Annual General Meeting

Thursday 12 September 2019, 3.30–5.30pm
Room G02AB, 160 Tooley Street London, SE1 2QH

From 3.00pm: Refreshments will be served and attendees are invited to come and speak with members of the CCG’s Governing Body.

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda item</th>
<th>Presented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.30pm</td>
<td>Welcome and introductions</td>
<td>Chair, AGM</td>
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<tr>
<td>3.35pm</td>
<td>Minutes of the previous AGM</td>
<td>Chair, AGM</td>
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<tr>
<td>3.40pm</td>
<td>Presentation of CCG Annual Accounts 2018/19</td>
<td>Director of Finance, Southwark CCG</td>
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<tr>
<td>3.55pm</td>
<td>Presentation of CCG Annual Report 2018/19</td>
<td>Chair, AGM</td>
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<td>4.00pm</td>
<td>Looking back: key achievements over the last 12 months</td>
<td>Clinical leads and commissioners</td>
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<tr>
<td>4.30pm</td>
<td>Looking forward: Partnership Southwark, new developments, and changes to the NHS in south east London</td>
<td>Clinical leads and commissioners</td>
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<td>4.45pm</td>
<td>Questions from the public</td>
<td>Panel</td>
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<td>5.25pm</td>
<td>Closing remarks</td>
<td>Chair, AGM</td>
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<td>5.30pm</td>
<td>Close of AGM</td>
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Minutes

Governing Body Members Present:

Dr Jonty Heaversedge (JH)  CCG Chair, NHS Southwark CCG
Andrew Bland (AB)  Chief Officer, CCG, and Accountable Officer, South East London Commissioning Alliance
Ross Graves (RG)  Managing Director, CCG
Caroline Gilmartin (CG)  Director of Integrated Commissioning, CCG
Malcolm Hines (MH)  Chief Financial Officer, CCG
Professor Ami David (AD)  Registered Nurse Member, CCG
Dr Mike Khan (MK)  Secondary Care Doctor Member, CCG
Andrew Nebel (AN)  Lay Member, CCG
Richard Gibbs (RG)  Lay Member, CCG
Robert Park (RP)  Lay Member, CCG
Dr Nancy Kuchemann (NK)  Clinical Lead, CCG
Dr Emily Gibbs (EG)  Clinical Lead, CCG
Dr Yvonneke Roe (YR)  Clinical Lead, CCG
Dr Rob Davidson (RD)  Clinical Lead, CCG

Other CCG staff present:

Rebecca Scott (RS)  Estates Programme Director, CCG
Dr Payam Torabi (PT)  Clinical Lead, CCG
Nick Harris (NH)  Programme Manager, CCG
Chair's welcome and introductions

JH welcomed attendees to the meeting.

He described the purpose of the meeting as reflecting on the CCG’s progress and achievements over the past year. He emphasised the importance of ensuring transparency around the ongoing constraints and challenges faced, and demonstrating to the public the CCG’s commitment to providing excellent care – whilst delivering the best value for taxpayers’ money.

JH explained that the meeting would focus on the CCG’s vision for community based care, and stressed the value of partnerships in delivering this. He highlighted in particular the relationship between the CCG, the local authority and public health, and thanked colleagues for their efforts to continually develop and strengthen these partnerships.

JH thanked everyone working under challenging circumstances to provide care and improve outcomes in the borough: the frontline staff in hospitals, GPs, community services, social care, the voluntary sector and enormous numbers of carers in the borough.

Finally, he expressed his gratitude to CCG staff who have worked resiliently and positively amidst continual change.
Presentation of CCG Annual Report and Key Achievements 2017/18

RG presented a summary of the CCG’s key achievements and progress during 2017/18.

He highlighted the CCG being rated ‘outstanding’ by NHS England – an improvement from ‘good’ in 2016/17 – and noted the areas in which high performance was maintained and improved.

RG identified the areas in which the CCG had helped deliver broader projects to improve health outcomes. He pointed to performance around cancer two week referrals; the roll-out of GP-to-hospital electronic referrals; and the work around community estates.

He presented some of the highlights from the annual 360 stakeholder survey, which saw improved scores around confidence in CCG leadership. RG then listed some of the areas where the CCG plays a leadership role, for example commissioning for King’s College Hospital, the London Ambulance Service and primary care services; and the partnership roles with the council and through the South East London’s Sustainability and Transformation Partnership.

In terms of quality improvements, RG referenced projects delivered by the Medicines Optimisation Team around virtual clinics for atrial fibrillation and antibiotic stewardship, together with the work of Clinical Effectiveness Southwark.

On the Southwark Five Year Forward View, RG highlighted some areas of significant process, including the Better Care Fund to reduce hospital and care home admissions; the development of the Joint Mental Health and Wellbeing Strategy; and progress towards joint commissioning through Southwark Bridges to Health and Wellbeing. He also emphasised the importance of Local Care Networks (LCN) in delivering community based care.

He concluded by talking about the CCG’s efforts to engage and empower residents and service users.

Presentation of CCG Annual Accounts 2017/18

MH presented a summary of the CCG’s annual accounts for 2017/18, beginning with an overview of the CCG’s statutory financial performance targets – all of which had been met. He noted that external auditors signed-off the accounts with an unqualified audit opinion.

MH explained that the CCG had achieved a surplus of over £11 million in 2017/18, against a target of over £9.7m. This, he said, is an accumulated surplus which will be carried forward into future years. He noted that due to national rules, the CCG can only draw on its surplus in certain circumstances.
MH then presented a chart displaying a breakdown of CCG’s expenditure in 2017/18, highlighting and providing further clarification on spend in areas such as acute hospital services, mental health and the Better Care Fund.

He then provided a financial outlook for the next few years, explaining that the CCG has been given a budget for a five-year period (2016-2021), but that annual funding increases do not keep pace with pressures around demand and expectation. He clarified that the CCG needs to make savings each year, starting with around 16.5m in 2018/19 – a target the CCG is confident of achieving. MH also noted that the CCG is planning to make a surplus in 2018/19 of £1m, as part of an overall target for south east London set by NHS England.

In conclusion, he acknowledged the Government announcement, made in June this year, of additional funding for the NHS, but noted the details are still under discussion.

Questions and answers

A question from the floor regarding the CCG’s accumulated surplus and the circumstances in which it can be used. The questioner asked for an explanation of what the money is, what it can be used for and whether the CCG is permitted to spend it.

Responding to the question, MH explained that the surplus is essentially a savings account, which is pooled together with the accounts of 200-plus organisations across the NHS – establishing a national contingency fund. He clarified that the money is held by the Treasury, not Southwark CCG, and will only be released according to the financial position of the NHS as a whole. Nonetheless, the money is guaranteed for Southwark, but due to the overall position of the NHS, the money is unlikely to be freed up over the next couple of years.

Tutiette Thomas (a patient participation group member, SLaM service user and co-chair of Southwark independent advisory group on improving outcomes for African and African/Caribbean people) commented that the minutes from last year’s AGM had not correctly recorded her contribution. She asked that the minutes be documented accurately this year.

JH explained that the CCG makes every effort to record proceedings accurately, but apologised that her comments had not been captured correctly. He asked that she contact the CCG so that this could be rectified.
### Community Based Care – improving care for patients

JH introduced the second section of the afternoon: a focus on community based care and how this vision is being delivered across Southwark and south east London.

### South East London Commissioning Alliance: working together to improve care

AB opened by emphasising the importance of building and maintaining effective partnerships – a key reason why NHS Southwark CCG was rated ‘outstanding’ in 2017/18. He thanked staff for their contribution.

He explained that the six CCGs in south east London are collaborating through the South East London Commissioning Alliance to tackle area-wide health challenges at scale; but stressed that this does not reduce the individual responsibility of each CCG to deliver services for residents.

AB noted some of the practical benefits of greater collaboration, for example sharing commissioning expertise; eliminating duplication so that resources can be focused on delivering frontline patient services; and an increased strength and influence when negotiating contracts and bidding collectively for additional NHS funding.

He concluded that there’s already interdependence within the system across south east London, with people, treatment and care currently moving across borough boundaries. He pointed out the importance of understanding and managing this through engendering a system-wide collaborative approach.
Community based care: making a difference to Southwark residents

RG introduced a more in-depth explanation of the community based care programme, and how it's working in practice.

He played two video case studies, produced by Guy’s charity, which showed the differing experiences of two patients living with multiple-long terms conditions and how a community based care approach helps and supports them receive better care. Commenting on the video, RG pointed out that supporting people with complex, multiple long-term conditions requires a joined-up approach.

He explained that community based care supports the CCG’s vision of making Southwark the best place to be born, live and grow old, by: keeping people healthy and able to manage their conditions; activating support from friends, family, carers and the wider community; and providing great quality, whole person care closer to home.

Community based care, he continued, helps deliver Southwark’s Five Year Forward View strategy through three strands: Local Care Networks; the development of contractual arrangements with providers; and transforming commissioning so that it is based on populations and outcomes.

Concluding, RG introduced three projects that support the overall community based care programme and explained that through building greater capability and infrastructure in Southwark, the CCG and partners will be able to deliver better outcomes.
RS started with an overview of community estates (i.e. the buildings from which health services are provided), pointing out that these estates are numerous and varied – in terms of ownership, size and suitability.

She explained the context of CCGs work around community estates – noting population growth and the resultant pressure on health services – and the CCG’s plan to provide more care in the community setting, with greater focus on prevention. To address these additional needs, RS explained, the CCG plans to deliver a network of community health hubs, which will provide not just primary care, but also a range of other health and community services.

The example of the health centre at Dulwich (currently under construction) provides the CCG with a prototype for the community health hubs, with the idea having been developed following two years of public engagement and consultation around what local people want. RS illustrated the results of this engagement work.

RS described the plan for Dulwich, which will have general practice at its core, but will also integrate a range of primary care services, children’s services, diagnostics like blood testing, physiotherapy, renal dialysis, mental health services and support for people with long-term conditions. She noted that the CCG is also looking at housing other services at the centre, and emphasised the desire for joint clinics so that patients with multiple conditions can be seen by two or more specialists at the same time.

RS finished by stressing the health centre at Dulwich’s role as a community location, confirming that it will have a space for voluntary sector organisations to support patients, particularly with long-term condition. She also pointed out that there are ongoing discussions with the council about the centre being linked to other public and community services, such as housing, employment and recreation, and the hub being used as a space for community activities. This, she concluded, is about creating a more holistic approach to health and wellbeing.
Supporting Community Based Care through digital development

JH’s presentation focused on the prevalence of digital technology and the potential for digital solutions to support patients and deliver the CCG’s priorities.

He noted that digital technology is virtually ubiquitous and that this makes it a significant factor, alongside the development of physical infrastructure, in future health service planning and delivery. One of the biggest challenges, he stressed, is integrating digital technology, whilst ensuring the retention of the personal nature of care that health service users value.

JH referenced the CCG’s engagement work with GP practices and patients around the opportunities digital technology offers: empowering people to take control their health and wellbeing; improve access to services; reduce workloads for clinicians and administrative staff; and help carers and healthcare professionals work more collaboratively – a key tenet of community-based care.

He then reflected on some examples of the progress being made to improve digital communication and connectivity. These included shared care records so that clinicians can access patient information across the health system; an online GP consultation and self-help tool – eConsult; electronic referrals by GPs to secondary care to better manage complex conditions; and investment in VisualDX technology to help GPs make effective diagnoses and referrals.

JH then showed a video which provided a more focused demonstration of eConsult and how the online tool can potentially save patients time and effort, while allowing practices to support them differently depending on their requirements.

He concluded by introducing a few scenarios of how digital technology can support patients in different circumstances.
Supporting Community based care through clinical effectiveness

PT explained that Clinical Effectiveness Southwark (CES) aims to develop a systematic approach to tackle health inequalities and variations in care – ‘making the right thing to do, the easy thing to do’.

He stressed the importance of partnerships to this work, highlighting the top-up funding received from the Health Foundation, and constructive relationships with King’s College London, the Health Innovation Network and Healthwatch Southwark.

PT acknowledged that the approach has been tried successfully in east London, illustrating this with a graph showing improved pulse rate checks for atrial fibrillation (the cause of irregular heart rhythms) in Tower Hamlets – a trend replicated in other health areas like blood pressure, cholesterol management and diabetes.

To implement this approach in Southwark, PT explained that the CES and partners develop ‘GP-friendly’ guides, which are summaries of evidence-based best practice. Prioritising medical conditions that are treated frequently in Southwark, the team tailors national guidelines to local pathways, runs education events for clinicians in protected learning time, and ensures practices can easily and consistently record data for analysis and future health planning.

NH took over from PT to provide an operational update on the work.

He explained that CES launched its first three guides (atrial fibrillation, type 2 diabetes, and hypertension) in May, and plans to launch its next tranche of guides in October. These, he confirmed, will be around breathlessness, heart failure, asthma and chronic obstructive pulmonary disease. This will be followed by a period of reflection and engagement with practices to establish whether the packages of support can be refined or enhanced, and time speaking to patients to test the approach.

Finally, NH described the plans to finalise the robust evaluation criteria with the independent evaluation partner, King’s College London, to help the team learn as it goes along – with other health areas to be covered over the next 18 months – and establish the impact CES has made.
Community Based Care: focus for 2018/19 – 2019/20

Concluding the community based care section, RG described the areas of focus over the next 12 months as:

1. Continuing to develop the Local Care Networks as the model for joined-up, integrated care for neighbourhoods;
2. Building more formal, collaborative arrangements to commission the new joined-up services;
3. Take forward the Southwark Bridges to Health and Wellbeing model as a new approach to commissioning; and
4. Work on projects that deliver the infrastructure and capabilities to support community based care in Southwark.

‘A bold vision’, he concluded, but one the CCG is excited about.

Questions and answers

A question from the floor about shared health records. The questioner accesses a limited amount of private healthcare through a healthcare plan, but believes there is unwillingness in general practice to share health records or upload records received from private health providers. This has resulted in him visiting hospital and there being no record of anything he’s had done privately.

Responding, JH highlighted the technical challenges that still exist in the way information is recorded and stored, with different systems not yet being aligned or able to understand each other. He clarified that GPs can provide patient’s records if requested for another medical appointment, but that there may be technical issues around uploading larger files (e.g. results of an MRI scan). The ambition, however, is to move to a situation where all clinicians can access patient information, but to do so safely and with the patient’s permission, so that confidential information is not shared without consent.

Further to the presentation about digital access to GP services, Caroline Climpson (Southwark Dementia Action Alliance) noted that some people with mental health conditions, such as dementia, already find it difficult accessing GP services, and rely on face-to-face contact in order to build relationships before being comfortable to speak about their conditions. She asked for clarification on how the CCG would maintain the face-to-face services that patients currently value.

JH agreed that some people will not be able to use digital technology to access their GP, but assured the room that there are no plans to reduce people’s ability to access services in other ways. The hope, he continued, is that digital innovations will make it possible for people, especially those with complex long-term conditions, to have longer face-to-face appointments. He praised the work organisations like Dementia Action Alliance and others in the voluntary sector for the care they provide, and noted the importance for commissioners of ensuring that these services are sustainable in the future.
Raymond Cole, a patient at St. John’s practice, asked that commissioners ensure education is not excluded when planning health services, so that people are aware about how they themselves can help prevent ill-health.

CG explained that the CCG does commission education, but mainly as part of specific pathways of care, for example if someone has diabetes or has suffered a heart attack. She pointed out that preventing illness and helping people take charge of their health and wellbeing is a joint responsibility between the CCG and local authority, with the public health team at the forefront of identifying issues of concern and how to address them.

Tutiette Thomas asked about the CCG’s progress around personal health budgets (PHB) to help improve outcomes according to ethnicity. She noted the guidance from NHS Digital for CCGs to submit a proposal for the number of PHBs to be in place by 2019.

CG pointed out that the CCG does have a programme of PHBs and is working to increase their reach. She explained some of the benefits of PHBs, including the capability of individuals to manage their lives, but that people still need to meet eligibility criteria to qualify. CG said the CCG would provide the questioner with more detailed information.

Ephraim from Southwark Carers asked for more information about community estates and the spaces that will be available for voluntary sector organisations.

RS answered that the voluntary space idea for the health centre at Dulwich arose following a focus group with voluntary organisations, and that the CCG has created an information point at the hub of the centre so that different organisations can work there on different days – aligning this where possible with specific clinics that are running on the day. She explained that further conversations about this, and the potential for a more integrated approach to delivering care, will take place closer to the opening date.

A final question from the floor about diabetes, with the questioner noting that the condition takes up 10% of the NHS budget and that one in 25 children moving from primary to secondary school is considered “grossly obese”. He pointed out that these children will be the pre-diabetics of the future and asked whether the CCG has a policy for childhood obesity, or whether this is a more widespread problem that must be solved nationally.

JH confirmed that reducing childhood obesity is recognised across the country as a serious issue and is a priority for the Mayor of London and London’s Health and Care Strategic Partner Board. He explained that in Southwark there’s an evidence-based healthy weight strategy, which was developed alongside the public health team, and emphasised the need for a comprehensive approach, through education, restricting access to unhealthy foods for kids, and encouraging activity in schools – initiatives like the Daily Mile.

Closing remarks

JH re-emphasised the importance of partnership working across Southwark, expressed his pride in the organisations that contribute to this work, and thanked everyone for their attendance and contributions.
Annual Report 2018/19

I am at the centre of my care and support: it is organised around me.
Contents

1 PERFORMANCE REPORT ................................................................. 4

1.1 Performance Overview .................................................................... 4

1.1.1 Welcome and overview of the year ............................................. 4

1.1.2 About us .................................................................................. 7

1.2 Performance analysis ..................................................................... 11

1.2.1 Delivering Southwark’s Five Year Forward View, Sustainability and Transformation Partnership and national commitments ................................................................. 11

1.2.2 Assuring delivery of performance and constitutional standards ................................................................. 26

1.2.3 Improving quality and safety ..................................................... 39

1.2.4 Commissioning high quality services ........................................ 46

1.2.5 Engaging people and communities .......................................... 52

1.2.6 Reducing health inequality ..................................................... 63

1.2.7 Sustainable Development ....................................................... 67

2 ACCOUNTABILITY REPORT .............................................................. 68

2.1 Corporate Governance Report ....................................................... 69

2.1.1 Members Report ........................................................................ 69

2.1.2 Statement of Accountable Officer’s responsibilities ................... 74

2.1.3 Governance Statement .............................................................. 76

2.1.4 Other sources of assurance ..................................................... 100

2.2 Remuneration and Staff Report ....................................................... 106

2.2.1 Remuneration Report ............................................................... 106

2.2.2 Staff Report ............................................................................ 113

2.2.3 Parliamentary Accountability and Audit Report .......................... 119

2.2.4 Independent auditor’s report to the members of the governing body of NHS Southwark Clinical Commissioning Group ......................................................... 120

3 ANNUAL ACCOUNTS ....................................................................... 123

3.1 The primary statements ................................................................. 123

3.1.1 Statement of Comprehensive Net Expenditure for the year ended 31 March 2019 ............................................. 123

3.1.2 Statement of financial position as at 31 March 2019 .................. 124

3.1.3 Statement of changes in taxpayers’ equity for the year ended 31 March 2019 ......................................................... 125

3.1.4 Statement of cash flows for the year ended 31 March 2019 ............ 126

3.2 Notes to the financial statements ................................................... 127
3.2.1 Accounting Policies ............................................................................................... 127
3.2.2 Other Operating Revenue ...................................................................................... 136
3.2.3 Revenue .............................................................................................................. 136
3.2.4 Employee benefits and staff numbers ................................................................. 136
3.2.5 Operating expenses ............................................................................................ 141
3.2.6 Cash and cash equivalents .................................................................................. 146
3.2.7 Trade and other payables .................................................................................... 147
3.2.8 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018 ............ 148
3.2.9 Provisions .......................................................................................................... 149
3.2.10 Financial instruments ....................................................................................... 149
3.2.11 Joint arrangements - interests in joint operations .............................................. 152
3.2.12 Related party transactions ............................................................................... 153
3.2.13 Events after the end of the reporting period ...................................................... 156
3.2.14 Financial performance targets ......................................................................... 156
3.2.15 Effect of application of IFRS 15 on current year closing balances .................. 156

GLOSSARY ....................................................................................................................... 157

How to search this document

This report is organised into three sections:

Performance report – this includes information about who we are, our main programmes of work and how we performed against local and national targets.

Accountability report – this is about how we have discharged our statutory responsibilities; how we are governed; our systems for assurance and information about our CCG staff.

Annual accounts - this is our full audited accounts.

There is some overlap within the sections but you can search for any word or term in this PDF document. Right click on your mouse and select 'Find' or use 'Ctrl + F' on your keyboard. The search window will then appear in the top right corner of your screen.
1 PERFORMANCE REPORT

1.1 Performance Overview
The performance overview provides an outline of the CCG and how we have performed during the year – our achievements and challenges.

1.1.1 Welcome and overview of the year
Welcome to this report on our activities and achievements in 2018/19. We had ambitions to change the way health and care services are organised here in Southwark and I think we have made a lot of progress in the last year. We have started to see the benefits of working collaboratively with colleagues in CCGs across south east London through the South East London Commissioning Alliance. I’m particularly pleased to report that our work in Southwark to address health inequalities and involve patients and the public in important areas of development is reflected throughout this document.

Integrated care
We have continued the good work to bring services together to deliver holistic care for residents living with three or more long term conditions. We are building on our experience to widen this to look at how we can work together to create better health and wellbeing outcomes for everyone living in our borough. We have set up Partnership Southwark to bring together health, social care and voluntary and community organisations to help us realise this aim.

Health centre development in Dulwich
Another exciting development has been the construction of the new health centre on the old Dulwich Hospital site. The health centre is well on the way to becoming a great asset for people in Dulwich and south Southwark. In 2018 the CCG ran procurements to identify new providers for GP practices where contracts had come to an end. To help us decide, we ran patient surveys and held meetings to talk about what was important to patients about their surgeries. Two of the practices with a new provider will move to the new health centre in Dulwich when it opens in 2020 alongside a range of community health and wellbeing services.

GP appointments
We know that getting a GP appointment is still a concern for many patients and we have continued to work hard with surgeries to improve this. We have expanded the scope of services available through the Extended Primary Care Service and hope this will help with some of the access issues people can experience. Digital developments will increasingly improve services for patients. Online access allows patients to make appointments or order repeat prescriptions from home and GPs are now referring patients to hospital electronically, through the e-RS referral system. We are working toward all practices having an online consultation capability for their patients by 31 March 2019 using the eConsult online consultation platform or MyGP system.
Urgent care

We recognise that there is continued pressure on urgent care services. We continue to develop services in the community to help increase the number of patients getting care closer to home and reducing their need to going to local emergency departments. Jointly with our South East London colleagues we also commissioned a new Integrated Urgent Care Service (111) which we hope will help in solving some of the problems that we know exist in the urgent care system. We also undertook significant work with health and care organisations to ensure that patients can be transferred from hospital more efficiently and that local hospitals are able to make full use of community and social care services designed to support patients to be able to leave hospital to go home or to a suitable care setting when they are medically ready to do so.

King's financial challenges

Recognising the financial and performance challenges at King’s, we have continued to work closely with the Trust to ensure it has recovery plans in place and that the quality of care patients receive does not suffer as a result of the current pressures in the system. We continue to take part in regular meetings with the Trust and its regulators, and we keep a close eye on quality and safety issues through our own GP alerting systems and the Clinical Quality Review Group.

Tackling diabetes and obesity

There are many health challenges amongst the population of Southwark including high rates of obesity and diabetes. Both conditions put patients at risk of complications and other illnesses. We have been successfully identifying people at risk of diabetes so that we can help prevent them getting the disease. In 2015, 4,500 people were identified as being at risk of diabetes and in 2019 we increased this to over 23,000. The number of people attending pre-diabetes and diabetes courses has also grown and, led by Southwark CCG, people with diabetes can now attend diabetes self-management programmes anywhere in south London at a time and place convenient to them.

Prevention

Prevention is a vital part of our role and will become an even greater priority for us as we put in place the commitments set out in the NHS Long Term Plan. Our medicines management team was 'highly commended' for its work on pharmacist-led virtual clinics at the Health Service Journal Awards, held in November 2018. This work, led by pharmacists in Southwark and Lambeth, aimed to improve rates of blood clot prevention treatment (anticoagulation) to help manage atrial fibrillation (AF) [a condition causing an irregular heart rate] in general practice. This resulted in an additional 1,200 patients receiving the blood clot prevention treatment and, in the following three years, has seen the rate of AF-related strokes fall by 25% - compared to a 3% fall nationally.

Reforming our commissioning structures

Looking ahead to 2019/20, CCGs in south east London will be building on the collaboration that began in April 2018 with the launch of South East London Commissioning Alliance. As part of the Alliance, we expect to develop proposals for a new way of organising our
commissioning structures so that we can commission more effectively and efficiently across south east London and also become an integrated care system, again a commitment set out in the NHS Long Term Plan.

We will play a key role in influencing this development alongside our staff, member practices, partner organisations, public and other stakeholders but we will also be retaining our focus on Southwark and meeting our commitments to ensure that residents have access to high quality and safe services.

