602</td>
<td>0</td>
<td>3,056</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS receivables: Capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>35</td>
<td>0</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td>Private finance initiative and other public private partnership arrangement prepayments and accrued income</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Finance lease receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Operating lease receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables</td>
<td>9</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>6,298</strong></td>
<td><strong>0</strong></td>
<td><strong>6,896</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Current 2013-14</th>
<th>Non-current 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Total current and non current</strong></td>
<td><strong>6,298</strong></td>
<td><strong>6,896</strong></td>
</tr>
</tbody>
</table>

Included above:
Prepaid pensions contributions | 0              | 0                   |
### 20.5.17.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By up to three months</td>
<td>432</td>
<td>3,488</td>
</tr>
<tr>
<td>By three to six months</td>
<td>23</td>
<td>60</td>
</tr>
<tr>
<td>By more than six months</td>
<td>177</td>
<td>537</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>632</td>
<td>4,085</td>
</tr>
</tbody>
</table>

£66k of the amount above has subsequently been recovered post the statement of financial position date.

Give details of any collateral held and, if possible an estimate of the fair value.

### 20.5.17.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2014</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amounts written off during the year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amounts recovered during the year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Increase) decrease in receivables impaired</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer (to) from other public sector body</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Receivables are provided against at the following rates:

- NHS debt: £000
20.5.18. **Other financial assets**

The clinical commissioning group had no other financial assets as at 31 March 2015.

20.5.19. **Other current assets**

The clinical commissioning group had no other current assets as at 31 March 2015.

20.5.20. **Cash and other equivalents**

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balance at 1 April 2014</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Net change in year</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td><strong>27</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service: 27
- Cash with Commercial banks: 0
- Cash in hand: 0
- Current investments: 0

**Cash and cash equivalents as in statement of financial position**: 27

- Bank overdraft: Government Banking Service: 0
- Bank overdraft: Commercial banks: 0

**Total bank overdrafts**: 0

**Balance at 31 March 2015**: 27

Patients’ money held by the clinical commissioning group, not included above: 0

20.5.21. **Non-current assets held for sale**

The clinical commissioning group had no non-current assets held for sale as at 31 March 2015.

20.5.22. **Analysis of impairments and reversals**

The clinical commissioning group had no impairments or reversals of impairments recognised in expenditure during 2014/15.
20.5.23. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest payable</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>NHS payables: revenue</td>
<td>9,197</td>
<td>0</td>
<td>11,403</td>
<td>0</td>
</tr>
<tr>
<td>NHS payables: capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>3,695</td>
<td>0</td>
<td>3,591</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>5,005</td>
<td>0</td>
<td>3,102</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables: capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>10,537</td>
<td>0</td>
<td>9,151</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>42</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>51</td>
<td>0</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Payments received on account</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other payables</td>
<td>117</td>
<td>0</td>
<td>544</td>
<td>0</td>
</tr>
<tr>
<td>Total Trade &amp; Other Payables</td>
<td>28,644</td>
<td>0</td>
<td>27,881</td>
<td>0</td>
</tr>
</tbody>
</table>

Total current and non-current: 28,644, 27,881

Other payables include £55k outstanding pension contributions at 31 March 2015 (£32k 2013/14).

20.5.24. Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2015.

20.5.25. Other liabilities

The clinical commissioning group had no other liabilities as at 31 March 2015.

20.5.26. Borrowings

The clinical commissioning group had no borrowings as at 31 March 2015.

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 2015.

20.5.28. Finance lease obligations

The clinical commissioning group had no finance lease obligations as at 31 March 2015.

20.5.29. Finance lease receivables

The clinical commissioning group had no finance lease receivables as at 31 March 2015.
### 20.5.30. Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2014-15 £000</th>
<th>Non-current 2014-15 £000</th>
<th>Current 2013-14 £000</th>
<th>Non-current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pensions relating to former directors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pensions relating to other staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Restructuring</td>
<td>0</td>
<td>0</td>
<td>176</td>
<td>428</td>
</tr>
<tr>
<td>Redundancy</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Agenda for change</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equal pay</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Legal claims</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing care</td>
<td>429</td>
<td>0</td>
<td>386</td>
<td>387</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>75</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>439</strong></td>
<td><strong>0</strong></td>
<td><strong>638</strong></td>
<td><strong>814</strong></td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td><strong>439</strong></td>
<td><strong>1,452</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Balance at 1 April 2014

<table>
<thead>
<tr>
<th></th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pensions relating to Former Directors</td>
<td>0</td>
<td>0</td>
<td>604</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>773</td>
<td>75</td>
</tr>
<tr>
<td>Pensions relating to Other Staff</td>
<td>0</td>
<td>0</td>
<td>177</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>386</td>
<td>0</td>
</tr>
<tr>
<td>Restructuring</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>177</td>
<td>0</td>
<td>(717)</td>
</tr>
<tr>
<td>Redundancy</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Legal claims</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>10</strong></td>
<td><strong>429</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