Acknowledgement

As ever, our achievements would not have been possible without the hard work of NHS staff and those who support them. I would like to give my personal thanks to all those on the frontline, both clinical and operational, who work tirelessly to care for local people, sometimes in very challenging circumstances.

Dr Jonty Heaversedge Chair,
NHS Southwark Clinical Commissioning Group
1.1.2 About us

NHS Southwark Clinical Commissioning Group is the statutory body responsible for planning and commissioning high quality health services for Southwark residents. All GP practices in the borough are members of the CCG and guide the organisation through our Governing Body. In 2018/19 we were responsible for a budget of £484,885 million, which we used to plan, monitor and pay for hospital, GP, community and mental health services for people living in the borough.

You can read our full audited accounts in the financial statements section of this report. The accounts have been prepared under a direction issued by NHS England under the National Health Service Act 2006 (as amended). In the following pages is a breakdown of spending for the period from 1 April 2018 to March 2019.

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

1.1.2.1 Our objectives

Corporate objective 1: commissioning services we know are high quality, safe and effective

Corporate objective 2: delivering key standards, securing financial sustainability and running robust and effective governance

Corporate objective 3: delivering our programme of system transformation

Corporate objective 4: fully involving local people, member practices and partners in the work of our organisation

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

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

1.1.2.2 Financial position

In 2018/19, we had a budget of £484,885 million, received from NHS England and other NHS agencies. At the year end, the CCG had managed its cash flow and stayed within the cash target of having less than 1.25 per cent of the amount of cash drawn down in March remaining.

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<td>£’000s 487,912</td>
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Capital resource use does not exceed the amount specified in Directions | 216 | 214
---|---|---
Revenue resource use does not exceed the amount specified in Directions | 475,104 | 473,828
Capital resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0
Revenue administration resource use does not exceed the amount specified in Directions | 6,581 | 6,510

1.1.2.3 Break down of spending

### NHS Southwark CCG Annual Spend 2018/19 (£m)

- Acute - South East London: 198
- Acute - Other: 7
- Non Acute - Mental Health: 14
- Non Acute - Community: 12
- Non Acute - Continuing Care: 8
- Primary Care - Prescribing: 16
- Primary Care - GP Delegated: 31
- Primary Care - Other: 21
- Running Costs: 36
- Other: 65
- Better Care Fund: 34
- Surplus: 14
1.1.2.4 Going concern

The accounts in section 3 of this report have been prepared on the going concern basis. The CCG is a statutory organisation that receives government funding to plan and fund health services for the borough of Southwark. Point 3.2.1.1 in the notes to the accounts provides more detail about NHS Southwark CCG’s going concern status.

1.1.2.5 Our duties

Under the National Health Service Act 2006, CCGs have several 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

The statutory duties of the CCG require us to arrange for the provision of hospital and other accommodation and medical and other services to meet the reasonable needs of the people we are responsible for. This includes people who are provided with primary medical (GP) services by a member of the CCG; or people who usually live in the London Borough of Southwark. Additionally, the CCG is charged with arranging for the provision of ambulance services and emergency services for every person present within the London Borough of Southwark.

The CCG has a variety of powers to fulfil our statutory duties, including:

- Entering into contracts with providers of relevant services;
- Participating in corporate entities to provide relevant facilities and services;
- Delegating functions to other bodies;
- Pooling budgets (for example with Southwark Council);
- Provision of grants and loans.

In this annual report, we describe how we have fulfilled these duties to improve the quality of local services, reduce health inequalities, promote involvement of each patient in their own care, offer patient choice, support the integration of services, work together with the public and patients, and ensure that we have plans in place to deal with surges in demand for services and major incidents.

We certify that the NHS Southwark CCG has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

1.1.2.6 Health and wellbeing of people in Southwark

Southwark is a densely populated and diverse inner London borough, with a patchwork of communities, situated on the south bank of the River Thames, with Lambeth to the west and Lewisham to the east.

Our residents are living longer than ever before; with latest figures showing that boys born today can expect to live to 78.9 years; just less than five years longer than a boy born in Southwark in 2001. Girls born today can expect to live over four years longer than their counterparts born in 2001, with a life expectancy today of 84.4 years.

There have also been significant reductions in the rate of premature deaths in the borough, with the levels of cardiovascular deaths falling by more than half since 2001, and cancer falling by a fifth.
Key health issues

While there have been improvements in many areas, challenges remain, particularly in relation to sexual health, childhood obesity and mental health.

Southwark has high levels of sexual health need due to its young, mobile and diverse population, with the second highest rate of sexually transmitted infections and HIV in the country.

Healthy weight continues to be a complex challenge faced by many people in our communities. The prevalence of being overweight or obese among 11-year-olds in Southwark is among the highest in London, and above the national average.

It is estimated that almost 47,600 adults in Southwark experience a Common Mental Disorder, which comprises different types of depression and anxiety, and this is expected to rise to approximately 52,000 individuals over the next decade as our population grows.

Despite improvements, rates of premature death from cancer, respiratory diseases and liver disease continue to be substantially higher than the London average and are amongst the highest in the capital.

While the prevalence of smoking remains on a downward trend its impact continues to be felt, with rates of smoking-attributable hospital admissions and mortality significantly above the London average.

Approximately three-quarters of the predicted number of patients living with dementia have been diagnosed, and the effective management of diagnosed patients remains highly variable.

Although our residents are living longer than ever before, this improvement has not been the same across all our communities, and this discrepancy has been increasing over time for men but has stayed roughly the same for women.

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

1.1.2.7 Summary annual report

We will publish a summary annual report in August 2019. This will be available on the CCG website publications page: http://www.southwarkccg.nhs.uk/news-and-publications/publications/Pages/default.aspx
1.2 Performance analysis

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

1.2.1.1 Southwark Five Year Forward View

The Southwark Five Year Forward View sets out the shared vision for how Southwark Council and Southwark CCG are working with partners to integrate health and social care for patients so that they have better care from coordinated services and multidisciplinary teams. The strategy aims to drive more joined up population-based commissioning and place-based delivery models, so that we can make best use of the Southwark pound to deliver improvements in health and wellbeing outcomes for local people.

The Southwark Five Year Forward View recognises that improving the system locally requires fundamental changes to current ways of working. This includes:

- improving health and social care outcomes for Southwark people within available resources
- creating a much stronger emphasis on prevention and early action; equipping people to manage their own conditions, take part in activities that will help keep them well, and support others in their community
- commissioning based on populations rather than institutions, supported by the Southwark Bridges to Health and Wellbeing segmentation framework (see 1.2.1.3)
- driving much greater formal integration and coordination between the different providers of health and care services; seeing health, social care, housing, education, employment and voluntary and community sector (VCS) organisations, as equal value partners when working towards a healthier Southwark
- supporting development of new models of care at a neighbourhood (30 to 50,000 people), and ‘place’ (borough) level; enabling primary care, community services (physical and mental health), social care and broader community assets to work better together

The approach we are taking in Southwark aligns with and complements the aspirations set out in the NHS Long Term Plan, published in January 2019. This plan builds on the Five Year Forward View and sets out approaches for the NHS to overcome system challenges and barriers to improving health and wellbeing.
1.2.1.2 Deepening our collaborative arrangements

We are working with other health and care organisations in Southwark to develop new ways of bringing together services so that they do a better job of keeping people healthy and meeting patients' needs. This is often called "integrated community-based care". We have made a lot of progress over the last few years and many of the building blocks we need for integrated community-based care are in place. From 2019/20, we will strengthen this collaboration through Partnership Southwark; enabling commissioner and provider partners to drive the delivery of integrated community-based care more quickly and at greater scale.

Partnership Southwark will be an alliance, initially made up of Southwark CCG, Southwark Council, Guy's and St Thomas' NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Improving Health Limited and Quay Health Solutions CIC (Southwark's two GP Federations). Within Partnership Southwark we will work closely with other partners including King's College Hospital NHS Foundation Trust, the Voluntary and Community Sector, our local communities and organisations beyond health and care so that we can tackle the causes of health inequalities and prevent illness; and be more proactive in our approach to delivering care and support across organisational boundaries.

The Partnership Southwark alliance will be underpinned by a Memorandum of Understanding from 1 April 2019 setting out principles for collaboration and an intention to move to a more formalised alliance agreement in summer 2019/20. We hope to increase the scope and scale of partnership arrangements within the alliance over the next two years as we move to strengthen our approach to commissioning for outcomes and embed place-based models of care.
A Southwark Strategic Partnership Board will be established from May 2019. This will provide strategic direction and oversight of the Partnership Southwark programme in line with the following whole-system objectives:

1. Make best use of the Southwark pound to deliver improvements in health and wellbeing for local people
2. Be inclusive, and wider than health and care organisations so that we can tackle the causes of health inequalities and prevent illness
3. Ensure every part of the health and care landscape is clearly focused on common goals of supporting self-management, keeping everyone well, providing resilient high-quality services, meeting individual and population-level needs, and making it easier for people to access the information, advice, care and support they need
4. Support resilient and sustainable general practice, including enabling practices to work together within Primary Care Networks, and with other local health and care providers, around geographically coherent neighbourhoods
5. View health, social care, housing, voluntary and community organisations, education and employment as equal value/partners when working towards a healthier Southwark
6. Equip people to manage their own conditions, take part in activities that will help keep them well and to support others in their community.

During 2019-20 Partnership Southwark will focus on the following priorities:

- Develop neighbourhood networks. These networks will involve primary, community, social care, wider council (such as housing) and voluntary and community sector (VCS) colleagues to deliver as much care and support within the community as possible and better join up care particularly for people affected by several issues, such as social, physical and mental health. Each network will service a community of 30,000-50,000 people.

- Helping more people with long-term conditions/frailty to be supported in the community and their own home, which will reduce unnecessary hospital admissions and time spent in hospital once admitted for these patients.

- Providing focused support for residents of care homes and nursing homes to ensure better outcomes and experience and reduce unnecessary, unplanned and avoidable hospital admissions and sub-optimal medicine regimes.

- Improving the support that people with mental health issues receive in a primary and community care setting, reducing the need for people with stable moderate to severe mental health to be seen unnecessarily in specialist mental health services.

- Increased focus on prevention and self-management aligned to our commitment to the ‘Vital Five’ that supports people to live healthier for longer and works to prevent deterioration and the transition from one to many long-term conditions.

1 The vital 5 aims to improve health and prevent long-term conditions through standardised and routine recording and clinical management of five key indicators – blood pressure, obesity, mental health, smoking cessation, alcohol intake. It has been developed by King’s Health Partners in partnership with local commissioners and stakeholders.
- Supporting people to have greater control over their own health and wellbeing, enabling community connectedness and reducing social isolation for example, by connecting people to local community assets through social prescribing and community hubs.

- Developing our approach for children and young people, building on the Children and Young People’s Health Partnership and developing population-level outcomes for children and women during and after pregnancy using Southwark’s Bridges to Health and Wellbeing framework.

- Improving our population health analytics capability to better understand and proactively respond to population needs at a neighbourhood and borough level by sharing and linking data (within information governance safeguards) to bring maximum benefit to patients.

The Partnership Southwark programme will be underpinned and supported by several cross-cutting enabler workstreams, including:

- Implementing the Southwark Bridges to Health and Wellbeing segmentation framework (see section 1.2.1.4)
- Population health data and informatics
- Workforce, training and development
- Clinical effectiveness, evaluation and quality improvement
- Estates and assets of place
- Digital innovation

1.2.1.3 Neighbourhood-based care and wellbeing

Over the last 18 months, we have made good progress in developing our approach to care coordination for people with complex health, care and wellbeing needs through local care networks and we are building on this as we work to develop our neighbourhood model.

- We carried out extensive engagement with adults with multiple long-term conditions and with members of the north and south Southwark patient participation groups to understand what health and wellbeing outcomes are most important to them and, what is important to have access to at a neighbourhood level. See chapter 1.2.2 for more information.

- We delivered a multi-disciplinary training programme to about 120 frontline staff across Lambeth and Southwark from June 2018 – January 2019 to develop skills and competencies around care coordination and support learning across professional and organisational boundaries.

- We have been testing new ways of organising and delivering care within four learning partnerships in Dulwich, Peckham, Rotherhithe and the Walworth Triangle bringing together frontline staff, the voluntary community sector and local people to inform the development of our neighbourhood model.

Our engagement with local people has highlighted the need to better understand people’s needs holistically (rather than by setting, professionalism or service), to ensure that people feel safe and comfortable where they live, are enabled to make valued contributions to their
family, friends and community, and have increased agency in the context of their health and wellbeing.

We also want to make the right thing the easy thing to do for our front-line staff including those within the voluntary and community sector. Engagement with staff has highlighted several areas that our emerging neighbourhood model needs to support, including improving relationships within the neighbourhood, improving the interface within mental health services, improving communication within the neighbourhood, supporting self-care and social prescribing and making the most of the voluntary and community sector. During 2019/20, we will continue to test and refine our approach to neighbourhood working with local people and frontline staff; with the development of the model sitting as a key priority within the Partnership Southwark programme.

1.2.1.4 Southwark’s Bridges to Health and Wellbeing approach

Under Southwark’s Bridges to Health and Wellbeing approach the CCG and Southwark Council have been working together to look at the whole of our population and how we can work together to create better health and wellbeing outcomes. Bridges to Health provides a way of dividing our population so that we can look at people who share certain characteristics, for example adults diagnosed with multiple long-term health conditions whose aim is to stay healthy, or children with specialist needs who require coordinated care. Commissioners and providers are coming together to consider the key outcomes they can help people achieve and how we can use resources, such as libraries, parks and employment opportunities, to deliver those outcomes.

We introduced the Bridges to Health and wellbeing model to provider staff at a workshop in December 2018 attended by 130 representatives. Attendees agreed that the next phase of putting the approach into action will be co-produced with providers and local people.

We have selected two key population groups in phase 1 to test the approach before applying learning to the wider population:

- **Adults:** Frailty, Dementia and End of Life
- **Children and Young People:** Protecting vulnerable children (0 to 18 years) – Keeping Families Strong; Maternity and All Southwark Children (up to 5 years) including those with Specialist or Complex needs

Developing our approach to Southwark Bridges to Health and Wellbeing will be an important area of focus for the Partnership Southwark programme during 2019/20.

1.2.1.5 Creating an estate to deliver community-based care

During 2018 the CCG completed a review of its estates strategy and worked with partner CCGs across south east London on the wider health estate. In Southwark, this means that we aim to create three community health care hubs and three support hubs to ensure all residents in the borough can access community-based services. We are currently building a new health care hub at Dulwich and preparing the business case for the support hub for the Aylesbury Estate area. We are working with the council, South Bank University and developers to create schemes covering the rest of the borough, aiming to create a network of both health and wellbeing services for our population.
Developing a new healthcare centre for Dulwich and south Southwark

We set up the Dulwich Programme 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. In 2012 we undertook a thorough engagement exercise where we talked to local people and clinicians providing services in the area and asked them what they thought. Based on proposals that we developed in 2013 we ran a formal, public consultation. 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. We began building a new centre in May 2018 to provide improved local primary care and community health services for the population of south Southwark.

Our new building is 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. It is being built through the local NHS LIFT partnership on a 25 year 'Land Retained Agreement', which means that the land remains in NHS ownership, and the building is funded through rent payments. The building returns to the NHS at the end of the lease.

We have held several targeted public engagement events, with a further workshop during March 2019, so that we can include the views of service users and staff in the design principles and appearance of the building.

The part of the site not needed for health purposes has been sold to the Education & Science Funding Agency, which has opened Phase 1 of a secondary school development. Phase 2 will start once the NHS services have been moved to our new building. The health centre is due to be completed and ready for opening in April 2020.

Managing the programme

This work is managed by the Dulwich Programme Board. It has representation from relevant local NHS organisations, Healthwatch and additional patient representatives. It is scheduled to meet alternate months, and once approved, the minutes of each meeting are available on our website. The focus has been on the building project, but we have now turned our attention to agreeing how the clinical services will work together – we have recently undertaken a tendering exercise to provide GP services from a single provider covering two existing practices which will relocate to the new building when it is ready. Discussions are now happening with the provider trusts and we plan to include a commercial pharmacy in the new building. At the same time, we are considering all of the many details required to open the building – furniture and equipment, IT services, art, the move of the community physic garden from the front of the existing hospital, how the cleaning and other services should operate, and a long list of other items.
Topping out ceremony held on 12 April 2019

From left to right: Malcolm Hines, Director of Finance, NHS Southwark CCG; Helen Hayes MP; Malcolm Twite, CCO, Community Health Partnership (CHP); Matthew Brown and Chris Tredget, Willmott Dixon; Sarah Beaumont-Smith, Chief Executive Officer, Fulcrum; Gerry Owen, Programme Director and Ross Graves, Managing Director, NHS Southwark CCG; The Mayor of Southwark, Councillor Catherine Rose; Robert Park, Chair of the Dulwich Project Board, NHS Southwark CCG; and Mark Tribe, Fulcrum.

1.2.1.6 Better Care Fund

The Better Care Fund (BCF) is a national policy initiative that requires local Health and Wellbeing Board areas to agree plans for integrating and transforming community-based health and care services. Under these arrangements Southwark Council and the CCG agreed a two-year plan BCF plan for the use of a joint £31m budget over 2017/18 rising to £35m in 2018/19 in line with BCF planning requirements. The plan was fully assurred by NHS England.

The BCF covers a range of health and care related services that support people in the community, reduce avoidable hospital and care home admissions and help people to be transferred smoothly and safely from hospital with an appropriate care package at home to promote independence and wellbeing.

The delivery of the plan is overseen by the Health and Social Care Partnership Board, which has established a senior BCF Planning Group. Quarterly returns are provided to NHS England to provide assurance that the fund is being spent in line with requirements. A mid-point evaluation of the two-year plan was undertaken to ensure investments were correctly targeted before 2018/19 and performance has been monitored closely during 2018/19.
A key focus of the plan is to minimise delayed transfers of care, for which challenging targets are set nationally. This is an area where Southwark has been a strong performer and met its monthly target on all but one occasion over the two years of the plan, although this remains an ongoing challenge. Very strong performance has been achieved on reducing delayed discharges attributable to a lack of social care service provision. In addition, there are performance metrics on non-elective admissions to hospital, admissions to care homes and reablement outcomes that have proved challenging. The BCF funded services are a major part of the Community Based Care system and ongoing efforts to improve the effectiveness and coordination of these services is an ongoing priority.

Joint work with the council will continue to ensure that these strong partnership arrangements are built upon throughout 2019/20. This will include planning for 2020/21 when the current national BCF arrangements are scheduled to be replaced by new arrangements.
1.2.1.7 Our Healthier South East London

In transforming how we commission and deliver services in Southwark, we continue to work closely in partnership with Lambeth and more widely within south east London’s Sustainability Transformation Partnership (STP).

OHSELS is South East London’s Sustainability and Transformation Partnership (STP) and brings together our health and social care partners in south east London to make sure we are doing all we can to work in partnership to get the best health outcomes for our population.

OHSELS evolved from a commissioner-led strategy – established in 2013 - into a partnership between local commissioners and providers, working with local authorities, patients and the public.

Published on 4 November 2016, the original Sustainability and Transformation Plan (full version and summary) was a series of plans for different clinical areas and enablers, such as workforce and estates, which are at different stages of development. Our south east London Sustainability and Transformation Plan was one of the first in the country to be made public.

The NHS Long Term Plan was published on 7 January 2019 with a requirement for us to review our existing plan and agree a refreshed version based on the commitments set out in the new Long Term Plan. We will be submitting our revised plan for the next five years in autumn 2019.

In December 2018, we completed an 11 week aspirant Integrated Care System (ICS) programme. The vision set out in the Long Term Plan is for all STPs to become ICSs by 2021. As part of the programme we looked at delivering better joined up care at borough level as well as networking more specialist services. We will be taking forward work toward becoming an ICS in 2019/20.

Our STP has set the following five priorities:

1. Developing consistent and high quality community based care (CBC), primary care development and prevention. This is an essential building block of our Integrated Care System approach alongside the development of at scale approaches to preventing ill health and reducing health inequalities.

2. Improve quality and reduce variation across both physical and mental health. This includes better integration of mental health and reducing the pressure on and simplifying urgent and emergency care.

3. Reducing cost through provider collaboration. This includes consolidation of some clinical and non-clinical support services such as pathology and finance back office functions.

4. Developing sustainable specialised services. This includes mental health collaboration, renal and cardiac work.

5. Changing how we work together to deliver transformation. This focuses on how we can make sure that we are able to provide care for the population of south east
London as it grows and ages, in a way that is affordable and meets the needs of a 21st century population. It looks at new and more effective ways of providing care; avoiding the need to visit hospitals and making the best use of new technology.

Engagement

The models of care developed through Our Healthier South East London are the result of several years of partnership working between clinicians, commissioners, council social care leads and local hospitals and have been informed by extensive engagement at south east London level and through CGGs with local communities, patients and the public.

**Patient and Public Advisory Group (PPAG):** We have patient and public voices (PPVs) on each of our clinical workstreams influencing all our key programmes of work and feeding into our PPAG. The PPAG is made up of 14 PPVs, each of whom covers one or more specific workstreams. PPAG meets on a bi-monthly basis.

**Elective Orthopaedic Clinical Network:** Orthopaedic surgery is one of the main reasons for people having operations in south east London. Formed in 2018, our network aims to ensure equal outcomes at all our hospitals across the STP. The network is comprised of healthcare professionals and a patient representative with personal experience of receiving elective orthopaedic care at Orpington Hospital. This year we have agreed a standard pathway for people having hip and knee replacements. We set up focus groups of patients who had experienced these procedures, to inform development of the standard pathway.

**Maternity Voices:** A Maternity Voices Partnership (MVP) is a group made up of women and their families, commissioners and healthcare professionals working together to review and contribute to the development of local maternity care. There are MVPs across all of the six boroughs of south east London and each MVP has a local action plan. In addition there is MVP representation on both the south east London maternity public health workstream and the south east London Better Births Plan workstream. The role of the MVP member within these workstreams is to be the voice of the women who will use the maternity services, providing guidance around the needs of this group of women and fully contributing to all discussions around the workstream objectives.

**Stakeholder and Equalities Reference Group meetings:** We continued to hold these meetings in 2018/19 to ensure our plans are assured around patient and public engagement and equalities issues. The Stakeholder Reference Group submitted feedback as part of NHS England’s initial engagement on developing the NHS Long Term Plan.

Some highlights from 2018/19

**Cancer - Better access to diagnosis and advice** through a new nurse-led out-of-hours helpline for all cancer patients across south east London; targeted bowel cancer screening for people with learning disabilities; free home testing kits for patients showing potential signs of colorectal cancer but at low risk; a new Rapid Access Diagnostic Clinic, which is now also working more closely with mental health services; a new academy at Guy’s Cancer Centre to enhance excellent cancer care.

**Community Based Care - Introducing the Red Bag Pathway** across south east London. This reduces the time taken for ambulance transfers, A&E assessments and helps reduce
avoidable hospital admission for care home residents through a systematic and easily recognisable way of transferring paperwork, medications and personal belongings.

**Better estates** – developing our estates strategy; receiving national capital and other funding for projects to support improved access to a broader range of more joined up services in community settings; starting to redevelop Gallions Reach Health Centre in Thamesmead, one of the largest community estates investments in our STP.

**Mental health** – Increasing access for young people through a free online counselling service, Kooth; increasing support for women in the first year after birth; increasing access to support for people with mental ill health by training peer mentors who have lived experience of mental ill health.

**Urgent and Emergency Care** - The new 111 Integrated Urgent Care (IUC) service was launched earlier this year. This new service improves access to advice and services for those who dial 111. Available 24 hours a day, the service provides a new Clinical Assessment Service comprised of GPs, pharmacists and nurses who, where appropriate, can offer clinical consultations to residents across south east London.

The IUC service can also provide patient information, issue prescriptions to a pharmacy of choice, book a GP appointment, and, if necessary, refer people to emergency services.

**Developing our workforce** – by increasing their skills and increasing the range of professionals working in GP surgeries. For example, the Physician Associate Development Programme aims to increase the number of physician associates working in south east London and enhance the skill mix and capacity of GP practices in our boroughs.

**Pathology** - In 2018, provider trusts and clinical commissioning groups in south east London started to work together to implement a network for delivering pathology services under a single shared specification, in line with NHS Improvement’s national pathology strategy. The chosen option was to procure a networked model and a south east London pathology board was established to oversee the process.

### 1.2.1.8 South East London Commissioning Alliance

Launched on 1 April 2018, South East London Commissioning Alliance brings together the six CCGs in south east London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) to build on our existing collaboration to commission services more efficiently and effectively for local people in each borough and across south east London.

Each CCG in south east London retained their sovereign status and accountability for commissioning primary, community, mental health and hospital services for residents in their boroughs.

As part of the new arrangement, Southwark, Bexley, Bromley, Greenwich and Lewisham CCGs agreed to share a single Accountable Officer and single Chief Finance Officer (CFO). Andrew Bland took on the role of Accountable Officer from 1 April 2018 and Usman Niazi started as CFO on 12 February 2019. The CCG Directors of Finance acted as CFOs for their CCGs until Usman’s appointment. Andrew Eyres remained as Accountable Officer for Lambeth and Croydon CCGs.
Ross Graves was appointed as Managing Director for Southwark CCG in September 2017 and is responsible for the CCG's local commissioning of services and the local team of CCG directors. (to be updated according to CCG).

In its first year the Alliance explored opportunities for CCGs to work more collaboratively looking at functions that can be carried out once on behalf of all CCGs including development of a South East London Assurance team, and activities where greater collaboration brings better outcomes for patients. Toward the end of 2018, we undertook focused work on our model for becoming an Integrated Care System through an 11-week programme with NHS England.

2018/19 highlights

The Integrated Contracting Delivery Team (ICDT) significantly streamlined our contracting and negotiating functions and brought about improvements across all our providers. The team also works closely with each of the CCGs so that we can roll out initiatives at scale. A good example of this is in Planned Care, where we have rolled out a range of tools, such as Consultant Connect and VisualDx which help support GP decision making and reduce the need for patients to be referred to hospital.

Bexley, Greenwich and Lewisham CCGs started to develop ways of working to address the challenges within those three boroughs for commissioners, providers and local authorities. With a focus on Quality, Innovation, Productivity and Prevention, a new team and different governance structure was set up to support new joint working arrangements help to reduce the demands on each CCG.

As a system, we have also made smaller changes that contribute to being more effective and making better use of funding, for example by implementing a single software package for managing governing body and committee papers across all CCGs.

Looking forward to 2019/20 the Alliance will continue to support even greater collaboration to support us in refreshing our plans following publication of the NHS Long Term Plan and our move toward becoming an Integrated Care System.

1.2.1.9 Healthy London Partnership

Southwark CCG, along with all of London’s 32 CCGs, Greater London Authority, London Councils, Public Health England and NHS England (London) contributed funding towards Healthy London Partnership (HLP) in 2018/19. The aim was to bring together the NHS and partners in London to work towards the common goals set out in Better Health for London, NHS Five Year Forward View and the devolution agreement.

HLP works as a partnership across London’s health and care system and beyond to achieve these goals. This includes NHS organisations in London, including Southwark CCG, NHS England, NHS Improvement, hospital trusts and providers, as well as working across health and care with the Greater London Authority (GLA), the Mayor of London, Public Health England and London Councils. Additionally, HLP hosts the London Health and Care Strategic Partnership Board which provides oversight and leadership for devolution plans, working closely with the London Health Board secretariat. HLP is supporting the
development of the refreshed shared vision for health and care to ensure all partners are clear about their role in making London the world’s healthiest city.

2018/19 has been another busy year for Healthy London Partnership. Through successful partnership working across health and care in London, HLP has helped to deliver a range of programmes, outputs and achievements spanning primary and community care, secondary care and mental health, as well as those focussed on integration of health and care and place based care. All this work is part of the partnership’s collective aim to make London the world’s healthiest city.

HLP director, Shaun Danielli, outlines how by working together we are improving Londoners’ health and wellbeing, so everyone can live healthier lives:

“There has been significant progress in areas such as mental health, greater use of technology and increased access to family doctors. None of this would be possible without key agencies, organisations and people working together. Partnership working is the only way in which we will tackle London’s most complex health and care challenges and ensure that we meet our shared aim of making London the healthiest global city.

“As we look ahead, the NHS Long Term Plan and a five year funding settlement gives us a huge opportunity to transform the way we support the health and care of Londoners. Everyone involved with HLP looks forward to shaping and implementing improvements for London.”

During 2018, there was a collaborative focus on social prescribing, which is a way of linking patients in primary care with sources of support within the community for non-medical needs. The HLP proactive care team has worked closely with partners to develop a draft ‘Social Prescribing Vision for London’. The draft vision was developed by the GLA, NHS England, HLP and the London Social Prescribing Network, in collaboration with partners across the NHS, local authority and voluntary, community and social enterprise (VCSE) sector to support the scale and spread of social prescribing across London.

Other engagement highlights in 2018/19 include a number of significant projects undertaken by Thrive LDN, the citywide movement launched by Mayor Sadiq Khan to improve the mental health and wellbeing of all Londoners. This included helping young Londoners to organise a festival of cultural activity as part of Thrive LDN’s wider Are we OK London? campaign, which this year had a potential reach of over 23 million people.

This year’s campaign engaged with a more diverse audience, grew Thrive LDN’s followers and subscribers and increased discussion and action around how inequality and discrimination can affect Londoners’ mental health and wellbeing.

More recently, Thrive LDN published Londoners Said… – a report summarising the findings of the 17 community conversations run in partnership with the Mental Health Foundation (MHF) in half of London’s boroughs. Each community conversation produced a comprehensive write-up to underpin a plan for local action. The report includes 10 recommendations from Londoners on how to ensure people have the right support to stay mentally healthy.

Page 23 of 162
Following on from the Great Weight Debate, which engaged Londoners on how best to tackle childhood obesity, HLP has worked with fast food shops, businesses and charities and young people in three London boroughs (Southwark, Lambeth and Haringey) to pilot their ideas for making high streets healthier for children and young people through the Healthy High Streets Challenge. The Challenge provided invaluable insights into how to make healthier choices easier on London’s high streets. The findings informed obesity strategies across all London boroughs and the Mayor’s policy to restrict the advertising of food and drink that is high in fat, sugar and salt across Transport for London’s advertising estate from February 2019.

Further focus on children and young people was demonstrated through London’s annual #AskAboutAsthma campaign. Led by HLP in conjunction with NHS England London region, the campaign coincided with the start of the new school year when hospital admission rates for asthma are at their highest. The campaign reached over 5.9 million people online in 2018. Additionally, HLP has developed the London asthma standards for children and young people, bringing ambitions for how asthma care should be delivered across the city with national and local standards, along with a new online toolkit for staff which to date has been accessed just under 19,000 times.

2018 saw a further increase in patients across London accessing online GP appointment booking, ordering of repeat prescriptions and access to coded information in records. HLP has been working with London’s CCGs and NHS England London region to support GP practices to offer and promote online services to patients.

Elsewhere on digital developments in 2018, London saw the full rollout of an NHS e-Referral Service (e-RS) across 23 providers one month earlier than the national target date. This was achieved through proactive and successful partnership working between London’s health and care organisations and now means that all GP practices in the capital can manage a patient’s first referral from primary care to hospital through a paperless process.

The London Mental Health Dashboard makes a wide range of London’s mental health data publicly accessible in one place. Urgent suspected cancer referral activity data is also now presented in a useful interactive dashboard developed by HLP.

There has also been a strong focus on mental health transformation across London during 2018/19. London’s crisis care system has been working to improve the quality and consistency of care for people in mental health crisis. Through HLP, London’s A&E departments and police forces have worked together to develop a handover process for voluntary mental health patients in emergency departments, which has resulted in 83% fewer people going missing from A&E during a mental health crisis compared to the previous year. The handover process was awarded the Best Patient Safety Initiative in A&E at the 2018 HSJ Awards.

This year saw the NHS in London invest an extra £6 million into specialist mental health services to support women during pregnancy and in the first year after giving birth. From March 2019, services for perinatal mental health problems will be available across all of London. The extra resource has resulted in 79 new whole time equivalent clinicians for London during 2018/19 and this important specialist care is now offered to nearly 5,300 women a year.
HLP also launched a Mental Health in Schools Toolkit in 2018 which provides a range of information for schools, governors and commissioners on mental health and emotional wellbeing in schools. The suite of resources includes links to relevant guidance, practical tools and resources, and examples from across London of new initiatives and approaches in schools or across local authorities.

By October 2018, Good Thinking – London’s unique digital mental wellbeing service – had supported over 100,000 Londoners to actively tackle anxiety, sleeplessness, stress and depression. Since its launch at the end of 2017, Good Thinking has offered personalised new ways to improve mental wellbeing for Londoners.

Elsewhere through partnership working in 2018, a whole system estates planning function has been established through the London Estates Board. In spring 2019, the first London Health and Care Estates Strategy was developed which will support a coordinated approach to using capital and the release of surplus to requirement NHS estate, meaning much needed money is reinvested back into London’s health and care system.

Finally, the clinically-led London Choosing Wisely programme concluded its work in 2018 to develop eight pan London commissioning policies. Managed by HLP, the programme established clinical expert working groups to inform the harmonisation of clinical commissioning policies for a limited number of specific treatments. The policies were presented to CCG governing bodies in December 2018 for further engagement as required, prior to any implementation. Once implemented, the policies will reduce variation of care for patients across London.

This is only a snap shot of all HLP’s work to make London the healthiest global city. You can explore HLP’s various programmes via its website or search the HLP resources section for publications or case studies.
1.2.2 Assuring delivery of performance and constitutional standards

1.2.2.1 NHS Constitution standards and national performance indicators in 2019-20

In this section we set out how the CCG performed against national NHS Constitution Standards and mandatory key performance indicators (KPIs) in 2018/19. A summary of the target is described together with year-to-date performance and a short description of the performance position.

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

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</tr>
</thead>
<tbody>
<tr>
<td>KCH</td>
<td>78.8</td>
<td>79.8</td>
<td>82.7</td>
<td>78.0</td>
<td>80.5</td>
<td>76.3</td>
<td>78.1</td>
<td>73.8</td>
<td>71.7</td>
<td>71.9</td>
<td>70.4</td>
<td>73.7</td>
</tr>
<tr>
<td>GSTT</td>
<td>86.5</td>
<td>86.1</td>
<td>85.6</td>
<td>86.6</td>
<td>89.3</td>
<td>86.0</td>
<td>86.7</td>
<td>86.7</td>
<td>85.2</td>
<td>87.5</td>
<td>86.1</td>
<td>85.4</td>
</tr>
</tbody>
</table>

Like many health systems across England, our local trusts, King’s College Hospital NHS Foundation Trust (KCH) and Guy’s and St Thomas’ NHS Foundation Trust (GSTT) have been challenged in delivering target standards for A&E waiting times during the year.

The CCG has undertaken significant work with health and care partner organisations to ensure that patients can be transferred from hospital more efficiently and that local hospitals are able to make full use of community and social care discharge pathways such as ‘@home’ and supported discharge. Our Continuing Healthcare Team continues to work closely with local providers and has helped minimise the number of patients that were Delayed Transfers of Care (DTOCs) or Medically Fit for Discharge (MFFD).

London Ambulance Service (LAS) performance:

2018/19 was the first full year since the implementation of the Ambulance Response Programme. Introduced in July 2017, the programme was a new set of performance targets applied to all 999 calls. The new targets are expected to lead to faster lifesaving treatment and an end to “hidden waits” for millions of patients. Over the past year the programme has done well to enable us to meet the performance targets. We met all our targets except for two targets in two months.
Referral to Treatment (RTT) waiting times (92% target - incomplete pathways): The percentage of patients waiting for treatment who have waited less than 18 weeks.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of calls per Category</th>
<th>National Standard</th>
<th>How long does the ambulance service have to make a decision?</th>
<th>What stops the clock?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>8%</td>
<td>7 minutes mean response time</td>
<td>The earliest of: The problem being identified. An ambulance response being dispatched. 30 seconds from the call being connected.</td>
<td>The first emergency vehicle that arrives on scene stops the clock. (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation.)</td>
</tr>
<tr>
<td>Category 2</td>
<td>48%</td>
<td>18 minutes mean response time</td>
<td>The earliest of: The problem being identified. An ambulance response being dispatched. 240 seconds from the call being connected.</td>
<td>If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.</td>
</tr>
<tr>
<td>Category 3</td>
<td>34%</td>
<td>120 minutes 90th centile response time</td>
<td>The earliest of: The problem being identified. An ambulance response being dispatched. 240 seconds from the call being connected.</td>
<td>If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.</td>
</tr>
<tr>
<td>Category 4</td>
<td>10%</td>
<td>180 minutes 90th centile response time</td>
<td>The earliest of: The problem being identified. An ambulance response being dispatched. 240 seconds from the call being connected.</td>
<td>Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 1</td>
<td>7 min (mean)</td>
<td>00:06:53</td>
<td>00:06:52</td>
<td>00:06:57</td>
<td>00:06:14</td>
<td>00:06:32</td>
<td>00:05:43</td>
<td>00:06:28</td>
<td>00:05:55</td>
<td>00:06:13</td>
<td>00:06:22</td>
</tr>
<tr>
<td></td>
<td>15 min (90% Centile)</td>
<td>00:11:32</td>
<td>00:10:51</td>
<td>00:11:22</td>
<td>00:10:08</td>
<td>00:11:39</td>
<td>00:09:28</td>
<td>00:10:30</td>
<td>00:09:29</td>
<td>00:10:09</td>
<td>00:10:18</td>
</tr>
<tr>
<td>Cat 2</td>
<td>18 min (mean)</td>
<td>00:14:25</td>
<td>00:16:04</td>
<td>00:16:16</td>
<td>00:13:27</td>
<td>00:15:09</td>
<td>00:13:17</td>
<td>00:13:49</td>
<td>00:14:23</td>
<td>00:15:14</td>
<td>00:15:22</td>
</tr>
<tr>
<td></td>
<td>40 min (90% Centile)</td>
<td>00:28:33</td>
<td>00:31:55</td>
<td>00:33:34</td>
<td>00:25:45</td>
<td>00:31:50</td>
<td>00:26:44</td>
<td>00:27:40</td>
<td>00:28:16</td>
<td>00:30:12</td>
<td>00:31:27</td>
</tr>
<tr>
<td>Cat 4</td>
<td>180 min</td>
<td>01:53:03</td>
<td>02:00:00</td>
<td>02:22:11</td>
<td>01:40:16</td>
<td>01:55:12</td>
<td>02:05:51</td>
<td>01:52:41</td>
<td>01:44:54</td>
<td>03:05:32</td>
<td>02:04:50</td>
</tr>
</tbody>
</table>

Referral to Treatment (RTT) waiting times (92% target - incomplete pathways): The percentage of patients waiting for treatment who have waited less than 18 weeks.

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<tr>
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<th>Apr</th>
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</thead>
<tbody>
<tr>
<td>SCCG</td>
<td>85.1</td>
<td>86.0</td>
<td>85.3</td>
<td>85.4</td>
<td>84.7</td>
<td>83.6</td>
<td>83.7</td>
<td>83.6</td>
<td>82.7</td>
<td>83.0</td>
<td>83.2</td>
<td>82.5</td>
</tr>
<tr>
<td>KCH</td>
<td>80.6</td>
<td>81.2</td>
<td>80.8</td>
<td>80.5</td>
<td>80.6</td>
<td>79.4</td>
<td>79.1</td>
<td>79.0</td>
<td>77.9</td>
<td>77.9</td>
<td>78.1</td>
<td>76.9</td>
</tr>
<tr>
<td>GSTT</td>
<td>89.1</td>
<td>89.8</td>
<td>89.5</td>
<td>89.9</td>
<td>88.9</td>
<td>87.9</td>
<td>87.6</td>
<td>87.6</td>
<td>86.6</td>
<td>86.9</td>
<td>87.1</td>
<td>86.2</td>
</tr>
</tbody>
</table>
Referral to Treatment (RTT) 52 week waits: The number of Referral to Treatment (RTT) incomplete pathways greater than 52 weeks. The number of patients waiting longer than 52 weeks for treatment at March 2018 to be halved by March 2019.

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>SCCG</td>
<td>73</td>
<td>78</td>
<td>102</td>
<td>111</td>
<td>107</td>
<td>95</td>
<td>99</td>
<td>77</td>
<td>60</td>
<td>66</td>
<td>66</td>
<td>50</td>
</tr>
<tr>
<td>KCH</td>
<td>305</td>
<td>331</td>
<td>408</td>
<td>448</td>
<td>455</td>
<td>449</td>
<td>403</td>
<td>331</td>
<td>248</td>
<td>261</td>
<td>262</td>
<td>192</td>
</tr>
<tr>
<td>GSTT</td>
<td>8</td>
<td>16</td>
<td>12</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>24</td>
<td>20</td>
<td>26</td>
<td>32</td>
<td>30</td>
<td>36</td>
</tr>
</tbody>
</table>

Southwark CCG breached the incomplete RTT pathways target throughout 2018/19.

Our approach to improving RTT waiting times

Southwark, Lambeth and Bromley CCGs have established a planned care programme with KCH and GSTT to find solutions to improve waiting times and ensure that patients are seen in the right place, first time. You can read more about the planned care programme in section 1.2.2.2.

Cancer waiting times standards:

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

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

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

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</thead>
<tbody>
<tr>
<td>2 weeks</td>
<td>95.9</td>
<td>95.2</td>
<td>91.7</td>
<td>93.9</td>
<td>92.6</td>
<td>90.1</td>
<td>92.0</td>
<td>94.2</td>
<td>95.7</td>
<td>92.1</td>
<td>92.1</td>
<td>91.8</td>
</tr>
<tr>
<td>31 days</td>
<td>98.8</td>
<td>96.7</td>
<td>97.0</td>
<td>98.0</td>
<td>95.6</td>
<td>97.2</td>
<td>100</td>
<td>97.6</td>
<td>98.8</td>
<td>98.0</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>62 days</td>
<td>86.0</td>
<td>78.0</td>
<td>84.0</td>
<td>77.3</td>
<td>73.7</td>
<td>70.3</td>
<td>70.2</td>
<td>93.6</td>
<td>82.1</td>
<td>70.8</td>
<td>81.6</td>
<td>85.7</td>
</tr>
</tbody>
</table>

Cancer performance continues to be monitored through the 62 Day Leadership Group, and a south east London cancer delivery plan has been developed to ensure that the south east London providers can improve performance and treatment times for tertiary referrals. The delivery of the 62-day cancer standard remains challenging for south east London providers, particularly as delivery of the overall 62 day cancer treatment standard is closely linked to reducing late referrals to GSTT from other trusts. Improved timeliness of inter-hospital processes and transfers (ITTs) has been the key component of south east London recovery plans.
Across the system we introduced actions to improve waiting times. These include reducing the average waits for a first outpatient appointment to seven days for some pathways and consistent Straight to Test (STT) /one stop clinic models, which also support timely delivery of the overall pathway by shortening the early part of the pathway for relevant tumours.

Patient tracking software (Somerset) has been implemented across south east London providers. This supports management of the cancer patient tracking list and inter-trust working for patients moving between district general hospitals and specialist trusts.

**Diagnostic waits:** The percentage of patients waiting six weeks or more for a diagnostic test. The target is 1% or less.

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</tr>
</thead>
<tbody>
<tr>
<td>SCCG</td>
<td>1.2</td>
<td>1.3</td>
<td>1.8</td>
<td>0.9</td>
<td>1.2</td>
<td>0.9</td>
<td>0.5</td>
<td>1.5</td>
<td>2.8</td>
<td>5.2</td>
<td>2.3</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Southwark CCG diagnostic performance varied between 0.5 and 5.6% through 2018/19.

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

a. **IAPT access rate (first treatments):** the number of people entering treatment. The target of 664 people set for Southwark is based on 19% of the estimated prevalence of people who have depression and/or anxiety disorders in Southwark. The target is to achieve this by quarter four of 2019/20, which is equivalent to 4.75%.

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

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</thead>
<tbody>
<tr>
<td>First Treatments (Rolling 3 month quarter performance)</td>
<td>3.80%</td>
<td>4.05%</td>
<td>3.74%</td>
<td>4.05%</td>
<td>3.99%</td>
<td>4.10%</td>
<td>4.39%</td>
<td>5.08%</td>
<td>4.82%</td>
<td>5.07%</td>
<td>4.73%</td>
<td></td>
</tr>
<tr>
<td>Recovery (Rolling 3 month quarter performance)</td>
<td>47.5%</td>
<td>48.4%</td>
<td>47.7%</td>
<td>46.5%</td>
<td>47.7%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>48.2%</td>
<td>49.1%</td>
<td>49.1%</td>
<td></td>
</tr>
</tbody>
</table>

The Southwark IAPT service has experienced issues in achieving recovery and access targets since the start of the new contract with South London and Maudsley NHS Foundation.
Trust (SLaM) in April 2016. However, 2018/19 has seen an overall improvement from 2017/18 and the recovery target was achieved from September to November 2018.

The access target for 2018/19 was to reach 19% of the estimated prevalence of people who have depression and/or anxiety disorders in Southwark by the last quarter of 2018/19. NHS Southwark CCG achieved this in quarter two of 2018/19.

There are also targets that measure waiting times from referral to treatment in improving access to psychological therapies (IAPT) services for people with depression and/or anxiety disorders. These are 75% for a waiting time of six weeks and 95% for a waiting time of 18 weeks. These targets have been achieved throughout 2018/19.

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

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</tr>
</thead>
<tbody>
<tr>
<td>% Diagnosed</td>
<td>75.3</td>
<td>75.1</td>
<td>75.4</td>
<td>68.2</td>
<td>68.5</td>
<td>69.4</td>
<td>68.4</td>
<td>76.5</td>
<td>75.9</td>
<td>75.7</td>
<td>75.7</td>
<td>77.8</td>
</tr>
</tbody>
</table>

High diagnosis rates have continued during 2018/19, following the successful work in recent years with GP practices to ensure good diagnosis and recording of dementia. To note: There was a large decrease in the reported number diagnosed in July 2018. This is a reporting error due to a recent change in primary care provision to care homes and has now been corrected.

The CCG has worked with partners during 2018/19 on the following areas:

- New Dementia NICE guidelines to Primary care and Secondary Care are being introduced in Southwark.
- Improved support for people with Young Onset Dementia
- Support for GPs working with care homes to make dementia diagnosis.

**Early intervention in psychosis:** Referrals to and within SLaM with suspected first episode psychosis or at ‘risk mental state’ that start a NICE-recommended care package.

<table>
<thead>
<tr>
<th></th>
<th>Q1 18/19</th>
<th>Q2 18/19</th>
<th>Q3 18/19</th>
<th>Q4 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals to and within the trust with suspected first episode psychosis or at ‘risk mental state’ that start a NICE-recommended package care package in the reporting period within two weeks of referral.</td>
<td>11</td>
<td>8</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Number of referrals to and within the trust with suspected first episode psychosis or at ‘risk mental state’ that start a NICE-recommended care package</td>
<td>16</td>
<td>13</td>
<td>12</td>
<td>13</td>
</tr>
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Healthcare acquired infections

Incidence of healthcare-associated infection – MRSA: target zero

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<tr>
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<tbody>
<tr>
<td>SCCG</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

Incidence of healthcare-associated infection – Clostridium Difficile (CDiff): target 45 or less for full year, 3.75 per month.

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</thead>
<tbody>
<tr>
<td>SCCG</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Targets for the year have been exceeded for MRSA and are expected to be exceeded for CDiff.

Infection prevention and control (IPC) issues, including MRSA bacteraemia and Clostridium difficile infections (CDI), are discussed at the monthly Clinical Quality Review meetings for KCH and GSTT. KCH and GSTT undertake a root cause analysis (RCA) on all MRSA bacteraemia and CDI cases attributed to their organisations. These are discussed at acute hospital IPC meetings which are attended by the CCG’s IPC Lead Nurse, who also presents quarterly IPC update reports to the CCG’s Quality and Safety Committee.

**Friends and Family Test:**

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

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

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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<th>Nov</th>
<th>Dec</th>
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<th>Mar</th>
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<tbody>
<tr>
<td>KCH</td>
<td>83</td>
<td>83</td>
<td>82</td>
<td>84</td>
<td>83</td>
<td>82</td>
<td>78</td>
<td>78</td>
<td>74</td>
<td>75</td>
<td>69</td>
<td>73</td>
</tr>
<tr>
<td>Denmark Hill</td>
<td>83</td>
<td>83</td>
<td>82</td>
<td>84</td>
<td>83</td>
<td>82</td>
<td>78</td>
<td>78</td>
<td>74</td>
<td>75</td>
<td>69</td>
<td>73</td>
</tr>
<tr>
<td>GSTT</td>
<td>85</td>
<td>83</td>
<td>83</td>
<td>84</td>
<td>89</td>
<td>84</td>
<td>86</td>
<td>87</td>
<td>88</td>
<td>89</td>
<td>83</td>
<td>84</td>
</tr>
</tbody>
</table>
Inpatients – % of patients recommending care

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<th>Nov</th>
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<th>Jan</th>
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<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>KCH Denmark Hill</td>
<td>95</td>
<td>95</td>
<td>94</td>
<td>93</td>
<td>93</td>
<td>94</td>
<td>94</td>
<td>93</td>
<td>96</td>
<td>94</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>GSTT</td>
<td>96</td>
<td>95</td>
<td>95</td>
<td>96</td>
<td>95</td>
<td>94</td>
<td>95</td>
<td>97</td>
<td>95</td>
<td>95</td>
<td>96</td>
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</tr>
</tbody>
</table>

Performance is similar to the London average for inpatients recommending care at GSTT and KCH. The percentage of patients recommending the care at KCH A&E is significantly below the London average. The CCG would expect to see improvements in ratings for A&E as waiting times improve as a result of initiatives in urgent care.