#### Expected timing of cash flows:

- **Within one year**: 0 0 0 0 0 0 0 10 429 0 439
- **Between one and five years**: 0 0 0 0 0 0 0 0 0 0 0 0
- **After five years**: 0 0 0 0 0 0 0 0 0 0 0 0

#### Balance at 31 March 2015

<table>
<thead>
<tr>
<th></th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>429</td>
<td>0</td>
</tr>
</tbody>
</table>

At 31 March 2014, the Governing Body provided for expected costs for the Trust Special Administrator relating to the dissolution of South London Healthcare NHS Trust. A provision was set up over four years to reflect the expected payments. However, due to the timing of payments to providers, to cover costs, NHSE required the full funding to be paid in 2014/15. The provision has therefore been utilised in full in 2014/15.

As at the 31st March 2015, NHS England carried a provision of £1,747k relating to Southwark Continuing Healthcare claims relating to periods of care occurring before 31 March 2012. These claims are dealt with centrally as they relate to periods of care prior to the establishment of the CCG, and are therefore legacy claims relating to Southwark PCT.
20.5.31. **Contingencies**

The clinical commissioning group had no contingent liabilities or contingent assets as at 31 March 2015.

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 2015.

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 2015.

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 NHS 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 NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

20.5.33.1.1 **Currency risk**

The NHS 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 NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and 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 NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS 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**
NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS 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>2014-15 £000</td>
<td>2013-14 £000</td>
<td>2014-15 £000</td>
<td>2013-14 £000</td>
</tr>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>3,953</td>
<td>0</td>
<td>3,953</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>602</td>
<td>0</td>
<td>602</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>27</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total at 31 March 2015</strong></td>
<td>0</td>
<td>4,591</td>
<td>0</td>
<td>4,591</td>
</tr>
</tbody>
</table>

<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>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>1,349</td>
<td>0</td>
<td>1,349</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>3,056</td>
<td>0</td>
<td>3,056</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>0</td>
<td>4,419</td>
<td>0</td>
<td>4,419</td>
</tr>
</tbody>
</table>
### 20.5.33.3 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Embedded derivatives</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Payables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>12,892</td>
<td>12,892</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>15,659</td>
<td>15,659</td>
</tr>
<tr>
<td><strong>Private finance initiative, LIFT and finance lease obligations</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other borrowings</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other financial liabilities</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2015</strong></td>
<td>0</td>
<td>28,551</td>
<td>28,551</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
<th>Total 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Embedded derivatives</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Payables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>0</td>
<td>14,995</td>
<td>14,995</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>0</td>
<td>12,253</td>
<td>12,253</td>
</tr>
<tr>
<td><strong>Private finance initiative, LIFT and finance lease obligations</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other borrowings</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other financial liabilities</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>0</td>
<td>27,248</td>
<td>27,248</td>
</tr>
</tbody>
</table>

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland
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 2014-15.

20.5.36. NHS LIFT investments

The clinical commissioning group had no NHS LIFT investments as at 31 March 2015.

20.5.37. Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other Central Government bodies</td>
<td>77</td>
<td>0</td>
<td>1,235</td>
<td>0</td>
</tr>
<tr>
<td>- Local Authorities</td>
<td>528</td>
<td>0</td>
<td>2,881</td>
<td>0</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>3,715</td>
<td>0</td>
<td>483</td>
<td>0</td>
</tr>
<tr>
<td>- NHS Trusts and Foundation Trusts</td>
<td>1,934</td>
<td>0</td>
<td>12,409</td>
<td>0</td>
</tr>
<tr>
<td>Total of balances with NHS bodies:</td>
<td>5,649</td>
<td>0</td>
<td>12,892</td>
<td>0</td>
</tr>
<tr>
<td>- Public corporations and trading funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Bodies external to Government</td>
<td>44</td>
<td>0</td>
<td>11,636</td>
<td>0</td>
</tr>
</tbody>
</table>
## Total balances at 31 March 2015

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables 2013-14 £000</th>
<th>Non-current Receivables 2013-14 £000</th>
<th>Current Payables 2013-14 £000</th>
<th>Non-current Payables 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,298</td>
<td>0</td>
<td>28,644</td>
<td>0</td>
</tr>
</tbody>
</table>

### Balances with:
- Other Central Government bodies: 123 0 511 0
- Local Authorities: 2,949 0 900 0

### Balances with NHS bodies:
- NHS bodies outside the Departmental Group: 1,629 0 962 0
- NHS Trusts and Foundation Trusts: 2,149 0 14,033 0