**Better Care Fund performance:** (see section 1.2.1.6)

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

**Delayed transfers of care** – target is a reduction in bed days lost in line with national targets

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
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</thead>
<tbody>
<tr>
<td>BCF Target</td>
<td>434</td>
<td>449</td>
<td>434</td>
<td>449</td>
<td>434</td>
<td>449</td>
<td>434</td>
<td>449</td>
<td>449</td>
<td>449</td>
<td>405</td>
<td>449</td>
</tr>
<tr>
<td>New NHSE target</td>
<td>333</td>
<td>344</td>
<td>333</td>
<td>344</td>
<td>344</td>
<td>344</td>
<td>344</td>
<td>311</td>
<td>344</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual</td>
<td>310</td>
<td>367</td>
<td>279</td>
<td>341</td>
<td>283</td>
<td>369</td>
<td>403</td>
<td>525</td>
<td>410</td>
<td>571</td>
<td>737</td>
<td>766</td>
</tr>
</tbody>
</table>

Reducing delayed transfers of care is the key objective for the current BCF.

The original BCF targets for 2017-19 were mandated and until November 2018 had been achieved in every month, reflecting overall strong long term performance. However, since November there has been a significant deterioration which in part is due to pressures over the winter. New targets were set from September and these have also not been met. This is a key focus for service improvement.

**Care Home admissions** - target is a reduction in new permanent admissions

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
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<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual</td>
<td>16</td>
<td>14</td>
<td>14</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>9</td>
<td>16</td>
<td>12</td>
<td></td>
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</tbody>
</table>

The 2018/19 target was not to exceed 124. This is not on track to be achieved. The target was based on a 2015/16 baseline that is now considered to be not comparable given the growth in the population with dementia. In the next BCF planning round the target will be reviewed.
Effectiveness of re-ablement services

<table>
<thead>
<tr>
<th>Reablement effectivenss</th>
<th>18-19 Q1</th>
<th>18-19 Q2</th>
<th>18-19 Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65+ referred to supported discharge or re-ablement on discharge from hospital</td>
<td>165</td>
<td>184</td>
<td>211</td>
</tr>
<tr>
<td>Number still at home after 91 days</td>
<td>130</td>
<td>166</td>
<td>172</td>
</tr>
<tr>
<td>Percentage still at home after 91 days</td>
<td>79%</td>
<td>81%</td>
<td>82%</td>
</tr>
</tbody>
</table>

This target is about the number of people who are still living at home 91 days after being transferred from hospital with the support of a re-ablement or similar rehabilitation service, without having been re-admitted. Southwark did not meet the target but is in line with acceptable performance.

Non-elective admissions

The BCF is monitored against overall CCG Operating Plan trajectories for non-elective admissions agreed with NHS England.

The projected annual position representing a 10.6% adverse variance is as follows:

<table>
<thead>
<tr>
<th>Plan 18/19</th>
<th>Actual 18/19</th>
<th>Variation 18/19 (volume)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20,086</td>
<td>22,232</td>
<td>2,146</td>
</tr>
</tbody>
</table>

1.2.2.2 Planned care programme

Over the last few years, a combination of capacity issues at local providers and increasing levels of referrals to King’s College Hospital NHS Foundation Trust (KCH) and Guy’s and St Thomas’ NHS Foundation Trust (GSTT) have led to increased waiting times for elective or planned care. To review the situation and find solutions, Southwark, Lambeth and Bromley CCGs established a Planned Care Programme with KCH and GSTT. Much of the work of the planned care programme has focused on ensuring patients are seen in the right place, first time. As part of this, we introduced support tools to help GPs to manage patients, launched new community services and worked to improve and make the most of referral pathways.

Support tools available to primary care
Throughout 2018/19 we have worked hard to improve the support tools available to GP practices. This has involved improving advice and guidance services – both via the electronic referral system (e-RS) and telephone. On e-RS, we have increased the number of specialties available for advice and guidance and we have seen significant increases in the number of advice and guidance requests being made. In October 2017, we launched a pilot of Consultant Connect, which is a telephone advice and guidance service. The service allows GPs to call a specialist at one of our local acute trusts and ask for immediate advice from several specialties. Over the last year we have increased the number of specialties available on Consultant Connect from five to 11 and answer rates are above 70%. To add another dimension to the support offer for GPs, we piloted VisualDX, a diagnostic support tool for all conditions. The tool has a powerful differential diagnosis builder and a massive library of high-quality images which makes it particularly useful for diagnosing skin conditions.

Pathway development and optimisation

Over the last year, we have launched two new services: Optometrist Triage Service and a Community Dermatology Service, designed to improve the ophthalmology and dermatology pathways. These services treat patients for a range of conditions, closer to home and in much shorter waiting times. Both services provide a triage service which reviews referrals and ensures patients are seen in the right service, first time.

We have also worked closely with KCH and GSTT to look at how we can improve the referral pathways in other specialties. This has been focused on introducing clinical triage of referrals. The aim is to ensure patients are seen in the right place, first time. Referrals for patients who could be managed within primary care are returned to the GP with advice and a management plan, and referrals for patients who need to be seen by a specialist, are directed to community services (if appropriate) or referred to a specialist clinic in hospital.

Electronic Referral System (e-RS)

The Electronic Referral System (e-RS) combines electronic booking with a choice of place, date and time for first hospital or clinic appointments.

For 2018/19, national guidance required all hospitals to complete a paper switch-off programme and for all GP referrals to outpatient services to be made via e-RS from October 2018. Building on the progress made in 2017/18, Southwark CCG worked closely with Lambeth and Bromley CCGs, KCH, GSTT and the national e-RS team, as part of the e-RS Street Group, to drive up use and meet this national deadline.

Southwark CCG met the national deadline, with GSTT completing the transition to e-RS in April 2018 and KCH on 1 September 2018. All GP referrals to outpatients are now being made via e-RS. Throughout the year the CCG worked closely with GPs, GSTT and KCH to optimise use of e-RS, holding numerous training sessions for GP practice staff and having dedicated IT facilitators to support and visit practices.

1.2.2.3 Right Care – Commissioning for value

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

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

The CCG joined the Right Care programme as a ‘wave 2’ organisation. Since February 2017 we worked to analyse our Commissioning for Value information packs and identify opportunities to enhance the value of the services we commission and to enable better outcomes for our residents. Our Right Care programmes of care, intervention areas and QIPP opportunities have been developed in 2018-19 in a way that aligns with the Southwark Forward View. They will also align with the transformation work planned as part of the STP in south east London. In identifying the RightCare programmes of care we are taking forward in Southwark, we have looked at those areas that satisfy three principles:

- Is the CCG the responsible commissioner for the key service within the pathway?
- Do the programmes of care areas correlate with the objectives and approach to transformation set out in the CCG’s Five Year Forward View?
- Do the programmes of care areas suggest there is significant unwarranted variation locally and potential for CCGs to address this for the benefit of residents?
From this we have proposed QIPP opportunities and interventions that we have begun to implement. Commissioners are examining outcomes-based approaches that incentivise prevention, early detection and prompt planned treatment across the whole system that would help deliver these opportunities. The outcomes of this work will be received by the CCG’s Commissioning Strategy and Integrated Governance and Performance Committees.

Further details are available at:


### 1.2.2.4 CCG assurance annual assessment

NHS England has a statutory duty to conduct an annual performance assessment of every CCG.

The annual assessment is a judgement reached by taking into account the CCG’s performance in each of the NHS Improvement and Assessment Framework (IAF) indicator areas over the full year, balanced against the financial management and qualitative assessment of the leadership of the CCG. The NHS IAF includes indicators across four domains (Better Health, Better Care, Sustainability, and Leadership) and six clinical priorities (Mental Health, Dementia, Learning Disability, Cancer, Diabetes, and Maternity).

The [My NHS website](https://www.nhs.uk) gathers data from across the system into one place so professionals and the public can easily compare the performance of health and care services over a range of measures. It is important that information about how health services are performing is open and accessible as it can have a positive effect on the quality of the services delivered.

The CCG’s current IAF performance and ratings for leadership and in-year financial performance are available under the services section of this website, and the outcome of the CCG’s 2018/19 assessment will be published here by July 2019. My NHS can be accessed at [https://www.nhs.uk/service-search/Performance/Search](https://www.nhs.uk/service-search/Performance/Search)

### 1.2.2.5 National CCG 360 survey results

Every year NHS England commissions Ipsos-Mori to undertake a stakeholder survey on behalf of all CCGs. The purpose of the survey is to:

1. provide CCGs with insight into key areas for improvements in their relationships with stakeholders and provide information on how stakeholders’ views have changed over time.
2. contribute towards NHS England’s statutory responsibility to conduct an annual assessment of each CCG, through the CCG Improvement and Assessment Framework.

NHS Southwark Clinical Commissioning Group (CCG) achieved its highest response rate since the survey began in 2013/14 of 92% which was the second highest response in England.

The 2019 survey was shorter than in previous years with a number of the questions having changed or having been omitted, making comparisons with previous years difficult.

Overall the results for NHS Southwark Clinical Commissioning Group were positive with scores consistently higher than the national, regional and cluster average in most areas.
The table below shows comparison with 2018 where the questions have remained the same or the wording has only changed slightly:

<table>
<thead>
<tr>
<th>Question</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how would you rate the effectiveness of your working relationship with the CCG? % very / fairly good</td>
<td>92%</td>
<td>87%</td>
</tr>
<tr>
<td>2019 - Overall how would you rate the effectiveness of the CCG as a local system leader?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018 – How effective, if at all, do you feel your CCG is as a local system leader % very / fairly effective</td>
<td>92%</td>
<td>92%</td>
</tr>
</tbody>
</table>

The above two questions inform the assurance on the effectiveness of working relationships in the leadership domain as part of the CCG’s Improvement and Assessment Framework.

<table>
<thead>
<tr>
<th>Question</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 – How would you rate the effectiveness of the CCG at improving the quality of local services? % very / fairly effective</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>2018 - I have confidence that the CCG monitors the quality of the services it commissions in an effective manner % strongly / tend to agree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The CCG involves the right individuals and organisations when commissioning decommissioning services % strongly / tend to agree</td>
<td>82%</td>
<td>78%</td>
</tr>
<tr>
<td>2019 - The CCG demonstrates that it has considered the views of patient the public, including those groups which experience poorer health outcomes and/or barriers to accessing health and care, when it is commissioning/decommissioning services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018 – The CCG demonstrates that it has considered the views of patients and the public when making commissioning decisions % strongly / tend to agree</td>
<td>79%</td>
<td>78%</td>
</tr>
</tbody>
</table>

You can read the full set of the CCG’s results from Ipsos-Mori in the 360 survey results folder on the policies, strategies and registers page under publications on the CCG website.

### 1.2.2.6 South east London Integrated Governance & Performance Committee

The establishment of a pan-SEL CCG approach to performance and financial assurance

In November 2018 the south east London (SEL) Integrated Governance and Performance (IG&P) committee was established by agreement of the governing bodies of the six CCGs within the south east London Sustainability and Transformation Partnership (STP) area. Collectively the CCGs agree that some performance challenges (particularly those related to the acute sector) require a consistent approach is resolve these issues and this is best addressed at a south east London level. There is also a mutual dependency in respect of financial delivery, which impacts all SEL CCGs. SEL CCGs recognise the need to
understand the collective position and mitigations for each organisation’s contribution to the SEL financial position.

As such, the SEL IG&P has been established to monitor the delivery of provider organisations’ statutory and delivery responsibilities to ensure agreed actions and mitigations are followed through; to discuss and agree appropriate remediation; and to pro-actively identify and address declining performance indicators, ensuring deterioration is managed rapidly. The current scope of the SEL committee includes oversight of and coordination of the SEL CCGs’ response to: the delivery of the SEL CCG control total (and as such the individual annual CCG control totals); the sustainable delivery of the NHS Constitution standard for referral-to-treatment (RTT) waiting times, cancer and diagnostics; and identification and pro-active management of key strategic and operational risks relating to these areas.

The committee is chaired by an independent lay person (who does not sit on the governing body of any CCG). Membership is made up of representatives from all SEL governing bodies and the south east London commissioning alliance (SELCA) executive team.

During January and February 2019, the scope and approach of the SEL IG&P have been reviewed and recommendations for its future scope and function within CCGs’ governance structures will be taken to all SEL governing bodies for agreement.
1.2.3 Improving quality and safety

1.2.3.1 Putting quality at the heart of the CCG

In 2018/19 we consolidated our work to establish quality at the heart of everything we do by bringing previous initiatives into business as usual whilst also introducing new initiatives to reflect emerging priorities. Business as usual for the quality team in 2018/19 included:

- Providing monthly quality reports to the Integrated Governance and Performance Committee, and bi-monthly reports to the Governing Body and Primary Care Commissioning Committee covering highlights and emerging issues about patient safety, patient experience, and clinical effectiveness.

- Leading the CCG’s monthly Quality and Safety sub-Committee, comprised of clinicians and CCG officers. A variety of topics were covered including patient experience, shared care protocols, clinical information systems, and learning from incidents.

- Representing Southwark at monthly Clinical Quality Review Groups (CQRG) meetings between senior CCG representatives and each main provider (King’s College Hospital NHS Foundation Trust (KCH), Guy’s and St Thomas’ NHS Foundation Trust (GSTT), London Ambulance Service (LAS) and South London and Maudsley NHS Mental Health Trust (SLaM)). The Medical Director and senior teams present to CCGs to review the quality of care delivered and are held to account for the quality element of their contracts. Topics covered during 2018/19 included a mix of items to cover the Quality Schedule and deep dives into particular topics.

- Agreeing quality priorities for all main providers; the Health Act 2009 requires foundation trusts to publish annual quality accounts and commissioners to provide comment for inclusion in the document. As lead commissioner Southwark wrote the stakeholder feedback for KCH incorporating comments received from other local CCGs and provided comment to the lead commissioners to incorporate for GSTT, LAS and SLaM.

- Facilitating workforce development for GPs and practice staff; the CCG training team provide protected learning times (PLTs), forums, courses and events and participate in the Community Education Provider Network (CEPN). During 2018 the CCG noted:
  
  - 1,500 PLT attendances were recorded
  - Over 670 attendances by Practice Nurse and HCAs at forums and development events arranged for this group including immunisation, flu, mentoring, contraception and sexual health updates, Care certificates

[1] NHS foundation trusts must include a report on the quality of care they provide in their annual report to improve public accountability. It must be a quality account, not a quality report. Commissioners are legally obliged to provide comment on the Quality Account/report.
• Over 200 attendances from primary care staff at various other events (Me First, GDPR, Moving Healthcare Professionals, Acute Paediatric updates)

The CCG also provided Duty of Candour training for GPs and practice staff to help them understand their statutory duties

- Overseeing **Serious Incidents** at provider trusts affecting Southwark residents to ensure lessons are learned and changes are implemented as fast as possible.

- Tracking mechanisms to ensure quality is maintained such as Quality Impact Assessments, Clinical Effectiveness Southwark (CES), and **Optimise RX** (a pharmacy prescribing tool).

- Gathering feedback and acting on **Quality Alerts**; from April-March over 400 QAs were raised, including 6 commendations and 40 alerts about GP practices. As a result of information received from quality alerts, providers have made changes to reduce delays receiving radiology and diagnostic image reports in primary care. Quality alerts about GP practices have enabled changes to improve use of the new e-RS system and speed up patient referrals.

During 2018/19 we worked with other similar organisations in south London to improve quality assurance. Examples of this include

- Introducing a Directors of Quality network for CCGs in Southwark, Lambeth, Lewisham, Bexley, Bromley and Greenwich to share ideas and best practice, leading south east London representation on the Transforming Care Programme (TCP) and the GP10 (GP nursing) programme, and working closely with Lambeth, Lewisham and Croydon CCGs to review the effectiveness of the CQRG for SLaM. This resulted in appointing a new CQRG Chair (Lewisham GP) and two vice Chairs (Director of Quality for Southwark and Croydon CCG) with the meeting now providing considerably more assurance.

- A focus on patient safety in general practice has led the way to Incidents and Serious Incident investigations being reported and conducted: the CCG quality team work closely with practices providing support on the Root Cause Analysis method of investigation. Southwark CCG will build on these foundations in 2019/20 to establish mechanisms to manage, review and share learning from SI in primary care.

### 1.2.3.2 Clinical Effectiveness Southwark

Clinical Effectiveness Southwark (CES) is a partnership between NHS Southwark Clinical Commissioning Group (SCCG) and Southwark’s two GP federations; Quay Health Solutions (QHS) and Improving Health Limited (IHL). CES is designed to tackle health inequalities and address variation by delivering a systematic approach to quality improvement that strives to ‘make the right thing to do, the easy thing to do’, for Primary Care Clinicians.

Figure 1: CES model for delivering quality improvement:
CES is based on the successful Clinical Effectiveness Group (CEG) in east London, which has consistently delivered high quality primary care for a wide range of long-term conditions.

Led by local Southwark GPs, in 2018 the CES team produced seven CES clinical guides. CES guides localise and simplify clinical messages to support primary care clinicians to provide best-practice diagnosis and management. CES guides also inform the design of clinical templates.

To support development of the guides and templates in 2018/19, the CES team engaged with primary care teams through protected learning time sessions and other meetings. The CES Team strives to ensure that engagement with practices is underpinned by dynamic, real-time data in a clear and easy to use format.

Since going live, both the CES guides, templates and the GP-led PLT’s have been praised by local clinicians for ‘speaking the language of practices. Engagement with practices has helped refine the CES approach to quality improvement and enabled more in-depth conversations with practices about how the package of support can help make the right thing to do the easy thing to do and improve care quality for the local population.

Plans for 2019 include;

- Roll out the latest clinical templates
- Enhance data reporting and visualisation to support further practice engagement opportunities and inform evaluation of CES
- Develop CES patient leaflets to inform and empower patients’ consultations with their local GP or practice nurse.
1.2.3.3 CQC inspections of GP practices

The Care Quality Commission (CQC) continued its rolling programme of inspections of GP practices during 2018/19. The inspections assess whether the practice is safe, effective, caring, and well led, and that patients have a good experience. In 2017/18, the CCG produced a Learning Resource document based on themes and learning from visits to GP practices, to support quality improvements.

In April 2019, 36 Southwark GP practice contracts were registered with the CQC. Of these, two practices were rated overall as Inadequate, four were rated as Requires Improvement overall, 29 were rated Good overall and the new provider of The Lister Practice is awaiting an inspection. The Lister Practice is delivering GP services to patients who were previously registered with the former Dr Hossain and the Hurley Group at the Lister. Dr Hossain’s practice previously had no rating assigned by the CQC during the period of caretaking by the Hurley Group, the former Hurley practice at the Lister was rated at Good overall by the CQC.

The CCG worked with all practices who have had CQC inspections, alongside our GP federations, to both guide and assist but also monitor progress and feedback to the practices as they move through this improvement cycle.

Patients are understandably concerned when CQC inspections highlight serious problems that result in the practice being put in special measures. In these circumstances we work with the practice concerned to address the issues raised by the CQC to ensure that patients receive a safe and high-quality service, and that no significant harm has occurred to patients. The CCG and CQC also closely monitor improvement plans and the CQC normally undertakes further inspections at more frequent intervals.

Improving quality

The CCG takes its role in supporting practices to deliver high quality services seriously. We are committed to reducing unwarranted variation in quality and performance and driving out inequalities. The CCG’s primary care commissioning team and quality team work closely with all practices to offer support, guidance and expertise. This support is co-ordinated from across the CCG directorates including safeguarding, medicines management, infection control and clinical governance, for example incident reporting.

We have invested in the development of a new service (Clinical Effectiveness Southwark), which, working with GP federations and the CCG is embedding quality improvement processes across all our practices (see 1.2.3.2). Since taking responsibility under delegation from NHS England, the CCG has developed a General Practice Quality Assurance framework, which we are now beginning to work with. All these initiatives, alongside our longstanding approach to support general practice to work at scale through federations, will improve the quality and performance of general practice services in Southwark.

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

1.2.3.4 Complaints

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

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

The table below shows the total numbers of Complaints and PALS queries received by the CCG in 2016-2017 and in 2017-18 for Quarters 1, 2 and 3.

<table>
<thead>
<tr>
<th>Year</th>
<th>Complaints</th>
<th>Complaints closed</th>
<th>PALS Queries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-19*</td>
<td>18</td>
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<td>55</td>
<td>73</td>
</tr>
<tr>
<td>2017-18</td>
<td>40</td>
<td>39</td>
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<td>85</td>
</tr>
<tr>
<td>2016-17</td>
<td>45</td>
<td>36</td>
<td>67</td>
<td>112</td>
</tr>
<tr>
<td>2015-16</td>
<td>16</td>
<td>16</td>
<td>66</td>
<td>82</td>
</tr>
</tbody>
</table>

*Q 1, 2 and 3

1.2.3.5 Safeguarding adults and children

Keeping children and adults at risk of harm safe is a key priority for us and an integral part of all our planning, commissioning, contracting and monitoring arrangements.

The CCG Chief Officer is responsible for safeguarding. The Governing Body also includes a GP Clinical Lead for safeguarding and quality and the executive lead for safeguarding for both adults and children is the Director of Quality and Chief Nurse. There is a full complement of designated and named safeguarding professionals in the CCG including: a designated nurse for safeguarding children; an adults safeguarding lead nurse; designated doctors for safeguarding and looked after children; a designated nurse for looked after children; and two named GP’s for safeguarding - one for children and one for adults. In addition, the CCG commissions a designated paediatrician for child deaths. The Safeguarding Team now provide updates on a quarterly basis to the CCG Governing Body via the Information Governance and Performance Committee.

The CCG is a core member of the Southwark Safeguarding Children’s Board and the Southwark Safeguarding Adults Board. The CCG Director of Quality and Chief Nurse is the interim chair of the Adults Safeguarding Board and relevant Designated and Named Professionals attend both Boards.
Following the enactment of the Children and Social Work Act 2017, the Department for Education released the updated version of Working Together to Safeguard Children in July 2018. The revised version makes significant changes to Local Safeguarding Children Boards (LSCBs) who will be replaced by three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) with equal and joint responsibility as strategic leaders to make arrangements to work together with relevant agencies to safeguard and protect the welfare of children in the area and implement local and national learning including from serious child safeguarding incidents. In Southwark the CCG has been proactive in establishing the Safeguarding Children Board Executive and the Director of Quality and Chief Nurse for the CCG represents health in this Partnership.

Throughout 2018/19, NHS Southwark CCG has continued to work in partnership with the Southwark Safeguarding Boards and partner agencies to ensure robust safeguarding arrangements are in place within the organisation and via CCG commissioned health services. The Safeguarding Partnership has agreed the following priorities for 2018/19:

- Serious Youth violence
- Exploitation (to include criminal exploitation in addition to child sexual exploitation).
- Children living with vulnerable parents
- SEND and disability pathway 0-25
- Neglect

These objectives have been incorporated into the CCG safeguarding children work plan.

The CCG Safeguarding Executive Committee receives assurance that all health providers have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect adults at risk of harm from abuse or the risk of abuse. Assurance that commissioned organisations are compliant with their safeguarding responsibilities as defined in Section 11 of the Children’s Act of 2004 and Section 42 of The Care Act 2014 is a key priority for the CCG. This has also included development of policy to ensure compliance with the Mental Capacity Act 2005 as amended by the Deprivation of Liberty Safeguards.

The CCG has worked in partnership with the Local Authority in several areas including:

- developed Southwark’s approach to rolling out a learning disabilities mortality review and ensuring opportunities are in place to learn from the outcomes of the review at regional and national levels.
- worked with the Adult Safeguarding board to deliver an awareness raising event on Human Trafficking and Modern Slavery.
- worked in partnership with Southwark Local Authority to establish robust local governance arrangements to ensure shared responsibility and accountability in delivering the SEND Reforms introduced by the Children and Families Act 2014. To support this work the CCG employs a Designated Medical Officer (via SLA) and a Designated Clinical Officer (employed directly by the CCG) to coordinate the health involvement and provide assurance that Southwark CCG are meeting statutory duties for its SEND population. The CCG contributed to the SEND inspection that took place in 2018.
The CCG also continues to promote learning in primary care via the annual protected learning time (PLT) which focuses on both children and adult safeguarding themes. The CCG has also developed a Primary Care Safeguarding Forum which supports a network approach to developing, learning and sharing around safeguarding issues. The CCG encourages the participation and cascading of learning from serious case reviews (SCR), safeguarding adult reviews (SAR), concise reviews (CR) and domestic homicide reviews (DHR). The CCG is represented on the Southwark Channel Panels and works with Southwark Council to develop and deliver on the Prevent agenda.

You can read the CCG’s safeguarding declaration on the website:

1.2.4 Commissioning high quality services

1.2.4.1 Primary Care Services

APMS procurements

In 2018/2019 the CCG ran procurements to identify new providers for GP practices where contracts had come to an end. The practices included:

- A merged registered list of two previous practices at the Lister Primary Care Centre
- Falmouth Road Practice
- A merged registered list of Melbourne Grove Medical Practice and the Hambleden Clinic

As part of the procurement processes the CCG engaged with patients to tell them about the procurement processes and to find out what they valued about their current general practice and what they thought could be improved. We collected this information to ensure patient patients’ views were taken into account in deciding who would manage the GP surgeries in the future. During the procurement process potential bidders also had to demonstrate to the CCG that they would provide high quality services for patients and that they would work collaboratively with other health partners to improve health outcomes for patients.

A new contract was awarded to AT Medics for the Lister Practice and Falmouth Road Practice starting on 1 October 2018 for five years. There is an option to extend the contracts for a further five years if the CCG and patients are happy with the services that are being delivered.

Concordia Health Group was awarded the contract to be the new provider of Melbourne Grove Medical Practice and the Hambleden Clinic, starting on 1 April 2019. The practices will move in to the new Dulwich Health Centre when the development has been completed in 2020.

Silverlock relocation and Avicenna premises improvements

In July 2018 Silverlock Medical Centre, previously located at Warndon Street, SE16 2SB relocated to the Health Centre at 2 Verney Way, SE16 3HA, which is a purpose-built building.

The practice’s previous premises were not fit for purpose for the registered list size. National funding was also secured to complete refurbishment works at the health centre and to add four new consultation rooms. These will create capacity for an increase in population and to provide a larger range of services.

eConsult

The CCG’s ambition is that all practices will have an online consultation capability for their patients by 31 March 2019. 31 Southwark practices have implemented the eConsult online consultation platform for their patients, with a further five using the MyGP system.
The eConsult platform enables patients to consult their own NHS GP simply by completing a quick online form accessed via the practice website. It helps GPs to deliver better access to patients by providing a round-the-clock portal where patients can enter their symptoms and receive instant self-help advice, together with signposting to NHS 111, pharmacies and other healthcare services.

This is one of the digital initiatives that we are working on with our practices and patients and we will continue to work with both to further develop our local digital offer.

**GP Forward View - resilience funding, extended access**

NHS England’s [General Practice Forward View](#) made a commitment to support vulnerable practices through a national four-year resilience programme. 2018/19 was the third year of the programme. Practices were prioritised using a range of indicators including CQC ratings, number of complaints, GP patient survey results and QOF and funding and support has been agreed for four practices in Southwark. The progress of this is being monitored.

In 2017/2018 practices used funding in a variety of ways to support improvement in their resilience and sustainability. All practices that received funding in 2017/18 received improved CQC ratings after follow-up inspections and there is evidence of improved patient outcomes and experiences. All practices continue to benefit from the projects funded by resilience money and the CCG has continued to engage with these practices proactively to monitor further improvements in relation to resilience going forward.

**Care homes contract**

The CCG re-procured the extended primary care services to care homes with nursing beds contracts. As part of this procurement the CCG extended the service offer to larger residential homes in Southwark recognising the complexities of residents and their increasing health needs.

The aim of the service is to provide high quality care for residents of care homes with nursing beds through the delivery of care by a multi-disciplinary team approach and proactive clinical leadership.

Quay Health Solutions CIC, the GP Federation in north Southwark, was the successful provider and has been working with residential homes to transfer the care of patients to the new service.

**Extended Access**

The CCG continues to commission additional GP and nurse appointments 8am – 8pm, 7 days per week at the two extended access hubs in Peckham and Bermondsey.

Patients can access the service through their GP practice and a development in 2018/19 is that patients dialing 111 can also be booked directly into the service if they need to see a GP or nurse. Use of the service continues to improve; in December 2018 nearly 4500 patients had appointments booked at the service and in core hours (8am to 6.30pm) the service had 91% use.
**Premium specification and work to improve access and physical care for patients with severe mental illness**

2018/2019 has been the first full year where GP practices in Southwark have been delivering a new premium contract. The contract includes:

- Health checks for patients with severe mental illness (SMI)
- Care coordination for people with three or more long term conditions
- Improving access for patients

**Health checks for patients with severe mental illness**

We prioritised health checks for patients with severe mental illness as these patients are at greater risk of poor physical health and have a higher premature mortality than the general population. In England people with severe mental illness die on average 15 to 20 years earlier than the general population and two in three deaths are from preventable physical illnesses. Data for 2018/19 indicates that compared to the previous year 100 more patients with severe mental illness received a health check in Southwark and the CCG will be monitoring further improvements in future years.

**Care coordination for people with three or more long term conditions**

The contract also included coordinated care for patients with three or more long term conditions. For people with multi-morbidity/complex health and social care needs, coordinated care is essential to support their health and wellbeing. Many of these patients will be receiving care from several different services, which can become confusing and frustrating to patients if the services do not work in close collaboration. This fragmentation can have an impact on the quality of care and outcomes for patients and can result in duplication and increased workload for those involved in the care team. To support a more joined up approach to coordinated care locally, the local part of the GP contract states that practices will work with other local providers including hospitals, mental health services and the voluntary sector to collaboratively deliver care coordination for people with 3+ long-term conditions.

**Improving access for patients**

Access to general practice is one of the biggest concerns that the CCG hears from patients. Under the terms of the contract practices also must review their appointment systems to monitor need and capacity and identify actions to be taken to address gaps in provision and improve access for patients.

The CCG has commissioned the Apex Tool to support practices to review their access data and identify areas for improvement. The contract also includes key performance indicators in relation to patient experience and the percentage of patients that report they would recommend the practice and had a good experience of making an appointment. Practices report this data quarterly to the CCG.
1.2.4.2 Mental health and wellbeing

Southwark’s Joint Mental Health and Wellbeing Strategy (2018-21) outlines how we plan to work in partnership to deliver the best health and social care outcomes for Southwark residents. The Strategy recognises that we need to remove the stigma surrounding mental illness and shift emphasis onto prevention and early intervention, with care and support available closer to home away from hospitals or other institutional environments. At the heart of our approach is ensuring that people who experience mental ill health are not stigmatised or marginalised, and that they can receive the same quality of care and support as if they had a physical illness or condition. We will promote good mental health and wellbeing across all age and population groups, focusing on taking early action to prevent problems from developing.

Over the course of 2018 we have been finalising our implementation programme and nine workstreams have now been developed to drive delivery of the strategy. The workstreams include a range of actions to ensure we meet the objectives identified by local people during previous engagement events. The workstream areas are:

1. Wellbeing, Information, Advice and Support in the Community
2. Primary Care and IAPT and Improving Access to Psychological Therapies
3. Averting Crisis and Reducing Suicide
4. Children and Young People’s Services
5. Older People and Dementia
6. Housing and Move-on Options
7. Recovery, Volunteering and Employment
8. Engagement and Co-Design
9. Prevention and Mental Health Promotion

The strategy delivery programme is overseen by a Programme Board who review progress and provide feedback on how well the workstream action areas are being delivered. In future we will regularly engage with local people to outline our progress in delivering the Southwark Joint Mental Health Strategy. We aim to seek feedback on how the strategy programme has been developed and how we should involve local people and providers in its future delivery.

1.2.4.3 Children and Young People’s Mental Health

The Children and Young People’s Mental Health and Wellbeing Review was completed in October 2018. The review had strong engagement and numerous events were held with a wide range of stakeholders including children, young people, parents and carers. This process has continued with a reference group being setup to help shape the implementation of the findings of the review.

A Local Transformation Plan was also completed in this period, detailing how Southwark would tackle the priority areas of prevention, early intervention, providing improved access to specialist services and more responsive crisis care. This includes a focus on vulnerable young people in the justice system; those with Autistic Spectrum Disorder, learning disabilities and looked after children.

Southwark CCG is also a key sponsor of the South London Mental Health and Community Partnership (SLP), a collaborative endeavour across three mental health trusts in south
London. This has resulted in 75% reduction in the number of young people placed in inpatient facilities outside south London and a 40% reduction in the average length of stay in adolescent units.

1.2.4.4 NHS Continuing care

NHS Continuing Healthcare is free social care arranged and funded solely by the NHS for people with long term complex health needs. The CCG is responsible for making arrangements to assess people's need for this service and for commissioning a personalised package of care and support for people receiving NHS Continuing Healthcare.

This year the CCG has consistently met national targets for assessing people in a timely way and for making sure that assessments happen in the community, close to people’s homes, and not in hospital. The CCG is also close to achieving its target for the number of people who receive their services as a default option for people receiving NHS Continuing Healthcare in their own homes has played a large role in this achievement.

The CCG has also played an active role in a wider south east London collaboration to improve NHS Continuing Healthcare services across the STP. The aim of this collaboration is to improve the consistency, quality and clinical effectiveness of NHS Continuing Healthcare services for all south east London residents. Collaborative work in 2018/19 included securing the local supply of specialist care beds by working with local providers and making sure that NHS Continuing Healthcare teams across south east London are following the same procedures.

In 2019/20 the CCG expects to continue to meet the national targets for NHS Continuing Healthcare assessments and to continue to work collaboratively with other south east London CCGs.

1.2.4.5 Medicines optimisation

The Medicines Optimisation Team works to improve the quality of care and treatment available to patients, provide expert advice on prescribing to GPs and ensure that we get the best value from the money we spend on medicine. In 2018/19 we:

- took a lead on initiatives to improve the quality of antibiotic prescribing in general practice as part of the UK five year Antimicrobial Resistance Strategy. The initiatives have enabled a sustained reduction in the prescribing of broad-spectrum antibiotics, with the CCG’s performance in these indicators better than south London, London and England averages. The work undertaken on antimicrobial stewardship was shortlisted for the HSJ 2018 awards;

- used a virtual clinic model to improve the control of high-risk patients with uncontrolled blood pressure across Southwark practices. This work is part of a wider scheme to improve the detection and management of patients with high blood pressure across Southwark and in line with the NHS England strategy for cardiovascular disease (CVD) prevention. The results showed that in the cohort of patients reviewed in the clinic there was a 60% reduction in the risk of Coronary Heart Disease and a 75% reduction in the risk of stroke;
• promoted patient safety by supporting practices to implement national alerts about the risks or specific mediations such as the risk to pregnant women of taking epilepsy medication, Sodium Valproate. The team uses the prescribing system Optimise Rx to target safety messages to practices;

• developed a benzodiazepine resource pack in response to the NHS England letter in January 2018 which aimed to raise awareness of the potential risks of suicide associated with benzodiazepine prescribing and withdrawal. The pack will support health care professionals to review prescribed hypnotics and anxiolytics in primary care and aim to reduce harm associated with inappropriate benzodiazepines.

The Medicines Optimisation team was also shortlisted for a Health Service Journal award for the Atrial Fibrillation virtual clinic project across Lambeth / Southwark and King’s College Hospital NHS Foundation Trust, which saw a reduction of 25% in stroke in Southwark compared to the London average of 5-7%.
1.2.5 Engaging people and communities

Governance and assurance

The CCG has strong leadership and governance in its approach to patient and public engagement as illustrated by the diagram below.

In 2018, the CCG refreshed the terms of reference for the Engagement and Patient Experience Committee (EPEC), which provides assurance to the Governing Body for the engagement work carried out by the CCG, and which is chaired by the lay member for patient and public involvement. The CCG also developed a new role description for local people members of the committee and advertised locally for new members. Three new members were recruited to join an existing local person, alongside Healthwatch and the Forum for Equality and Human Rights in Southwark. Engagement projects for which EPEC provided assurance in 2018/19 included the review of emotional wellbeing and CAMHS services, engagement and patient experience in GP procurement, the internal design workshop for the health centre in Dulwich and the neighbourhood networks workshops with the Local Care Network. EPEC also receives six monthly reports on wider engagement activity and discussed the GP patient survey results.

You can read more about EPEC on the Engagement and Patient Experience Committee page under Get Involved on the CCG website.

The CCG updated its engagement guide for staff and commissioners in 2018 after discussions at EPEC. The guide sets out the principles for engagement that the CCG uses. These are the six principles from National Voices, which apply to the work that the Local Care Network are developing as part of the neighbourhood network work:

- Care and support is person-centred: personalised, coordinated and empowering
- Services are created in partnership with citizens and communities
- Focus is on equality and narrowing inequalities
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers
The CCG has also adopted the NHS England ten principles for participation and these are also outlined in the new guidance that the CCG developed and which can be seen on the our [approach to engagement web page under Get Involved]:

1. Reach out to people
2. Promote equality and diversity
3. Seek participation from people who experience health inequalities and poor health outcomes
4. Value people’s lived experience
5. Provide clear and easy to understand information
6. Plan participation, budget for it and involve people early
7. Be open, honest and transparent
8. Invest in partnerships and on-going dialogues
9. Review experience of involvement
10. Recognise people’s contributions and feedback

The Engagement Advisory Group meets to provide expert advice and guidance on engagement to commissioners and staff once they have drafted an engagement plan based on the CCG guidance. Membership includes Community Southwark, Healthwatch Southwark, the Forum for Equality and Human Rights in Southwark and Southwark Council. You can read more about the Engagement Advisory Group on the CCG website under [meetings and papers in the news and publications] section.

**Patient participation groups**

The CCG continues to support Patient Participation Groups (PPGs) and supports both a north Southwark and a south Southwark PPG. The north PPG meets four times a year and the south PPG meets six times a year. CCG clinical leads attend the meetings. Issues discussed this year include demonstrations of e-Consult, an online platform for patients, Clinical Effectiveness Southwark, update on the new health centre in Dulwich, GP patient survey results, the CCG’s draft policy on patient choice, developing support in the community for people living with cancer, the review of interpreting services and developing neighbourhood networks. Members also feed up issues discussed at the GP surgery PPG. You can find out more about the CCG’s patient participation groups on the locality patient participation groups page under Get Involved on the CCG’s website.

The CCG continues to support the development of PPGs within general practice through the Southwark PPG Network, a supportive forum for both patient and staff members who want to share ideas about developing PPGs. The CCG launched it tops tip for effective PPGs at the meeting in June 2018 as part of national PPG week and facilitated a wide-ranging discussion amongst participants about what they could do in their own PPGs. We followed this up with an interactive training session in November on running effective PPG meetings which was attended by 27 patients and two practice staff. In the February 2019 meeting the CCG provided training on using social media and how this could enhance the reach of surgeries for participation. This was attended by 20 patients and two practice managers. In addition, the membership and engagement team has visited eight GP surgeries or their PPGs to talk about how to develop PPGs or to present and lead discussions on agenda items such as changes at GP practices and procurement, the development of the new health centre in Dulwich and taking forward the five year forward view in Southwark.
You can read more about the PPG network on the Southwark PPG Network page under Get Involved on the CCG’s website.

Support for those who want to get involved.

The CCG’s approach to engagement is to engage with people who have experience of the area of work in which we are engaging. We go out to where local people meet as well as invite people to our meetings. We can provide transport to people who cannot use public transport and we provide refreshments at our meetings. In addition to providing training and informing people about training other partners such as NHS England or the NHS Leadership Academy put on, the CCG provides training. In November 2018 the CCG provided training on running effective engagement meetings and in February 2019 we provided training on social media for engagement as part of Southwark PPG Network meetings (see above). We also provided a training session / induction meeting for the new members of our Engagement and Patient Experience Committee based on our guide for engagement. The CCG also has a user incentive policy to support people taking part in our engagement activity.

Engagement projects

The main programmes of engagement that the CCG has undertaken in 2018/19 are:

- A review of the emotional and wellbeing services and Child and Adolescent Mental Health Services (CAMHS)
- Engaging patients in changes to their GP surgeries
- Workshops with people with three or more long term conditions and PPG members to inform the development of neighbourhood networks
- Developing the new health centre in Dulwich
- The review of the interpreting and translation service in general practice.

Review of emotional wellbeing services and the Children’s and Adolescents Mental Health Service

The CCG and Southwark Council undertook a review of the above in 2018 in order to:

- review the current outcomes and the potential future outcomes of children and young people using the service
- ensure the changing needs of the population group who require support with their mental health and wellbeing can be met through the CAMHS (and wider system) offer
- design a financially sustainable service model
- design an accessible and inclusive service model for all children and young people to enable prevention
- ensure the redesigned offer can meet the required outcomes and performance measures, as well as have the capability to address any potential changes to national strategy and NICE guidelines

A steering group to oversee the review was set up to oversee the and direct the review including the engagement undertaken and this started meeting in 2018. They also considered issues that had been raised by previous engagement carried out by Healthwatch.
Southwark with children and young people in 2016 on mental health and that the CCG had carried out in 2016 to inform the development of the Children and Young People’s Strategic Framework.

As part of the review the CHP partnership commissioning team and the engagement team engaged with local young people and their parent / carers as well as local stakeholders such as head teachers, GPs and other professional who refer to the CAMHS service through the following:

- discussions at GP locality meetings
- a focus group with primary and secondary school teachers, headteachers and safeguarding leads
- discussions with parents / carers at a Contact meeting
- discussions with young carers
- discussions with young people at a CAMHS user group meeting
- surveying all professional groups who refer to CAMHS, resulting in 130 responses
- undertaking an audit of CAMHS referrals including referrals which did not result in receiving the service
- putting on a stakeholder engagement event

Key themes which emerged from the review include the following:
need clarity about what services are available
need more publicly available information about what is on offer locally
there is a wide variety on what is available in local schools
issues around transitioning to adult services

Survey results included the following:

some very positive experiences of the service ‘valuable and inspiring’
the need for more services focused on lower need than is met by the CAM<HS service
genuine understanding of the pressures facing the CAMHS service
communication issues around referrals

Recommendations arising from the review include the following:

The Council and CCG continue to work together to take a Southwark-wide approach to funding and developing children and young people’s service
With the ongoing support of SLAM identify opportunities to improve the efficiency of our acute and specialist services
Consider the future development of mental health and wellbeing services in Southwark as part of:
  o System transformation
  o Service improvement
  o Cross cutting organisational change
Current spend needs to be maintained to cope with current need
Future funding, unless ring-fenced for a specific purpose, should be targeted at prevention and early intervention
Open-access online and face-to-face non-specialist services provided by qualified counsellors
Behaviour support for children and young people with neuro-developmental disability (including learning/intellectual disability) and challenging behaviour is an area requiring investment

The review was completed in October 2018 and it has been agreed that the engagement process will continue. A Reference Group has been set up to help shape the implementation of the findings of the review.

You can read more about the review including the report of all the engagement and the findings of the review on the children and young people’s page under Get Involved on the CCG website.

Changes to GP surgeries

The CCG engaged with patients of local GP surgeries in 2018 to inform the awarding of new contracts for GP surgeries whose contracts were due to end in September 2018. This was part of a London wide procurement exercise. The surgeries in Southwark were:

  Falmouth Road Group Practice
  The Hurley at the Lister
  The Caretaking practice at the Lister (formerly Dr Hossain’s practice)
The approach to engagement that the CCG took was to write to all patients registered at each surgery to explain what was happening, offer the opportunity to attend a day time or evening meeting at the surgery, complete an on-line or paper survey.

The table below shows this engagement for each practice.

<table>
<thead>
<tr>
<th>Name of surgery</th>
<th>Date of letter</th>
<th>Date of meeting</th>
<th>Numbers attending meeting</th>
<th>Dates survey open</th>
<th>Numbers completing survey</th>
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</thead>
<tbody>
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<td>26 January 2018</td>
<td>12 Feb 18</td>
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<td>29 January – 25 February 2018</td>
<td>20</td>
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<td></td>
<td></td>
<td>20 Feb 18</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hurley at the Lister</td>
<td>26 January 2018</td>
<td>13 Feb 18</td>
<td>0</td>
<td>29 January – 25 February 2018</td>
<td>16</td>
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<td></td>
<td></td>
<td>15 Feb 18</td>
<td>0</td>
<td></td>
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<tr>
<td>The Care taking surgery</td>
<td>26 January 2018</td>
<td>13 Feb 18</td>
<td>4</td>
<td>29 January – 25 February 2018</td>
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<td></td>
<td>15 Feb 18</td>
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</tr>
</tbody>
</table>

Themes the engagement highlighted included:

- Importance of a helpful and well organised reception and administrative team
- Ability to book appointments in a timely manner
- Ability to request a male or female GP
- More information about accessing 8 – 8 service
- Ability to book appointments and order medication on line
- Continuity of care is important to some patients
- More information about community pharmacists
- Need for user friendly web site

These themes helped the CCG form questions to ask as part of the tendering process and organisations were also helped.

A Southwark patient was part of the London wide procurement process although not directly involved in the procurement of the Southwark surgeries.

You can read more about the changes in these practices including more detail form the themes of the engagement and the demographics of who responded to the surveys on the changes to GP practices page under Get Involved on the CCG website.

**Supporting care coordination and neighbourhood development**

Following on from the work that the CCG has been supporting over the last two years with the Local Care Network working with people with multiple long-term conditions and care coordination, the CCG organised two workshops in September 2018 with people previously engaged in this work and with member of the north and south Southwark PPGs. The
purpose was to discuss what is important at a local neighbourhood level to help us plan what how we develop neighbourhood networks. The purpose was to discuss what is important at a local neighbourhood level to help us plan what how we develop neighbourhood networks.

17 local people attended the south workshops and 11 local people attended the north workshop. Of those people who filled in monitoring forms at the south workshop 56% identified as White British, 12.5% as Black British – African and 6% as either White Irish, Black British – Caribbean, Asian British – Indian, Chinese or mixed and 67% identified as having a long-term health condition, 33% as having a physical disability, 20% as deaf or hearing impaired and 13% as having mental health needs. Of those who filled in monitoring forms at the north meeting 75% identified as White British, 12.5% as White Other and 12.5% as Black British African, 14% as gay and 75% as long-term health conditions, 50% as having mental health needs, 12.5% as being visually impaired and 12.5% as being deaf or hearing impaired. Two thirds of participants in both workshops were women and the majority of participants in both workshops were over 65, with some people being over 80 and some younger than 65.

Participants took part in a ‘wishing line’ activity to explore what activities they take part in at a local level in Southwark, what organisations they are linked into, what else they might like to do, what they want from their health and care workers and whether there are any barriers to getting involved at a local neighbourhood level.

Many people are linked into community groups or leisure centres to do a range of activities and some people organise leisure or cultural activities with friends. Family is very important.
for people and seeing grandchildren and taking them out to football matches or other things. Some people volunteer with community groups or help out friends and neighbours even thought they might be frail themselves. Some participants want to learn how to use smart phones and or computers as a means of staying in touch with friends and family and the outside world now that they might find it harder to go out and some people would like to be part of peer group with people facing similar issues as themselves. Many participants would like their health or care worker to be able to introduce them to local activities. These issues are being considered as part of the development of the neighbourhood networks. See section 1.2.1.2 of this report.

You can read more about the engagement work that we have done to support the development of care coordination and neighbourhood development on the developing care coordination page under Get Involved on the CCG website.

Developing the new health centre in Dulwich

As we move forward with the project, we are involving patients and staff in the detailed design of the health centre's interior, building on the workshops with the architects that took place in 2015 and 2016.

In November 2018 we held a workshop for local people who will use the health centre and staff who will be working there.

The workshop provided an opportunity to look at and discuss the architect's plans for colours and signs, finishes and floors and ideas for colour combination. This was to ensure the internal design meets the needs of people who have a physical or sensory impairment or who have dementia.

The workshop was attended by 15 local people, 17 NHS provider services staff, five members of the voluntary and community sector, one GP, six members of the programme team, three people from the construction company, the architect and a speech to text typist. Of the 31 people who filled in monitoring forms 79% identified as White British, 10% as Black or Black British African, 7% as Black or Black British – Caribbean and 3.5% as Asian Indian. 43% identified as having a long term illness, 17% as being deaf or having hearing loss, 13%
as having mental health needs, 13% as having physical disabilities and 13% as having other disabilities.

Before the workshop, the CCG visited the following groups and organisations to talk to people to understand their views and what support they would need to take part in the workshop.

- Southwark Dementia Alliance
- Social group at the Southwark Resource Centre
- Blind Aid users and volunteers
- MS Support Group
- Linkage Southwark
- Southwark Disablement Association

The architect showed illustrations of what the interior of the centre could look like including colours, signs, different flooring and their texture and how different colours would work together. The architect also showed an animation of the interior of the building. Participants had many questions and we also had a lot of discussions in smaller groups. A report was written of all issues raised and shared with the architect, the programme team and all participants. A feedback session was held on 28 March 2019 where the architect presented the final design including an updated animation of the centre and explained how people’s feedback had informed the design. This was attended by five patients, eight NHS provider staff, three members of the voluntary and community sector, two colleagues from primary care, four members of the programme team, two people from the construction company, the architect and a speech to text typist.

You can see the updated animation, report from the November workshop and architect’s presentation from the March workshop on the preparing occupation page under improving services in Dulwich under our plans section of the website.

Review of the Interpreting and Translation Service in general Practice

Lambeth, Southwark and Lewisham (LSL) Clinical Commissioning Groups (CCGs) currently commission an interpreting and translation service (ITS) to deliver interpreting and translation support to general practice across the three boroughs. In addition, the service also offers ITS to dentists, optometrists, British Pregnancy Advice Service (BPAS) and Marie Stopes providers who are based in LSL. This activity is recharged to NHS England.

The current service offers a mixture of face to face (F2F), face to face British Sign Language (BSL), telephone, health promotion clinics (where interpreters are block booked for two to three hours) and written translation services. The service is delivered by multiple providers (including directly employed staff) each with their own contractual arrangements in place which are variable.