### Total of balances with NHS bodies: 3,778 0 14,995 0

### Total balances with Public corporations and trading funds: 0 0 0 0

### Total balances with Bodies external to Government: 47 0 11,475 0

## Total balances at 31 March 2014

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables 2013-14 £000</th>
<th>Non-current Receivables 2013-14 £000</th>
<th>Current Payables 2013-14 £000</th>
<th>Non-current Payables 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,897</td>
<td>0</td>
<td>27,881</td>
<td>0</td>
</tr>
</tbody>
</table>
## 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 SERVICES LTD</td>
<td>355</td>
<td>99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AYLESBURY MEDICAL CENTRE</td>
<td>146</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AYLESBURY PARTNERSHIP</td>
<td>52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BERMONDEY AND LANSDOWNE MEDICAL MISSION</td>
<td>91</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BERMONDEY SPA</td>
<td>80</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMBERWELL GREEN</td>
<td>76</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMBRIDGE HOUSE</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONCORDIA HEALTH &amp; CONCORDIA HEALTH GROUP</td>
<td>86</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ELM LODGE SURGERY</td>
<td>64</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GUYS AND ST THOMAS’S NHS FOUNDATION TRUST</td>
<td>120,782</td>
<td>208</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KINGS COLLEGE HOSPITAL NHS FOUNDATION TRUST</td>
<td>107,839</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MANDATUM LTD</td>
<td>172</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MANOR PLACE SURGERY</td>
<td>86</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS BROMLEY CCG</td>
<td>1,437</td>
<td>(584)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS ENGLAND</td>
<td>589</td>
<td>(1,618)</td>
<td>(570)</td>
<td></td>
</tr>
<tr>
<td>NHS LAMBETH CCG</td>
<td>1,136</td>
<td>(4,894)</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>NHS LEWISHAM CCG</td>
<td>640</td>
<td>(3,457)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SELDOC LTD</td>
<td>338</td>
<td>226</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOUTHWARK COUNCIL</td>
<td>4,418</td>
<td>(13,978)</td>
<td>2,701</td>
<td>(10)</td>
</tr>
<tr>
<td>SURREY DOCKS</td>
<td>179</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THE SURGERY EAST ST</td>
<td>141</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VILLA ST</td>
<td>62</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRANGE ROAD</td>
<td>39</td>
<td>(9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUNHEAD SURGERY</td>
<td>130</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QUEENS ROAD SURGERY</td>
<td>25</td>
<td>1</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>ADVANTAGE HEALTHCARE GROUP LTD</td>
<td>780</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALLEN LANE LTD</td>
<td>272</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALLIED HEALTHCARE GROUP LTD</td>
<td>250</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRITISH HOME &amp; HOSPITAL</td>
<td>406</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUPA CARE HOMES</td>
<td>1,319</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARE LTD</td>
<td>750</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CROHAM NURSING HOME</td>
<td>367</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EQUINOX</td>
<td>532</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAIRLIE HOUSE</td>
<td>1,985</td>
<td>159</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FOCUSED HEALTHCARE LTD</td>
<td>384</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FOUR SEASONS HEALTH CARE LTD</td>
<td>832</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GUYS &amp; ST THOMAS’ CHARITY</td>
<td>0</td>
<td>(498)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>HC-ONE LTD</td>
<td>671</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEXAGON HOUSING ASSOCIATION</td>
<td>827</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HFH HEALTHCARE LTD</td>
<td>496</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HURLEY CLINIC</td>
<td>522</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chair: Dr Jonty Heaversedge

Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people
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.

GP practices associated with members of the CCG’s Governing Body are regarded as being related parties.

Other organisations are regarded as being related parties if the transactions throughout the year are considered to be material to either the CCG or to the related party.

### 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

20.5.40.1 Losses

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>2014-15 Number</th>
<th>2014-15 £'000</th>
<th>2013-14 Number</th>
<th>2013-14 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative write-offs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fruitless payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Store losses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Book Keeping Losses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Constructive loss</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash losses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Claims abandoned</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
### 20.5.40.2 Special payments

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Cases</th>
<th>Total Value of Cases</th>
<th>Total Number of Cases</th>
<th>Total Value of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Extra contractual Payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ex gratia payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Extra statutory extra regulatory payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Special severance payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

### 20.5.41. Third party assets

The clinical commissioning group held no third party assets as at 31 March 2015.
### 20.5.42. Financial performance targets

NHS Clinical Commissioning Group has a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>400,472</td>
<td>393,195</td>
<td>Yes</td>
<td>385,889</td>
<td>381,705</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>379,826</td>
<td>372,549</td>
<td>Yes</td>
<td>365,120</td>
<td>360,936</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>7,621</td>
<td>6,811</td>
<td>Yes</td>
<td>7,220</td>
<td>7,170</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 20.5.43. Impact of IFRS

Accounting under IFRS had no impact on the results of the clinical commissioning group during the 2014/15 financial year.
Glossary

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

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

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

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

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

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

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

CAMHS: Child and Adolescent Mental Health Services.