The CCGs carried out a review of the service in 2018/19 as arrangements were not sustainable either financially, operationally and contractually due to the multiple contracts in place and there is, therefore, a need to commission a more streamlined service.
The CCGs developed a web page on each CCG’s website with text in English and audio files and links to surveys in the following languages as well as a film using British Sign Language (BSL):

1. Arabic
2. Cantonese
3. Mandarin
4. Polish
5. Portuguese
6. Somalian
7. Spanish
8. Turkish
9. Vietnamese
10. BSL

We developed an electronic survey aimed at primary care staff and promoted it through the weekly GP bulletin. We received 80 responses from primary care staff in Southwark. The review was also discussed at the Practice Manager’s Forum, North and south locality meetings and the Practice Nurse Forum.

The CCG proactively contacted voluntary sector and community groups working with users of the most requested languages in Southwark and also spoke about the review at the Forum for Equality and Human Rights in Southwark and north and south Southwark Patient Participation Groups.

The CCG promoted the survey in the following ways:

- 22 tweets between 27 November 2018 and 31 January 2019:
  - explaining the purpose of the review – using video content to support the messaging
  - encouraging followers to tell us their thoughts about services
  - emphasising that translated information is available and directing followers to our website
  - Promoting engagement events with community groups (e.g. Latin American community)
  - Thanking groups for their feedback following engagement sessions
- Email with links to survey to the CCG’s engagement mailing list on 4 December 2018
- Article in the CCG advertorial in the free Southwark Weekender, published on 26 December 2018

The CCG contacted different community groups to go out and visit to talk to local people in having a say about the interpreting service, using independent interpreters to explain the reason for the view, playing the audio files, facilitating discussion and supporting people to fill in paper copies of the survey in translation. We spoke about the review at the following groups and meetings:

- Advising Communities English Class for Spanish people at Pembroke House
- Turkish Cypriot Elders Group
- Vietnamese Mental Health Services
• Advising Communities Spanish Advice session drop in
• Latin American Disabled Person’s Project
• FULA (Age UK Latin American Group)
• Latin American Women’s Right Service
• Southwark Day Centre for Asylum Seekers

57 local people completed the survey with the majority Speaking Spanish (Latin American and European) and the next highest respondent group in Southwark was those speaking Turkish followed by Vietnamese and BSL users. Feedback from patients includes the following:

• (44%) of patient respondents said that they do need an interpreter to help booking an appointment.
• 29 (57%) of patients had not been told about access to an interpreting or translation service on registering with their surgery.
• 23 patients had asked for an interpreter but were told they could not have one (11 stated this for face to face, 9 for telephone interpreting and 3 for BSL).
• Patients at several focus groups mentioned that they were asked to bring along a family member to a GP appointment. Some of these patients said that they preferred a family member. A voluntary sector organisation at the Forum for Equality and Human Rights in Southwark meeting and the Latin American Women's Rights Service stressed the importance of not using family members especially if male family members are used as interpreters for women or girls.
• 22 comments were received about what needs to be improved in the service. These included the service being available at dentists and opticians, better medical terminology knowledge by the interpreters, lack of clarity over the telephone and the need for more interpreters.
• 32 (65%) of respondents said they would consider using an interpreter via a computer screen.

A paper outlining future commissioning options will be drafted for commissioners to consider and will be informed by the themes and issues arising from feedback from the engagement that has taken place.

You can read more about the review including the full engagement report on the review of interpreting and translation services page under Get Involved.
1.2.6 Reducing health inequality

1.2.6.1 The work of the Health and Wellbeing Board

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

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

The Health and Wellbeing Board met three times in 2017-18. Over the course of the year the board reviewed a number of items of business including; an overview of Southwark Health and Wellbeing Strategy and Progress to date; Mental Wellbeing of Young People in Southwark - Southwark’s Joint Strategic Needs Assessment (JSNA); Building Healthy Communities - Strategic Estates Planning; and Alcohol Action Plan 2017 – 2020; and Joint Review of Emotional Wellbeing and CAMHS Services.

The Board approved and monitored the Better Care Fund 2018-19. It also received regular updates for partner organisations.

Further details of the Southwark Health & Wellbeing Board can be accessed on Southwark Council’s website.

1.2.6.2 Our approach to equality, diversity and inclusion

1.2.6.3 Building on our approach to equality, diversity and inclusion

CCGs have a statutory duty to ensure that commissioning decisions reduce inequalities, improve quality of services for all patients, and involve and engage with a broad spectrum of individuals and communities (Health and Social Care Act 2012). At the same time, the Equality Act 2010, which incorporates the public sector equality duty (PSED), requires that CCGs, when commissioning services, do not unlawfully discriminate and must promote equality for the needs of people from the nine protected groups.

In 2018, NHS Southwark CCG has worked with pace and enthusiasm to continue building on the work of the previous year in embedding an active culture to respect equality, diversity and inclusion to both meet legal responsibilities and implement good practice.

This year the CCG has delivered progress in the following areas:

- Regularly keeping Governing Body up to date with the current issues of equality & inclusion and actively engaging the Governing Body’s lead
- Continuing to support the Equality Leadership Group, chaired by the Managing Director, to set and maintain the strategic focus for the CCG and coordinate and oversee the equality and diversity work programme.

Page 63 of 162
Further implementation of the NHS Equality Delivery System (EDS2), a performance improvement tool. Resulting in key feedback supporting the development of equality objectives.

Undertaken a range of patient and public engagement activities, which have ensured engagement with all groups, especially those less involved in healthcare commissioning.

Continuing to implement the NHS Workforce Race Equality Standard (WRES), both as an employer and as a commissioner of services. Taking a local system-wide view of the findings and looking at overarching themes that require constructive ways for the local NHS system to collaborate and implement the findings.

Delivering Governing Body leadership sessions on equality and inclusion.

Provided staff training on equality and diversity.

Monitored key providers on their equality duties as part of the clinical quality review process.

Equality objectives

A new set of Equality Objectives 2018-2022 have been developed, aligned to the NHS EDS2 and published along with the corporate action plan for 2018-2019.

The CCG continues to implement the EDS2 framework and will be looking at reviewing further services during 2019.

Equality Delivery System (EDS2)

The Equality Delivery System (EDS2) is a performance improvement tool to monitor and improve equality and diversity across four domains or ‘Goals’:

Goal 1: Better patient outcomes

Goal 2: Improved access and experience

Goal 3: A representative and supported workforce

Goal 4: Inclusive leadership

The EDS2 helps CCGs meet its Public Sector Equality Duty by reviewing its equality performance on each of these goals annually through evidence gathering and engagement with a range of stakeholders, including commissioning staff, provider organisations, patients, carers, members of the public, voluntary sector organisations and CCG Governing Body members. The purpose of the assessment to ensure the CCG is transparent and accountable to its key stakeholders and is working to continuously improve itself.

In 2018, the CCG continued to implement the EDS2. Using the information gathered from the three service reviews in 2017 - 2018 to create equality improvement action plans which have been regularly monitored through the Equality Leadership Group. The services we focused on were:

- Talking Therapies Southwark (IAPT)
- The Extended Primary Care Service (the 8 – 8 service)
- Continuing Healthcare
During 2018, the CCG has utilised a mix of organisational evidence, staff survey results, survey of Governing Body members and a panel including lay members and an external independent assessor to help us grade EDS2 Goals 3 and 4. Action to address some of the issues identified are included in the corporate action plan.

The CCG has also published its Workforce Race Equality Action Plan findings and actions which contribute to the corporate action plan.

You can read more about the engagement we carried out and the action plans that we have developed on the equalities page under shaping services under get involved on the CCG website.

One of the key actions in relation to address goal 3: a happy and representative workforce was to organise a staff away day on diversity, development and wellbeing and you can read more about this work in section 2.2.2.6.

Full details of the CCG’s work on equality and diversity can be found by following the link: http://www.southwarkccg.nhs.uk/about-us/equality-and-diversity/Pages/default.aspx.

1.2.6.4 Reducing diabetes and obesity

Diabetes Prevention

In 2018/19 Southwark CCG provided access to three pre-diabetes prevention programmes for people at risk of developing aged 18 years and over. These are:

- National Diabetes Prevention Programme (NDPP) which required attendance at 13 group sessions over nine months
- Walking Away from Diabetes; a three-hour workshop
- A digital option called OVIVA Prevent.

In Southwark we have seen an exponential increase in the number of people diagnosed with pre-diabetes rising from approximately 4,500 people in 2015 to over 23,000 people in 2019. To help address this rise over 2,000 people have been referred to the national prevention programme and over 80% of these people attended for assessment. The number of annual places available for the Walking Away from Diabetes programme increased in 2018-19 from 1,000 to 3,000 places. The OVIVA digital option was available from spring 2019.

People with diabetes can now attend diabetes self-management programmes anywhere in south London at a time and place convenient to them.

Tackling obesity

Southwark launched a pilot weight management programme in October 2017 based on healthy eating and physical activity with medical oversight and intervention. This programme is referred to as our Balance intervention. More recently the programme introduced a Total Meal Replacement (TMR) option (800 calories) within a multidisciplinary approach. This intervention is delivered over 12 months in a group setting. The first group to receive the TMR intervention started in October 2018. Average weight loss in the initial 12 week period was 14 Kg. Two further groups will start in February 2019 and a further three groups will start in March 2019.
Before launching TMR, we carried out extensive engagement to help us develop the specification for the programme. Several local residents were involved in helping develop the initial programme and have continued to support it acting as healthy weight champions and attending group sessions.

Motivated Individuals are referred by their GP and booked into an individual assessment with a specialist dietician. At this session the dietician and individual decide whether to opt for the TMR option or the more traditional healthy eating approach.

People attend 15 two-hour group sessions over a 12-month period. These sessions are delivered by a specialist dietician, psychologist and physical activity specialist. Individuals can opt into a portfolio of psychological interventions. A specialist app (OVIVA) with facilitated group discussions and direct interaction with the dietician and psychologist is available for use between group sessions.
1.2.7 Sustainable Development

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

We recognise sustainability goes beyond carbon emissions and environmental sustainability and have incorporated financial and social sustainability into our Procurement policy.

Statement of commitment

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

In our commissioning processes, this means designing services with sustainability in mind. Practically this means the CCG should make sure we do the following: plan services which are efficient and effective; procure services which provide highest quality at best value and which have the least impact on the environment, offer positive sustainable employment and deliver value for money.

Sustainability in commissioning

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

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

Sustainability within our organisation

Southwark CCG shares office accommodation with Southwark Council which was designed to the highest environmental standards including a biomass boiler and rainwater harvesting. As part of its approach to waste minimisation and management the council offices have systems in place for the recycling of paper, plastic and food waste. We continue to use a software application that enables governing body members to receive all agendas and papers electronically, reducing the requirement to produce paper copies.

Andrew Bland
Accountable Officer
24 May 2019
2 ACCOUNTABILITY REPORT

This section consists of the:

- Corporate Governance Report
- Remuneration and Staff Report for the CCG
- (The CCG is not required to submit the Parliamentary and Audit Report as it does not report directly to the UK parliament).

The Corporate Governance Report includes the Members Report, Statement of Accountable Officer’s Responsibilities and the Annual Governance Statement. The report explains the composition of the governance structures for the CCG and mechanisms that have been put in place to support the achievement of the CCG’s objectives. The CCG’s Constitution clearly sets out how it will demonstrate its accountability to members, local people, stakeholders and NHS England and affirms the Governing Body’s role in reviewing the CCG’s arrangements to ensure the principles of good governance are always upheld.

The Annual Governance Statement provides assurance on the CCG’s governance. It lays out the details of the CCG leadership in terms of individuals fulfilling various roles in the Governing Body, which takes all major decisions on behalf of the CCG. It presents details on self-effectiveness assessment and development of the Governing Body. The CCG’s risk framework is an important element of the internal control environment; it explains how the CCG identifies, evaluates and controls risks associated with the CCG’s commissioning functions and statutory responsibilities. The report also contains the head of internal audit opinion which provides assurance on the internal audits completed during the year. The CCG is also required to seek external audit assurances as well as third party assurances for its suppliers. These are presented on a regular basis to the CCG’s audit committee.

The Remuneration and Staff Report sets out the CCG’s remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers. In addition, the report provides details on remuneration and staff employment. It also provides information on persons in senior positions having authority or responsibility for directing or controlling major activities within the CCG i.e. those influencing the decisions of the whole CCG.
2.1 Corporate Governance Report

2.1.1 Members Report

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

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


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

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

2.1.1.1 Member profiles

See above

2.1.1.2 Member practices

From NHS Southwark CCG is made up of 36 practices delivering GP services over 40 sites. The average Southwark practice size is 8,500 registered patients.

There are two GP federations: Quay Health Solutions (QHS) in north Southwark and Improving Health Limited (IHL) in south Southwark.
Southwark practices are as below:

<table>
<thead>
<tr>
<th>North Southwark</th>
<th>South Southwark</th>
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<tbody>
<tr>
<td>301 East Street Surgery</td>
<td>3-Zero-6 Medical Centre</td>
</tr>
<tr>
<td>Albion Street Group Practice</td>
<td>Acorn and Gaumont Surgery</td>
</tr>
<tr>
<td>Bermondsey Spa Medical Practice</td>
<td>Camberwell Green Practice</td>
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<tr>
<td>Blackfriars Medical Practice</td>
<td>Concordia Melbourne Grove Medical Practice</td>
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<tr>
<td>Borough Medical Centre <em>(Dr Misra)</em></td>
<td>Concordia Parkside Medical Centre</td>
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<tr>
<td>Borough Medical Centre <em>(Dr Sharma)</em></td>
<td>DMC Chadwick Road</td>
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<tr>
<td>Falmouth Road Group Practice</td>
<td>Dulwich Medical Centre</td>
</tr>
<tr>
<td>Maddock Way Surgery</td>
<td>Elm Lodge Surgery</td>
</tr>
<tr>
<td>Nexus Health Group - Aylesbury Medical Centre</td>
<td>Forest Hill Road Group Practice</td>
</tr>
<tr>
<td>Nexus Health Group - Bermondsey &amp; Lansdowne Medical Mission at Decima</td>
<td>Hambledon Clinic</td>
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<tr>
<td>Nexus Health Group - Bermondsey &amp; Lansdowne Medical Mission at Artesian Health Centre</td>
<td>Lister Primary Care Centre - Dr Arumugaraasah</td>
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<td>Nexus Health Group - Commercial Way Surgery</td>
<td>The Lister Practice</td>
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<td>Nexus Health Group - Dun Cow Surgery</td>
<td>Nunhead Surgery</td>
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<td>Nexus Health Group - Manor Place Surgery</td>
<td>Queens Road Surgery</td>
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<tr>
<td>Nexus Health Group - Sir John Kirk Close Surgery</td>
<td>St Giles Surgery, Drs Roseman &amp; Vasant</td>
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<tr>
<td>Nexus Health Group - Surrey Docks Health Centre</td>
<td>St Giles Surgery, Dr Begley</td>
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<tr>
<td>Old Kent Road Surgery</td>
<td>Sternhall Lane Surgery</td>
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<tr>
<td>Park Medical Centre</td>
<td>The Gardens Surgery</td>
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<tr>
<td>Penrose Surgery</td>
<td>The Lordship Lane Surgery</td>
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<td>Silverlock Medical Centre</td>
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<td>The New Mill Street Surgery</td>
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<td>The Trafalgar Surgery</td>
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<tr>
<td>Villa Street Medical Centre</td>
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2.1.1.3 Composition of Governing Body

Chair and Managing Director

- The CCG Chair is Dr Jonty Heaversedge
- Ross Graves is the Managing Director for the CCG

South East London Alliance of CCGs - Persons with significant management control:

- Andrew Bland is the Accountable Officer for South East London Alliance of CCGs, and the SEL Strategic Partnership (STP) Senior Responsible Officer.
- Usman Niazi – Chief Financial Officer for South East London Alliance of CCGs

CCG directors

The directors of the CCG are as follows:

- Malcolm Hines, Director of Finance (Bexley, Bromley and Southwark)
- Kate Moriarty-Baker, Director for Quality and Chief Nurse
- Caroline Gilmartin, Director of Integrated Commissioning (until March 19)
- Sam Hepplewhite, Director of Integrated Commissioning (joined Feb 19)
- Ross Graves, Managing Director, also deputising for Director of Transformation
- Mark Kewley, Director of Transformation, is seconded to a role at NHS England, London.

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. See AGS for details on composition of the Governing Body.

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

Governing Body appointments in 2018-19

GP Clinical Leads

In May 2018, following contract expiry of 4 GP clinical leads and 1 practice nurse posts of the Governing Body, NHS Southwark CCG started the selection election process for recruitment to these posts. In June, the CCG wrote to all eligible GPs on the Southwark ‘performers list’ and practice nurses to invite self-nominations for anyone interested in standing for these posts. All GPs registered in Southwark (including locums) working a minimum of one session per month were eligible to stand.

The selection / election process involved a self-nomination, a selection interview involving an independent panellist, followed by an election. The CCG engaged Electoral Reform Services (ERS) to run the election for the CCG to ensure equity and transparency.
After no other nominations were received for the post of GB Clinical Lead Practice Nurse, Linda Drake was re-elected unopposed, as is the practice in uncontested elections.

The self-nomination stage for the 4 GP clinical leads posts closed on Monday 14 May 2018, with the CCG receiving five applications by the deadline.

All applicants undertook and passed the selection process.

Total no. of nominations/applications received = 5

No. of applicants interviewed = 5

In the ensuing elections conducted independently by ERS, each GP in Southwark was allowed to vote. The ballot closed on 10 June and the following GPs were re-elected:

Re-appointed members: Dr Jonty Heaversedge, Dr. Nancy Kuchemann, Dr. Emily Gibbs and Dr. Robert Davidson.

Lay member (Patient and Public Involvement)

This post was advertised for in October 2018; in addition to the current post-holder there was one other applicant. After an interview process was completed, Joy Ellery was re-elected as the lay member for patient and public involvement for a period of 3 years.

Secondary Care Doctor on the Governing Body

The contract for Secondary Care Doctor expired in February 2019. It was extended by one year to February 2020 to align with South East London Alliance’s collaborative working review across south east London CCGs.

Directors on Audit Committee

There are no directors as ‘members’ of the CCG Audit Committee.

The Accountable Officer, Chief Financial Officer, Director of Finance and Managing Director are in attendance only.

2.1.1.4 Committee(s), including Audit Committee
See 2.1.3.3 - Committees of the Governing Body

2.1.1.5 Register of Interests

The CCG follows its Conflict of Interest Policy which is aligned to NHS England guidance Managing conflicts of interest: Revised statutory guidance for CCGs 2017 released in June 2017.

All requisite registers are published on the CCG website.

NHS Southwark CCG’s Register of Interests and is made publicly available on the CCG’s website at [http://www.southwarkccg.nhs.uk/about/Governance/Pages/ConflictofInterest.aspx](http://www.southwarkccg.nhs.uk/about/Governance/Pages/ConflictofInterest.aspx)
The register is maintained by CCG Governance team and is constructed in line with national guidance and the CCG’s Conflicts of Interest Policy which can be found at: http://www.southwarkccg.nhs.uk/news-and-publications/publications/policies-strategies-registers/Pages/default.aspx.

The Register of Interests contains details of all members of the CCG’s Governing Body and its formal committees and sub-committees, as well as senior staff involved in procurement, recruitment and contract management. The interests of those individuals that are in attendance only are captured in the minutes of the meeting concerned unless those in attendance are employees of the CCG or the Commissioning Support Unit (the arrangements for those individuals are addressed by their contract of employment and their Job description) who are not members of the committee in question. The register is reviewed every quarter by the Audit Committee and published on the CCG website, along with the gifts and hospitality register and the procurement register.

2.1.1.6 Personal data related incidents

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

2.1.1.7 Statement of Disclosure to Auditors

Each director of the CCG at the time the Members’ Report is approved, confirms:

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

Modern Slavery Act

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

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities),
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

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

• Prepare the financial statements on a going concern basis.

• Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Southwark CCG’s auditors, KPMG, are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Andrew Bland
Accountable Officer
24 May 2019
2.1.3 Governance Statement

2.1.3.1 Introduction and context

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

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

As at 1 April 2018, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006:

- NHS Southwark Clinical Commissioning Group has been authorized to commission health services for its population https://www.england.nhs.uk/ccg-details/
- In 2018-19, the clinical commissioning group’s licence continued being approved without conditions.

NHS Southwark Clinical Commissioning Group is a membership organisation made up of 38 practices on 43 sites, as on 31 March 2019. We are responsible for commissioning healthcare services for the people of Southwark. Our Constitution sets out the way we operate.

As a member organisation we work through the Council of Members and our Governing Body to ensure health services are commissioned effectively and meet the needs of local people. We do this in line with our agreed mission, vision and values. The CCG is made up of two localities, North Southwark and South Southwark, together comprising all of our 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, NHS Improvement, King’s Health Partners and Healthwatch Southwark to ensure that our combined efforts have the greatest impact and to oversee the delivery of the Health and Wellbeing Strategy for Southwark.

We work together with other CCGs, across south-east London in particular, on areas where our local strategies find common ground, and have established the South East London STP and South East London Alliance of CCGs in collaboration with NHS England.

Scope of responsibility

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

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

2.1.3.2 Governance arrangements and effectiveness

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

CCG Constitution:

The CCG’s constitution is made between the members of NHS Southwark Clinical Commissioning Group and has effect from first day of April 2013, when the NHS Commissioning Board established the group. The constitution is published on the CCG website and applies to all of the member practices, the CCG’s employees, individuals working on behalf of the CCG, anyone who is a member of the CCG’s governing body, representatives on the council of members, and any other committee(s) established by the CCG or its governing body. The CCG’s constitution is available here: https://www.southwarkccg.nhs.uk/news-and-publications/publications/policies-strategies-registers/Documents/Southwark%20CCG%20Constitution%20-%20July%202018.pdf

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.

Scheme of Reservation and Delegation:

The constitution contains the Scheme of Reservation and Delegation which sets out the key functions of the CCG and to whom the CCG has delegated responsibility for fulfilling them.
Governance Structure:

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. Some committees of the Local Authority where the CCG is represented are also shown.

Figure 1 – Governance Structure of NHS Southwark CCG

Council of Members

Representatives from all member practices constitute the Council of Members; meetings are held regularly throughout the year. This is the forum where clinicians from member practices can engage directly with and hold to account the Governing Body. The Council of Members met four times during the year (23 May 2018, 19 September 2018, 13 February 2019 and 27 March 2019). The Council of Members receives regular updates on the CCG financial position, approves the CCG budgetary framework, constitution changes and contributes to the development of the priority areas of work for the CCG to take forward.

The Council of Members has delegated most governance related duties to the CCG Governing Body whilst retaining key responsibilities such as signing off CCG plans, Annual Accounts and Annual Report and approving changes to the CCG Constitution. More details are available in the CCG’s Scheme of Delegation. The Council of Members holds the
Governing Body accountable for ensuring the CCG carries out its obligations as set out in the NHS Act 2006 (as inserted by section 26 of the 2012 Act).

Dr Jonathan Love is the Chair of Council of Members and Dr Mitu Pandey the Deputy Chair.

The Governing Body

The Governing Body for NHS Southwark CCG ensures that the CCG has appropriate arrangements for complying with its obligations under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and such generally accepted principles of good governance as are relevant to it.

The Governing Body does this through its main function which is to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance.

The CCG Constitution serves as the terms of reference for the discharge of functions by the Governing Body.

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

Composition of the Governing Body

The Governing Body for NHS Southwark CCG has strong clinical leadership and comprises:

- Six GP Representatives of Member Practices - one of whom is the Chair of the Governing Body – all voting; Chair does not have a casting vote,
- Four lay members - one of whom is the Deputy Chair of the Governing Body – all voting,
- Two registered nurses - one from community care and one nurse from a Member Practice – both voting,
- one Secondary care specialist doctor - voting,
- Accountable Officer - voting,
- Managing Director – voting,
- Chief Financial Officer – voting,
- Director of Finance – non-voting,
- Director of Public Health/ Deputy - voting,
- Local Health Watch representative - voting,
- Local Authority representative – non-voting,
- LMC representative – non-voting,
- CCG Director of Integrated Commissioning – non-voting,
- CCG Director of Quality and Chief Nurse – non-voting,
- CCG Director of Transformation – non-voting,
- Secondary Care Doctor from local NHS trust (co-opted member) – non-voting.
The responsibilities and scope of work of the Governing Body is detailed in the CCG’s Constitution.

2.1.3.3 Committees of the Governing Body

The Governing Body has appointed the following committees, all of whom have delegated authority to form sub-committees to assist them in the discharge of their duties. Highlights of the work carried out by the different committees are as follows:

Audit Committee: The CCG Audit Committee membership is made up of four lay members and two clinical leads. The Director of Finance is a regular attendee. The committee is also attended by the internal and external auditors, counter fraud service manager and other officers of the CCG, as required. The committee met five times during the year including two end-of-year meetings in April and May to sign off draft and final accounts and Annual Report. The year-end meetings are attended by representatives of the CCG Council of Members.

All meetings during 18-19 were well-attended by lay members and Clinical Leads. All meetings were quorate. The committee is chaired by the lay member leading on audit and governance. Some of the significant issues that the committee considered and reviewed were internal audit reviews as detailed in the Head of Internal Audit Opinion section, external audit report, audit plans, Counter fraud and Security management workplans, risk analysis and progress updates. The committee also regularly received the registers for publication for sign off (i.e. Conflicts of Interest Register, Gifts and Hospitality Register and Procurement Decisions Register). There were also some useful benchmarking reports produced by internal audit on risk management and conflicts of interest management across London CCGs. The committee routinely received finance and governance updates and approved the tenders and waivers reports each quarter.

Remuneration Committee: There were two Remuneration committee meetings during the year to decide on:
- remuneration for the Lay member Chair of SEL Integrated Governance and Performance Committee and
- the extension of Secondary Care Doctor contract.

See Remuneration Report for details of the membership of the Remuneration Committee.

Integrated Governance and Performance Committee: The Committee provides oversight of the activities of the CCG and providers, particularly in respect of: finance, QIPP, performance, Assurance and governance, quality, and safety. It received a Board Assurance Framework and Risk Report every month.

This committee met every month of the year 2018/19 and quorum requirements were satisfied. Regular agenda items include: finance report, risk reporting and board assurance framework, and the Improvement and Assessment Framework assurance report, quality updates.

The IGP discussed strategic risks on a regular basis and recommended the report to the Governing Body. The committee also monitored assurances on effective functioning of the following areas for both the activities of the CCG and of its main contracted providers: safeguarding – adults and children; medicines management, continuing healthcare;
information governance; equality delivery system; human resources policies, information governance toolkit, emergency planning and business continuity.

The committee regularly received minutes from its sub-committees: Quality and Safety Sub Committee, Information Governance Steering Group, Safeguarding Executive, Medicines Management Committee, Lambeth and Southwark ICT Steering Group.

*Commissioning Strategy Committee:* The Commissioning Strategy Committee met every month of the financial year 2018-19. Every meeting held met quorum requirements and had good attendance from clinical and non-clinical Governing Body members. The committee scrutinised, debated and recommended CCG commissioning plans, strategies and proposals to the Governing Body. The committee was also regularly attended by the finance, performance and quality leads within the CCG. It received Locality Reports on a regular basis.

Some of the items the committee considered during the year were as follows: Review of Partnership Commissioning Team, 360 degree stakeholder survey feedback, Update on Southwark Community based Care Programme, CYP Health Partnership – GSTT Charity Offer and Reporting, CAMHS Review, Voluntary Care Sector Strategy, Lambeth, Southwark and Lewisham HIV Transition Programme, Optimising Referrals, Determinants of emergency department activity metrics, Partnership Southwark updates, Minor Eye Conditions Scheme business case and Latent TB Screening Programme update.

*Commissioning Development Groups (CDGs) and the Joint Commissioning Strategy Committee (JCSC):*

Three Commissioning Development Groups (CDGs) drive forward the partnership commissioning agenda for Children and Young People, Adults and Serious Mental Illness continued to meet monthly during 2018-19. The groups also provide a forum for the joint discussion of any commissioning work streams that will benefit from ensuring an integrated approach is taken. The group members include senior representatives from the Council and CCG commissioning functions, Public Health and clinical leads together with Healthwatch representation. The groups have a key role in developing the population based approach to commissioning as set out in the Five Year Forward view. This involves looking at the needs of population groups and considering how to best align commissioning and service provision across organisations to better improve outcomes.

*Adults CDG:* Some of the items the group discussed in 2018-19 were as follows: Development of the Bridges to Health and Wellbeing population based commissioning model including adults’ prioritisation areas for phase 1; Intermediate Care – business case for further accommodation based models; Voluntary Sector Hub model and Social Prescribing; Nursing Care Strategy; Delayed transfers and updates on work of the Southwark and Lambeth Transfers of Care Group; Dementia pathway work and Carers Strategy.

*Children and Young People’s CDG:* Items considered by this group in 2018-19 were: Child Health and Wellbeing Strategy; Parents and Communities Together (PACT); NHS Long Term Plan; Maternity issues, early help offer and CAMHS review.
Serious Mental Illness (SMI) CDG: The group received presentations from Public Health on Joint Strategic Needs Assessment in relation to personality disorder, prescription drugs and rough sleepers. We also have regular discussions in connection with substance misuse and dual diagnosis and have had several updates from the CCG’s Medicines Optimisation Team; update on the Mental Health Strategy delivery programme during every meeting.

Joint Commissioning Strategy Committee (with Southwark Council): met every quarter and considered the work of the CDGs. Its business during 2018-19 consisted of: Development of the Bridges to Health and Wellbeing approach to joint population based commissioning for outcomes; Review and oversight of work undertaken by Commissioning Development Groups and the Partnership Commissioning Team; Discussions on Community Based Care programme including Partnership Southwark; Review of future arrangements for the Partnership Commissioning Team, Review of CAMHS; Homelessness and Health and Review progress of integration between social care and community health (Intermediate Care Southwark)

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

In 2018, the CCG refreshed the terms of reference for the Engagement and Patient Experience Committee (EPEC), which provides assurance to the Governing Body for the engagement work carried out by the CCG, and which is chaired by the lay members for patient and public involvement. The CCG also developed a new role description for local people members of the committee and advertised locally for new members. Three new members were recruited to join an existing local person, alongside Healthwatch and the Forum for Equality and Human Rights in Southwark. Engagement projects for which EPEC provided assurance in 2018/19 included the review of emotional wellbeing and CAMHS services, engagement and patient experience in GP procurement, the internal design workshop for the health centre in Dulwich and the neighbourhood networks workshops with the Local Care Network.

Primary Care Commissioning Committee: CCG delegated commissioning of primary care in 2017/18 along with the other CCGs in south east London. As a result, the committee became Southwark’s Primary Care Commissioning Committee. This committee met in public six times during 2018/19. The agenda for the committee in this period was a blend of issues pertaining to general practice in Southwark especially mergers, closures, procurements, PMS negotiations, CQC inspections, procurement of clinical services at Dulwich site. Every meeting held in the year was quorate. For details please see pages 35-36 of Annual Report.

All 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 into them. The Governing Body has approved and keeps under review the terms of reference for the committees, which includes information on the membership of the committees.

**Other Joint Committees**

1. **South East London (SEL) Integrated Governance and Performance Committee:** This committee was set up with a view to seek assurance on issues affecting finances and provider performance across CCGs in south east London. The committee is made up of Accountable Officers, Chief Financial Officers and key directors in SEL CCGs.

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

3. **Lambeth, Southwark and Lewisham (LSL) Infection Control Committee:** LSL Infection Control Committee met quarterly to ensure LSL CCGs fulfilled the criteria set out in the Health and Social Care Act 2008 and other relevant infection control standards. This committee reports to the Integrated Governance Committees in Lambeth and Southwark CCGs. It is currently chaired by the Director of Public Health in Lambeth. The committee draws membership from a range of healthcare stakeholders across the patch, including membership from all three acute trusts located in LSL, corresponding community and CCG infection control leads, representatives from medicines management teams, Public Health England South London Health Protection team and Lambeth and Southwark public health teams. The committee oversees infection control activities and develops and annual work plan covering primary and secondary care. At each meeting the members review progress against actions along with mandatory surveillance targets and any local issues arising in the previous quarter.

4. **Health and Wellbeing Board:** Established and hosted by the local authority, the Health and Wellbeing Board brings together the NHS (CCG), public health, adult social care and children’s services, including elected representatives and Southwark Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health (see section 1.2.6.1 The work of the Health and Wellbeing Board).

5. **Health and Social Care Partnership Board:** The Health and Social Care Partnership Board includes senior commissioning, finance and public health leads meets quarterly. It focuses on the governance of joint arrangements under Section 75 arrangements such as the provision of population health services commissioned by the CCG on behalf of the council, and the Better Care Fund pooled budget. It also discusses public health issues, including the development of the JSNA and the provision of public health support to commissioners. Key items considered by the board in 18-19 were as follows: Oversight of Section 75 agreements for public health services commissioned via the CCG on behalf of the council, and monitoring of performance; oversight of Integrated Community Equipment Services (ICES)
Section 75 agreement; monitoring and development of the Better Care Fund Section 75 pooled budgets arrangements; discussions on future Section 75 agreements for mental health services and oversight of JSNA workplan.

**Governing Body Attendance:**

**Attendance record for public meetings in 2018-19**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Attendance</th>
</tr>
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<tbody>
<tr>
<td>1  Dr Jonty Heaversedge</td>
<td>Chair and GP Clinical Lead</td>
<td>5/6</td>
</tr>
<tr>
<td>2  Andrew Bland</td>
<td>Accountable Officer</td>
<td>6/6</td>
</tr>
<tr>
<td>3  Usman Niazi</td>
<td>Chief Financial Officer</td>
<td>1/6</td>
</tr>
<tr>
<td>4  Malcolm Hines</td>
<td>Director of Finance/Deputy MD</td>
<td>6/6</td>
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<tr>
<td>5  Ross Graves</td>
<td>Interim Managing Director</td>
<td>6/6</td>
</tr>
<tr>
<td>6  Kate Moriarty-Baker</td>
<td>Director of Quality and Chief Nurse</td>
<td>4/6</td>
</tr>
<tr>
<td>7  Caroline Gilmartin</td>
<td>Director of Integrated Commissioning (until 20/3/19)</td>
<td>6/6</td>
</tr>
<tr>
<td>8  Sam Hepplewhite</td>
<td>Director of Integrated Commissioning (from 5/2/19)</td>
<td>1/6</td>
</tr>
<tr>
<td>8  Dr Nancy Kuchemann</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>9  Dr Noel Baxter</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
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<tr>
<td>10 Dr Yvonneke Roe</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>11 Dr Emily Gibbs</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>12 Dr Robert Davidson</td>
<td>GP Clinical Lead</td>
<td>6/6</td>
</tr>
<tr>
<td>13 Prof Ami David</td>
<td>Registered Nurse</td>
<td>3/6</td>
</tr>
<tr>
<td>14 Linda Drake</td>
<td>Practice Nurse Lead</td>
<td>4/6</td>
</tr>
<tr>
<td>15 Dr Richard Gibbs</td>
<td>Vice-Chair and lay member</td>
<td>6/6</td>
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<tr>
<td>16 Robert Park</td>
<td>Lay member</td>
<td>6/6</td>
</tr>
<tr>
<td>17 Joy Ellery</td>
<td>Lay member</td>
<td>5/6</td>
</tr>
<tr>
<td>18 Andrew Nebel</td>
<td>Lay member</td>
<td>6/6</td>
</tr>
<tr>
<td>19 Dr Michael Khan</td>
<td>Secondary Care Consultant</td>
<td>4/6</td>
</tr>
<tr>
<td>20 Prof Kevin Fenton</td>
<td>Director of Health and Wellbeing, London Borough of Southwark</td>
<td>4/6</td>
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An online self-assessment survey was conducted by the CCG’s Governing Body members during March 2019 to individually assess how effective they considered the Governing Body had been over the past year. In all there were 11 out of 16 respondents, achieving a response rate of 68.75%.

Questions sought respondents’ views about the effectiveness of the Governing Body, clarity about individuals’ roles in performing Governing Body duties as well as their view on main committees of the governing body; challenge provided by the Governing Body, role in ensuring effective financial control, planning and value for money as well as suggested areas of improvement.

The following observations were made based on the 11 responses.

- All respondents agreed that the Governing Body understands what its role is and has been clear on responsibilities that can be delegated to committees or officers and those which should be reserved to the Governing Body. (up from 92% last year).
- 91% (10) respondents were ‘very clear’ about their role as the GB member, while 1 was ‘somewhat clear’. (up from last year when it was 84%).
- 81.82% (9) respondents felt that overall NHS Southwark CCG Governing Body does a good job of holding the CCG to account for the delivery of their goals and strategic objectives.
- 90.91% (10) respondents feel that the Governing Body ensure effective financial control, financial planning and value for money (this is the same as last year).
- 100% of members are satisfied with the CCG’s conflict of interest arrangements, (this is same as last year).
- 81.82% (9) respondents feel that the Governing Body is effective in assuring quality and safety of commissioned services. (up from last year’s 69%)
- 90.91% felt the Governing Body encourages critical challenge of colleagues to ensure the best decision is made. (this is up from 69% last year)
- 91% (10) respondents agree that the Governing Body has adequate opportunity to explore challenges and opportunities NHS Southwark CCG might face. (up from last year when it was 84%).
- 90.91% (10) respondents agreed that the Governing Body works as an effective team (up from 76% in 2018)
- 81.82% respondents think the committees they sit on perform useful functions (this is marginally down from last year when it was 84%). 2 individuals somewhat agreed with this statement.
- The verdict was evenly split when asked if the committees they sat on had too many items for information.
- When asked if the information they are asked to read and review in preparation for meetings is presented in a digestible form; the majority (27% agreed and 63.63% somewhat agreed, which may be an area for improvement in future).
- 63.64% respondents feel able to contribute to effective engagement with the community and stakeholders; while 36.36% somewhat agree that they do.

Q9 - When asked how the effectiveness of meetings could be improved, the members responded with the following suggestions:

- Receiving meeting papers consistently in a timely manner
- Short breaks between packed back to back meetings
- Clearer identification of specific issues needing decision or discussion and encouraging individuals with specific interests/ knowledge in the subject matter to speak up more
- Shorter and business specific agendas, lesser time on NHS restructuring matters
- Chair training

Q19 When asked what the Governing Body should do more or less of, the members responded with the following suggestions:

“The informal lunch time meetings with Clinical Leads and Lay Members have turned out to be really helpful in discussing a range of topics that may not make formal committee time or act as very useful briefing for up and coming meetings. As much informal but focussed time as possible helps us understand and work with each other better. I consider the GB of SCCG to be well led and the Clinical Leads supported by the commissioning team officers to enable them to make a valuable contribution. The SMT and their teams prepare their documentation and presentations clearly, and the clinical leads feel able to challenge decisions between themselves and with the officers. The chairman’s approach to team building and his concept of taking a mindful approach to our work has been central in ensuring the GB functions well and also this has resulted in the SCCG being a caring organisation. Challenging issues such as some members of staff’s negative workplace experiences are swiftly addressed and brought into the open, allowing remediation at whole organisation level to occur. The CCG awayday, addressing employees’ experiences of discrimination, bullying/ harassment is a good example of how seriously SCCG takes potential inequalities and promotes a healthy working environment”.

“Wider discussions with informal networks and those more directly impacted by the service, performance and governance issues. Unfortunately, there is limited resource in time and capacity to get a fully representative discussion”.

“We will have to rethink what we need to do locally as the SEL structure takes further steps forward. There is a risk of duplication at the local and system tiers.”

“Less looking at past performance, and more forward looking to our transformation and primary care work.”

Overall, the results of the 2019 Board Effectiveness survey indicate a positive improving picture of an effective governing body that works as a team and recognises its areas of strength and challenges. There is progressive improvement in the understanding of roles and responsibilities and thus effectiveness since the CCG was established in 2013.

The findings will be fed into the CCG’s Organisational Development plan with a view to prioritising areas which saw a weaker or medium response and reducing development focus on any areas already working well. The CCG will include continuing to build team working between staff and governing body and a culture of challenge via workshops, 360 degree
appraisals, master classes, governing body seminars and personal development will be pursued.

2.1.3.4 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

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

For the financial year ended 31 March 2019, and up to the date of signing this statement, we complied with the provisions set out in the Code and applied the principles of the Code.

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

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

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

The NHS provides a comprehensive service available to all:

1. Access to NHS Services is based on clinical need, not an individual’s ability to pay;
2. 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;
3. NHS services must reflect the needs and preferences of patients, their families and carers;
4. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;
5. The NHS is committed to providing best value for taxpayer’s money and the most cost-effective, fair and sustainable use of finite resources;
6. The NHS is accountable to the public, communities and patients that it serves.

2.1.3.5 Discharge of Statutory Functions

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

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

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

2.1.3.6 Risk management arrangements and effectiveness

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

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

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

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

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

The Integrated Risk Management Framework for the CCG has been established to ensure that the principles, processes and procedures for best practice in risk management are consistent across the organisation and fit for purpose. The framework was put in place at the time of CCG authorisation and last reviewed in March 2018. It is due for review again in 2020. The framework 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 to share best practice risk management activities.

Risk appetite

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

The CCG risk appetite, the amount of risk it is prepared to accept before it takes action, is as follows:

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

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

Identification and evaluation of risk

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

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

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

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

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

Risk reporting and management structure

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

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

The CCG’s risk management reporting structure 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 Directorate Risk Registers comprise of operational risks to directorate and team objectives.

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

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

Committees reviewing BAF and Risk Registers

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

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

The Audit Committee provides additional assurance to the Governing Body through:

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

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

Prevention of risk

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

Policies

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

Training

CCG staff completed the following mandatory training during the year:

- Information Governance training toolkit (including a directorate face-to-face training as well as privacy impact assessment training)
- Health and safety awareness
- Fire safety
- Equality and diversity
- Safeguarding awareness
- Manual handling
- PREVENT awareness

In addition, the CCG Governing Body participated in numerous training and development activities throughout the year including Information Governance training.

Equality Impact Assessments

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

Stakeholder involvement

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

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

Counter Fraud and Security Management

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

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

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

Emergency Planning and Business Continuity

During the year, the CCG submitted its Emergency Planning, Response and Resilience assurance to NHS England and has achieved the highest rating of ‘full’ assurance. To maintain the CCG’s resilience and preparedness an extensive annual plan is in place including an annual review of the Business Continuity Plan. The CCG is regularly represented at the South London patch EPRR meetings conducted by NHS England. The Managing Director is the Accountable Emergency Officer for the CCG.

Brexit: The CCG also undertook its own Brexit risk assessment and participated in the Brexit Oversight Group.

Conflicts of Interest

The CCG takes conflict of interest management very seriously in view of its role as a membership organisation and has put in place numerous controls to manage the risks involved in the course of its commissioning duties. In addition to reviewing its policies, it has put in place a Conflicts of Interest (CoI) panel and is guided by the CoI Guardian, who is also the chair of the panel.

Prevent Awareness

The CCG has a Prevent programme lead who is also the Head of Safeguarding Adults and Children. All CCG staff are required to complete the Prevent training as part of annual mandatory training.

Capacity to Handle Risk

As the Accountable Officer I have overall responsibility for risk management and discharge this by:

- continually promoting risk management and demonstrating leadership, involvement and support
- ensuring an appropriate committee structure is in place and ensuring each receives regular risk reports
- ensuring that the Governing Body, directors and senior managers are appointed with managerial responsibility for risk management.
All Risk Owners have been trained in the risk management process and this has been supplemented with written guidance in the Risk Management Framework. In addition, on a regular basis, the Governance and Assurance Manager assists Risk Owners to review the controls and assurances in respect of each risk, and by this means good practice is shared between CCG staff. The Governing Body is responsible for the performance management of risk and systems of clinical, financial and organisational control. It oversees the overall system of risk management and assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and is supported in that function by its committees:

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

### 2.1.3.7 Risk Assessment

Management of the CCG’s Risk Profile

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

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

The total number of risks on the BAF is currently 22 and rated as below:

11 rated Extreme/ Red
8 rated High/ Amber
3 rated Moderate/ Yellow
Extreme Board Assurance Framework Risks: The 11 red risks for the CCG are as follows:

1. Acute providers not meeting **Referral to Treatment targets trajectory.**
2. Acute providers not meeting agreed trajectories for **A&E.**
3. Non-achievement of **62-day cancer monthly improvement trajectory.**
4. **CQC inspection outcome report** for some north Southwark practices impacting quality of care.
5. **Sustainability of general practices** in north and south Southwark.
6. **Planning for 19/20:** Uncertainty over 19/20 allocations and planning for breakeven CCG financial position.
7. **Significant financial and operational risks to Southwark mental health placements delivery in 2018/19.**
8. Risk of not meeting the **Transforming Care performance target.**
9. CSU Performance: Risk that **NEL CSU does not deliver high quality support to Southwark CCG GP practices** on ability to discharge business processes and access referral pathways.
10. The risk that the **number of long waiters (waiting more than 52 weeks) is not half (or less than) the level at March 2019** than it was at March 2018.
11. The risk of the CCG not being able to **maintain the patient tracking list (PTL) size at March 2018 levels.** (The PTL size is the total number of patients on the waiting list).

These risks have been presented to and discussed at Integrated Governance and Performance Committee and Governing Body public meetings as detailed before.
In year risks during 2018-19

1. **Achievement of trajectories for A&E, Referral to Treatment (RTT) and 62-day cancer waiting time targets by acute providers**

NHS performance in a number of important areas continued to be below the required standards in 2018/19: A&E, referral-to-treatment (RTT), and cancer waiting times in particular. As the commissioner of these services for Southwark residents, we are responsible for ensuring that all of the providers we commission deliver services in line with national waiting time standards.

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

It is worth noting that our performance in all of these areas is comparable to that in other areas of London and England, but the CCG is committed to ensuring that performance improvements continue to be made in order to meet NHS Constitutional Standards.

2. **King’s deficit and financial recovery plan - commissioner involvement**

KCH’s financial recovery plan discussions are on-going between commissioner, provider and system regulators. For 19/20 the detail is being finalised in the context of the Trust’s Control total, Cost Improvement Programme and the aligned incentive contractual agreement reached between the Trust and SEL CCGs.

3. **Significant financial and operational risks to Southwark mental health placements delivery in 2018/19 if robust governance arrangements are not developed in partnership with the Council and SLaM**

The CCG, Southwark Council and South London and Maudsley partners have implemented a new approach to mental health placements during 2018/19. However, there are still outstanding financial issues which need to be resolved.

4. **Improved Access for Psychological Therapy (IAPT) services**

Recovery rate target: The CCG is expecting the South London and Maudsley’s Southwark IAPT services to deliver the end of year target as performance during the year has improved. This is following a NHSI Intensive Support Team review and the subsequent development of a detailed improvement plan.

Access target: The CCG is expecting the South London and Maudsley’s Southwark IAPT service to deliver the end of year access target.

**Risks identified for 2019-20**

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

1. **Financial risks for south east London CCGs and provider sector**

The CCG intends to deliver the full range of its statutory duties and the planned break-even target.
However, partner CCGs in southeast London will likely be equally financially challenged in 2019/20 as they respond to the increased demand to fund cost pressures and activity growth across the system, whilst at the same time delivering significant QIPP reductions.

King’s College Hospital NHS Foundation Trust particularly continues to face very significant financial pressures. The CCG will continue to support King’s with its financial recovery plans in 2019/20, with a view to ensuring that the initiatives planned are all realised in a sustainable way, and contribute to the challenge of financial recovery.

2. Roll out of Primary Care Networks (PCNs)

During 2018/19 the revised GP Contract was published and as part of this proposal was the establishment of Primary Care Networks. From January to March 2019 NHS England published a range of documents to support the implementation of the Network Contract by 1 July 2019. The CCG will need to work within the guidance and the DES specification to ensure that the residents, practices and the Southwark system maximises all of the opportunities within the contract and builds on the work that has already done as part of the development of the neighbourhood approach. The CCG will also need to ensure that it is aligned with the South East London vision to ensure consistency of approach.

3. RTT, A&E, Cancer Performance

Acute performance still remains a large challenge for King’s College Hospital NHS Foundation Trust and Guy’s and St. Thomas NHS Foundation Trust. CCG’s Integrated Contracts Delivery Team is currently liaising with the trusts on agreeing trajectories for 19-20.

2.1.4 Other sources of assurance

2.1.4.1 Internal Control Framework

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

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

The CCG has put in place a suite of policies, processes and reporting procedures to ensure adequate oversight of the CCG’s control environment by governing body members.

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

2.1.4.2 Annual audit of conflicts of interest management

The continued to comply with the statutory guidance on managing conflicts of interest for CCGs (published June 2017) and accordingly undertook an annual internal audit of conflicts of interest management.

The CCG’s internal auditors have conducted an annual internal audit of conflicts of interest management. The audit received “Substantial Assurance”, which is the highest rating provided by auditors. There were no actions raised as recommendations and the audit identified several best practice examples of well-designed and compliance with controls.

The CCG has embedded conflicts of interest management processes and all governing body and CCG staff are aware of their duties and responsibilities around declarations and proactive management of conflicts. All Governing Body members and staff are required to undertake the annual mandatory online Conflicts of Interest training rolled out by NHS England.

2.1.4.3 Data Quality

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

The quality of the data used by the Membership Body and Governing Body is of an acceptable standard and improvements will continue to be made in 2019/20.

2.1.4.4 Information Governance

There is a complex legal framework governing the way in which the NHS handles information about patients and employees, including personal confidential data. This includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, and the Human Rights Act. The Data Security and Protection (DSP) Toolkit replaced the information governance toolkit in 2018/19, and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The DSP Toolkit allows organisations to measure their performance against the National Data Guardian’s 10 data security standards and to assist with compliance with the legal framework.

The annual DSP Toolkit internal audit was conducted in February 2019. At the time of writing, the auditors are on track to agree that the CCG will be able to fulfil all audited requirements.

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

We have assigned the roles of Senior Information Risk Owner and Caldicott Guardian, who attend all Information Governance Steering Group meetings.