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

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

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

CHD (Coronary Heart Disease): the narrowing or blockage of the coronary arteries, the major blood vessels around the heart. (See also CVD).
Commissioning: The planning, buying (procurement) and contract management of health and health care services. This can be for a local community a specific population or a specific condition. This can be done at National NHS, Local NHS or CCG levels.

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

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

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

CQC (Care Quality Commission): An organisation funded by the Government to inspect all hospitals, care homes and care services in England to make sure they are meeting government standards and to share their findings with the public.

CQUINs (Commissioning for Quality and Innovation): A contractual mechanism that allows commissioners to pay providers for completing activities that directly relate to improving the quality of care received by patients.

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

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

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

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

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

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

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

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

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

Financial surplus: the net financial position of an organisation where income is greater than expenditure (outgoings) – so there is a surplus of money at year end.
**Foundation Trust:** a NHS hospital that is run as an independent, public benefit corporation, controlled and run locally. Foundation Trusts have increased freedoms, including around funding of and investment in services. They are regulated by Monitor – The independent regulator of NHS Foundation Trusts.

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

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

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

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

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

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

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

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

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

**Implementation:** putting into practice the plans and strategies that have been developed

**Independent sector:** a range of non-public sector organisations involved in service provision, including private, voluntary and charitable organisations

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

**Intervention:** term for the point at which a medical, social care or other professional gets involved in a person’s healthcare. Early intervention is when this happens before a person’s health is severely affected. This term is also used as a general name for a medical or nursing procedure.
JSNA (Joint Strategic Needs Assessment): a document which analyses the health needs of a population to inform the commissioning of health, well-being and social care services. This document is updated annually.

KCH: King’s College Hospital NHS Foundation Trust.

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

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

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

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

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

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

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

Our Healthier South East London: 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 developing a five year commissioning strategy together in October 2013. Since October 2014, this has been known as Our Healthier South East London.

The strategy aims to improve health, reduce health inequalities and to ensure the provision of health services across south east London that consistently meet high standards of safety and quality and are sustainable in the longer term.

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

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

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

**Planned Care:** where a patient is referred for treatment and there is a pre-determined pathway of care.

**Primary care:** Sometimes used to describe the services provided by GPs, NHS dentists, optometrists (opticians) and community pharmacists. This may also include other community health services

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

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

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

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

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

**SEL:** south east London

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

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

**SLIC (South London Integrated Care):** a programme across Lambeth and Southwark looking at how to co-ordinate care for older people and people with long term conditions, so that people have a better experience of care and are supported to keep healthy and maintain independence. This involves a range of organisations working together including Lambeth and Southwark CCGs, GPs, Guy’s and St Thomas’ NHS Foundation Trust, King’s College Hospital Foundation Trust, South London and Maudsley NHS Foundation Trust and Lambeth and Southwark Councils.

**Social Care:** a range of non-medical services arranged by local councils to help people in need of support due to illness, disability, old age or poverty. Social care services are available to everyone, regardless of background. However rules about eligibility apply.
Specialist hospital: a hospital which provides specialist care for complex conditions. There are none in south east London but patients might be referred to one – for instance, the Royal Marsden cancer hospital or Moorfields Eye Hospital.

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

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

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

UCC (Urgent Care Centre): a centre which provides care and treatment for minor illnesses and injuries that require urgent attention but that are not critical or life-threatening.

Unplanned Care: is care that is not planned or pre-booked with your GP or hospital.

Voluntary and Community Sector / Organisations: not-for-profit organisations set up to offer services to specific groups in society. These can be run and staffed by paid professionals as well as volunteers.
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF NHS SOUTHWARK CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Southwark CCG for the year ended 31 March 2015 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 consent of the Secretary of State as relevant to the National Health Service in England.

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 pages 88 to 90 of the annual report.
- the table of pension benefits of senior managers and related narrative notes on pages 91 to 93 of the annual report.
- the table of pay multiples and related narrative notes on page 92 of the annual report.

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 the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. 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 Accountable Officer; 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 Welcome, Member practices introduction, Strategic report, Members’ report, areas of the Remuneration Report not subject to audit and Annual Governance Statement to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.
In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

**Opinion on regularity**

In our opinion, in all material respects the expenditure and income 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 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 2015 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 consent of the Secretary of State as relevant to the National Health Service in England.

**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 consent of the Secretary of State as relevant to the National Health Service in England; 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

Respective responsibilities of the CCG and auditor

The CCG is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

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 to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all significant respects, NHS Southwark CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.
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.

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

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28 May 2015