There are processes in place for incident reporting and investigation of serious incidents. We have established policies for information governance, and for the security, management and quality of information. We also have a framework in place for the management of information governance.

The CCG Governing Body undertook information governance training covering DSPT. Information Governance training is mandatory for all CCG staff, whether permanent or temporary.

The DSPT mandatory audit for 18-19 did not highlight any significant concerns.

2.1.4.5 Business Critical Models

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


For 2018/19, Southwark CCG has worked with other CCGs and NHS providers in South East London, through the Sustainability and Transformation Plan (STP), to develop the business and financial modelling for the five-year strategic plan. The modelling is led through South East London PMO and reports back to the South East London Finance Leads Group. The group includes Directors of Finance and Chief Finance Officers from all organisations within the STP. The group is chaired by our Chief Officer who acts as the Senior Responsible Officer for the development of the model. The output of the financial modelling is reviewed by a varied number of stakeholders from different disciplines, both internal and external, and underpins the modelling of the impacts of service changes over the next five years.

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

2.1.4.6 Third party assurances

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

2.1.4.7 Control issues

No significant control issues were identified on the CCG’s month 9 governance return.
2.1.4.8  Review of economy, efficiency and effectiveness of the use of resources

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

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

Governing Body is presented with the latest finance report at every meeting.

The Council of Members also receives a finance and performance update at every meeting.

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

Delegation of functions

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

Counter fraud arrangements

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

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

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

The focus of the work during 2018-19 has been to build on the processes implemented during the previous year fiscal year which are designed to mitigate against the risk of crime at Southwark CCG.

The Audit Committee with its four lay members and two clinical members provides proactive support and direction to the counter fraud work plan to ensure it accurately reflects the CCG’s remit of work and fraud risks.
TIAA’s Counter Fraud Specialist Manager (CFSM) has continued to raise awareness of fraud, bribery and corruption risks at Southwark CCG through the delivery of a series of workshops to CCG staff and external stakeholders. In addition, the CFSM has used other media forms to engage with staff and stakeholders, such as newsletters; intelligence briefings and information posters.

Counter fraud specialist also carries out any investigations on counter fraud referrals. CCG staff were given training in counter fraud at a staff meeting session and were alerted to mechanisms of reporting through staff bulletin. The training also included conflicts of interest management training. Counter fraud survey results will inform improved training and awareness for staff in 19/20.

The CCG’s Director of Finance is the executive board member with the responsibility to proactively tackle fraud, bribery and corruption.

The committee also approved the counter fraud annual workplan for 19/20.

Security Management arrangements:

TIAA Ltd. Also provides the CCG’s security management services. Assurance on its workplan is received by the Audit Committee on a regular basis. A physical security assessment of the CCG premises and a staff survey was conducted during the year to ensure staff are aware of policies and escalation mechanisms for safety issues.

The committee also approved its annual workplan for 19/20.

2.1.4.9 Head of Internal Audit Opinion 2018-19

This opinion is issued by RSM UK For the 12 months ended 31 March 2019, the head of internal audit opinion for Southwark Clinical Commissioning Group is as follows:

Factors and findings which have informed our opinion

Based on the work undertaken in 2018/19, as at 6 March 2019, there is a sound system of internal control, designed to meet the CCG’s objectives, and controls are generally being applied consistently. The reports issued following our internal audit reviews have received Substantial or Reasonable assurance opinions and have not identified any significant control issues.

- Conflicts of Interest – Substantial Assurance
- Risk Management and Assurance Framework – Substantial Assurance
- Financial Management and QIPP Benefits Realisation – Reasonable Assurance
- Primary Care Commissioning (joint SEL review) – Reasonable Assurance
- Models of Care – Reasonable Assurance
- Governance (joint SEL review) – Draft; Reasonable Assurance
- Data Security and Protection Toolkit – Draft; Advisory
We also conducted an Assurance Mapping exercise.

Whilst we have concluded positively on the control environment in place we note the continually challenging financial situation the CCG faces, with a requirement to achieve a balanced control total in collaboration with the other South East London CCGs. We have identified some areas for improvement and where those were highlighted, we have agreed actions with management with agreed deadlines for implementation.

**Topics judged relevant for consideration as part of the annual governance statement**

Based on the work we have undertaken on the CCG’s system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). The CCG may wish to consider whether any other issues have arisen, including the results of any external reviews which it might want to consider for inclusion in the Annual Governance Statement.

This opinion was issued by RSM Risk Assurance Services LLP, Southwark CCG’s internal auditors.

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

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

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

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

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

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

**2.1.4.11 Conclusion**

No significant internal control issues have been identified.

Andrew Bland
Accountable Officer
24 May 2019
2.2 Remuneration and Staff Report

2.2.1 Remuneration Report

The tables in this report are subject to our auditor’s opinion.

2.2.1.1 Remuneration Committee

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Member since</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Gibbs</td>
<td>Lay member, Chair</td>
<td>April 2013</td>
</tr>
<tr>
<td>Robert Park</td>
<td>Lay member</td>
<td>April 2013</td>
</tr>
<tr>
<td>Joy Ellery</td>
<td>Lay member</td>
<td>November 2015</td>
</tr>
<tr>
<td>Andrew Nebel</td>
<td>Lay member</td>
<td>April 2017</td>
</tr>
<tr>
<td>Dr Robert Davidson</td>
<td>Clinical Lead Governing Body</td>
<td>January 2016</td>
</tr>
<tr>
<td>Dr Nancy Kuchemann</td>
<td>Clinical Lead Governing Body</td>
<td>January 2016</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malcolm Hines</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Andrew Bland</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>Dr Jonty Heaversedge</td>
<td>CCG Chair</td>
</tr>
<tr>
<td>Ross Graves</td>
<td>Managing Director</td>
</tr>
</tbody>
</table>

Also see 2.1.3.2. for Committees of the Governing Body for more details on members of other committees, including Remuneration Committee

2.2.1.2 Policy on the remuneration of senior managers

The Committee’s deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures. There are no arrangements in place for additional payments or allowances to staff, at any level, outside of national regulations. The future remuneration policy is not expected to change.
2.2.1.3 Remuneration of very senior managers

The CCG’s policy concerning senior managers’ contracts is that they are of permanent duration, with a notice period of up to three months. Termination payments are calculated on the basis of national regulations, and Treasury advice. No termination payments occurred in 2018-19.

1 lay member contract expired in October 2018. This was advertised and the 2 applications received. The post-holder was re-elected following an interview process.

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

4 GP Clinical Leads and 1 Practice Nurse Clinical lead contracts expired in May 2018. These were advertised and appointments made as detailed in section 2.1.1.3.

Chief Financial Officer for SEL Alliance was appointed in February 2019.

The new Director of Integrated Commissioning was appointed in February 2019.

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

The section following below is subject to audit.

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2018/19</th>
<th>(a) Salary (bands of £5,000)</th>
<th>(b) Expense payments (taxable) to nearest £100</th>
<th>(c) Performance pay and bonuses (bands of £5,000)</th>
<th>(d) Long term performance pay and bonuses (bands of £5,000)</th>
<th>(e) All pension-related benefits (bands of £2,500)</th>
<th>(f) TOTAL (a to e) (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jonty Heaversedge</td>
<td>55-60 (65-70)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>55-60 (65-70)</td>
<td></td>
</tr>
<tr>
<td>Mr Andrew Bland *</td>
<td>25-30 (130-135)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (60-62.5)</td>
<td>25-30 (130-135)</td>
<td></td>
</tr>
<tr>
<td>Mr Usman Niazi * (from February 2019)</td>
<td>0-5 (N/A)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>17.5-20 (NIL)</td>
<td>20-25 (N/A)</td>
<td></td>
</tr>
<tr>
<td>Mr Malcolm Hines*</td>
<td>40-45 (110-115)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (0-2.5)</td>
<td>40-45 (110-115)</td>
<td></td>
</tr>
<tr>
<td>Ms Sam Hepplewhite (from Feb 2019)</td>
<td>15-20 (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>50-52.5 (NIL)</td>
<td>65-70 (NIL)</td>
<td></td>
</tr>
<tr>
<td>Mr Ross Graves</td>
<td>120-125 (55-60)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>27.5-30 (NIL)</td>
<td>145-150 (55-60)</td>
<td></td>
</tr>
<tr>
<td>Ms Kate Moriarty-Baker</td>
<td>105-110 (100-105)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>52.5-55 (32.5-35)</td>
<td>160-165 (135-140)</td>
<td></td>
</tr>
<tr>
<td>Mr Mark Kewley</td>
<td>105-110 (100-105)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>27.5-30 (30-32.5)</td>
<td>135-140 (130-135)</td>
<td></td>
</tr>
<tr>
<td>Ms Caroline Gilmartin</td>
<td>105-110 (100-105)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>37.5-40 (42.5-45)</td>
<td>145-150 (145-150)</td>
<td></td>
</tr>
<tr>
<td>Dr Nancy Kuchemann</td>
<td>35-40 (45-50)</td>
<td>100 (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>137.5-140 (NIL)</td>
<td>175-180 (45-50)</td>
<td></td>
</tr>
<tr>
<td>Dr Noel Baxter</td>
<td>45-50 (40-45)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>7.5-10 (0-2.5)</td>
<td>55-60 (265-270)</td>
<td></td>
</tr>
<tr>
<td>Dr Yvonneke Roe</td>
<td>35-40 (35-40)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>35-40 (35-40)</td>
<td></td>
</tr>
<tr>
<td>Dr Emily Gibbs</td>
<td>45-50 (40-45)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>45-50 (40-45)</td>
<td></td>
</tr>
<tr>
<td>Dr Robert Davidson</td>
<td>85-90 (80-85)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>85-90 (80-85)</td>
<td></td>
</tr>
<tr>
<td>Prof Ami David</td>
<td>10-15 (10-15)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>10-15 (10-15)</td>
<td></td>
</tr>
<tr>
<td>Ms Linda Drake</td>
<td>45-50 (45-50)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (35-37.5)</td>
<td>45-50 (85-90)</td>
<td></td>
</tr>
<tr>
<td>Dr Richard Gibbs</td>
<td>10-15 (10-15)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>10-15 (10-15)</td>
<td></td>
</tr>
<tr>
<td>Name and Title</td>
<td>2018/19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) Salary (bands of £5,000)</td>
<td>(b) Expense payments (taxable) to nearest £100</td>
<td>(c) Performance pay and bonuses (bands of £5,000)</td>
<td>(d) Long term performance pay and bonuses (bands of £5,000)</td>
<td>(e) All pension-related benefits (bands of £2,500)</td>
<td>(f) TOTAL (a to e) (bands of £5,000)</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
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<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Mr Robert Park</td>
<td>5-10 (5-10)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>5-10 (5-10)</td>
<td></td>
</tr>
<tr>
<td>Mr Andrew Nebel</td>
<td>5-10 (5-10)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>5-10 (5-10)</td>
<td></td>
</tr>
<tr>
<td>Ms Joy Ellery</td>
<td>10-15 (5-10)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>10-15 (5-10)</td>
<td></td>
</tr>
<tr>
<td>Dr Michael Khan</td>
<td>15-20 (15-20)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>15-20 (15-20)</td>
<td></td>
</tr>
<tr>
<td>Prof Kevin Fenton</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
</tr>
<tr>
<td>Mr Stephen Whittle</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
</tr>
<tr>
<td>Prof Ian Abbs</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
</tr>
<tr>
<td>Dr Jane Cliffe</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
</tr>
<tr>
<td>Ms Genette Laws</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td>NIL (NIL)</td>
<td></td>
</tr>
</tbody>
</table>

*Andrew Bland has been the Accountable Officer for Southwark CCG since April 2013. He took over the Accountable Officer role for Bexley CCG since 5 February 2018 and that for Greenwich, Lewisham and Bromley CCGs since 1 April 2018. His total salary for the year for these NHS roles was £140-145k, expenses £200, and pension related benefits £(2.5-5)k. Corresponding entries are shown in the other CCG accounts.

*Usman Niazi was appointed as the South East London Chief Financial Officer and he took up post in February 2019. His total salary for the part of the year for these NHS roles was £15-20k, expenses £0, and pension related benefits £87.5-90k. Corresponding entries are shown in the other CCG accounts.

*Malcolm Hines has been Director of Finance for Bexley, Bromley and Southwark CCG’s all period. His total salary for the year for these NHS roles was £125-130k, expenses £28, and pension related benefits £nil. Corresponding entries are shown in the other CCG accounts.

Only the Southwark proportion of these three officer’s salaries and other costs are included in the Southwark Remuneration report table above.

Mr Ross Graves was appointed as Managing Director from 1 April 2018.
Prof A David held the position of Registered Nurse member of the Southwark and Lambeth CCG governing bodies throughout the period. Her total salary for the 12-month period for these NHS roles was £25-30k, expenses £0 and pension related benefits £0.

Figures in brackets in the above table are prior year comparators

For GP clinical leads, the sums shown are just those pertaining to their work for the CCG, not their own practice income as a GP partner or Salaried GP.

**Pension benefits as at 31 March 2019** The section following below is subject to audit:

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>(a) Real increase in pension at age 60 (bands of £2,500) £000</th>
<th>(b) Real increase in pension lump sum at aged 60 (bands of £2,500) £000</th>
<th>(c) Total accrued pension at aged 60 (bands of £5,000) £000</th>
<th>(d) Lump sum at aged 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000</th>
<th>(e) Cash Equivalent Transfer Value at 31 March 2019 £000</th>
<th>(f) Cash Equivalent Transfer Value at 1 April 2018 £000</th>
<th>(g) Real Increase in Cash Equivalent Transfer Value £000</th>
<th>(h) Employer's contribution to stakeholder pension £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Andrew Bland, Accountable Officer*</td>
<td>0</td>
<td>0</td>
<td>5-10</td>
<td>65-70</td>
<td>444</td>
<td>374</td>
<td>59</td>
<td>0</td>
</tr>
<tr>
<td>Mr Usman Niazi, CFO*</td>
<td>2.5-5</td>
<td>0</td>
<td>20-25</td>
<td>0</td>
<td>198</td>
<td>127</td>
<td>68</td>
<td>0</td>
</tr>
<tr>
<td>Mr Ross Graves, Managing Director</td>
<td>0-2.5</td>
<td>0</td>
<td>0-5</td>
<td>0</td>
<td>32</td>
<td>8</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Ms Kate Moriarty-Baker, Director of Quality &amp; Chief Nurse</td>
<td>2.5-5.0</td>
<td>7.5-10</td>
<td>25-30</td>
<td>80-85</td>
<td>631</td>
<td>505</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>Ms Caroline Gilmartin, Director of Integrated Commissioning</td>
<td>0-2.5</td>
<td>5.0-7.5</td>
<td>30-35</td>
<td>95-100</td>
<td>782</td>
<td>659</td>
<td>103</td>
<td>0</td>
</tr>
<tr>
<td>Mr Mark Kewley, Director of Transformation</td>
<td>0-2.5</td>
<td>0</td>
<td>10-15</td>
<td>0</td>
<td>128</td>
<td>89</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>Dr Noel Baxter, Clinical Lead Governing Body</td>
<td>0-2.5</td>
<td>0</td>
<td>15-20</td>
<td>45-50</td>
<td>337</td>
<td>288</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>Ms Sam Hepplewhite Director of Integrated Commissioning (from February 2019)</td>
<td>0-2.5</td>
<td>0</td>
<td>40-45</td>
<td>95-100</td>
<td>993</td>
<td>647</td>
<td>327</td>
<td>0</td>
</tr>
<tr>
<td>Dr Nancy Kuchemann</td>
<td>5-7.5</td>
<td>15-17.5</td>
<td>10-15</td>
<td>40-45</td>
<td>215</td>
<td>104</td>
<td>108</td>
<td>0</td>
</tr>
<tr>
<td>Ms Linda Drake Practice Nurse, Clinical Lead Governing Body</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>10-15</td>
<td>40-45</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Mr Andrew Bland and Mr Usman Niazi held their SEL positions throughout the period. As the pension disclosure represents an actuarial valuation of their future benefits these have not been allocated across CCG’s but are included in full in each set of financial statements where they have received remuneration.

Mr Malcolm Hines has since left the NHS Pension scheme and therefore does not appear in the table above.

2.2.1.4 Cash equivalent transfer values

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

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

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

2.2.1.5 Real increase in CETV

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

Compensation on early retirement or for loss of office

The section following below is subject to audit. There has been no compensation on early retirement or for loss of office in 2018-19.

Payments to past members

There have been no payments in respect of past senior managers in 2018-19.

Pay multiples

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

The banded remuneration of the highest paid member in NHS Southwark CCG in the financial year 2018/19 was £143,356 (2017/18: £132,500). This was 2.66 times (2017/18: 3.84) the median remuneration of the workforce, which was £53,888 (2017/18: £34,495). The reason for the reduction in the difference between the median remuneration and the banded remuneration of the highest paid member in NHS Southwark CCG was due to a change in methodology of calculation where salaries were annualised in 2018-19.
In 2018/19, no employees received remuneration in excess of the highest-paid member. Remuneration ranged from £3,272 to £143,356 (2017/2018: £720 to £130,144).
2.2.2 Staff Report

Data as at 31 March 2019. The section following below is subject to audit

1.1.1.1 Number of senior managers

<table>
<thead>
<tr>
<th>Clinical Lead</th>
<th>Employee</th>
<th>Governing Body</th>
<th>Lay Member</th>
<th>Local Salary</th>
<th>VSM</th>
<th>Grand Total</th>
</tr>
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<tbody>
<tr>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>79</td>
<td>29</td>
<td>1</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>146</td>
</tr>
</tbody>
</table>

1.1.1.2 Staff numbers and costs

<table>
<thead>
<tr>
<th>Employee Category</th>
<th>Headcount</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time</td>
<td>100</td>
<td>100.00</td>
</tr>
<tr>
<td>Part Time</td>
<td>46</td>
<td>16.19</td>
</tr>
<tr>
<td>Grand Total</td>
<td>146</td>
<td>116.19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Band</th>
<th>Headcount</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Band 5</td>
<td>11</td>
<td>11.00</td>
</tr>
<tr>
<td></td>
<td>Band 6</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td></td>
<td>Band 7</td>
<td>12</td>
<td>11.20</td>
</tr>
<tr>
<td></td>
<td>Band 8a</td>
<td>17</td>
<td>16.21</td>
</tr>
<tr>
<td></td>
<td>Band 8b</td>
<td>16</td>
<td>14.86</td>
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<tr>
<td></td>
<td>Band 8c</td>
<td>8</td>
<td>7.40</td>
</tr>
<tr>
<td></td>
<td>Band 8d</td>
<td>9</td>
<td>8.68</td>
</tr>
<tr>
<td></td>
<td>Band 9</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td></td>
<td>Local Salary</td>
<td>20</td>
<td>5.06</td>
</tr>
<tr>
<td></td>
<td>VSM</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td>Female Total</td>
<td>101</td>
<td>82.41</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Band 5</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>Band 7</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Band 8a</td>
<td>5</td>
<td>3.40</td>
</tr>
<tr>
<td></td>
<td>Band 8b</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>Band 8c</td>
<td>7</td>
<td>6.80</td>
</tr>
<tr>
<td></td>
<td>Band 8d</td>
<td>9</td>
<td>9.00</td>
</tr>
<tr>
<td></td>
<td>Band 9</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td></td>
<td>Local Salary</td>
<td>12</td>
<td>2.58</td>
</tr>
<tr>
<td></td>
<td>VSM</td>
<td>4</td>
<td>4.00</td>
</tr>
<tr>
<td>Male Total</td>
<td>45</td>
<td>33.78</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>146</td>
<td>116.19</td>
<td></td>
</tr>
</tbody>
</table>

Of the 116.19 FTE reported in the table above, 58% relate to core CCG business and 11% are joint posts with Southwark Council that are hosted by NHS Southwark CCG. 24% of FTEs are posts which work across south east London CCGs and are hosted by NHS Southwark CCG. The remaining 8% work in different programmes also hosted by NHS Southwark CCG.
Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Permanent Employees</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>6,155</td>
<td>4,937</td>
<td>1,218</td>
</tr>
<tr>
<td>Social security costs</td>
<td>719</td>
<td>719</td>
<td>0</td>
</tr>
<tr>
<td>Employer contributions to the NHS Pension Scheme</td>
<td>739</td>
<td>739</td>
<td>0</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>22</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross Employee Benefits Expenditure</strong></td>
<td><strong>7,635</strong></td>
<td><strong>6,417</strong></td>
<td><strong>1,166</strong></td>
</tr>
<tr>
<td>Less: Recoveries in respect of employee benefits (note 4.1.2)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net employee benefits expenditure including capitalised costs</strong></td>
<td><strong>7,635</strong></td>
<td><strong>6,417</strong></td>
<td><strong>1,166</strong></td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>(51)</td>
</tr>
<tr>
<td><strong>Net employee benefits expenditure excluding capitalised costs</strong></td>
<td><strong>7,584</strong></td>
<td><strong>6,417</strong></td>
<td><strong>1,166</strong></td>
</tr>
</tbody>
</table>

Trade Union Facility Time

Facility time is paid time off for union representatives to carry out trade union activities. No facility time was taken by any CCG staff in 2018/19.
### 2.2.2.1 Sickness absence data 01-APR-2018 - 31-MAR-2019

<table>
<thead>
<tr>
<th></th>
<th>Average FTE 2018/19</th>
<th>Adjusted FTE days lost to Cabinet Office definitions</th>
<th>Average Sick Day per FTE</th>
<th>FTE-Days Available</th>
<th>FTE-Days Lost to Sickness Absence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>108.85</td>
<td>314.14</td>
<td>2.88</td>
<td>39,730</td>
<td>510</td>
</tr>
</tbody>
</table>

### 2.2.2.2 Staff policies

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

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

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

The following policies were in place during the year:

- Suspension policy, procedure and rules
- Stress, mental health and wellbeing policy
- Whistleblowing policy
- Organisational Change policy
- Individual Grievance Policy and Process
- Sickness Absence policy
- Bullying and Harassment policy
- Re-banding policy
- Shared Parental Leave Policy
- Annual and special leave policy
- Maternity, Paternity and Adoption leave policy
- Capability policy
- Disciplinary policy
- Flexible Working policy
- Training and Development policy
- Health and Safety policy
- Incident reporting policy for staff and visitors
- Security policy
- Violence and aggression policy
- Gifts and hospitality policy
2.2.2.3 Other employee matters

Staff surveys

The CCG continues to collect and act on staff feedback to continually improve the experience of working at the CCG. This year, we participated in or led the following staff surveys:

- NHS national staff survey
- Negative behaviours survey
- Staff health and wellbeing survey
- Confidentiality audit (Information Governance) survey - results were discussed at the IG Steering Group
- Security management survey - results were discussed at the Audit Committee.
- Counter fraud survey. - results were discussed at the Audit Committee.

Results from all staff surveys were discussed at the Senior Management Team meeting. Highlights were presented at one of the all-staff meetings, followed by an all-staff discussion to support actions to develop the CCG further.

In 2018/19, we focused on developing the following areas in response to feedback we have received as part of staff surveys:

- Redesigned and established a new appraisal format and reporting objectives on workforce, including training for all staff
- Improved communications such as Managing Director’s Question Time at the monthly all staff meeting and sharing the MD’s Report with staff
- Health and wellbeing survey and initiatives such as mental health awareness week, flu vaccinations and the ‘1000 miles for the NHS’ challenge
- The negative behaviours survey and making progress on reducing negative behaviours
- Staff away days

As part of the CCG’s response to the 2018 staff survey results, the CCG worked with Management Futures to develop a staff away day to have an open discussion around how we raise our game in some key areas which underpin any high performing culture. Trainers held confidential interviews with a cross section of staff and governing body members to help inform the content of the day. The themes explored on the day included:

- Diversity – creating an inclusive environment where we get the best out of all talent
- Development – exploring what we want from our line managers to help us achieve our full potential
- Wellbeing – defining the behaviours of a collaborative and supportive environment, and the behaviours which undermine wellbeing. Exploring how to challenge negative behaviours in a positive way.

The away day took place in September 2018 and was attended by staff and governing body members. 49 people filled in a brief on-line evaluation and on a scale of 1 – 10 for how worthwhile people found the day, the average rating was 7.9.
"The facilitators were refreshingly candid and managed to get large scale participation and some truthful thinking about what we can do differently to be an inclusive organisation."

The CCG is currently working with the trainers to plan further sessions for staff, managers and the governing body.

Plans for 2019/20 include developing appraisals further by introducing 360 degree feedback, staff training on mental health awareness and a formal staff recognition scheme.

**Staff health and safety**

NHS Southwark Clinical Commissioning Group is fully committed to its legal and moral Health and Safety obligations. More than this, it recognises that effective Health and Safety management is not 'common sense' but is based on a common understanding of reasonably foreseeable risks and how to control them as far as is reasonably practicable, brought about through good management.

We attach great importance to the health, safety and welfare of our employees, visitors and contractors. We intend to demonstrate an on-going and determined commitment to improving health and safety at work throughout our organisation.

We are committed to creating an organisational culture that actively promotes and maintains healthy and safe working practices and a healthy and safe working environment. This is supported by several staff policies:

- Health and safety policy
- Accident/incident reporting and investigating policy
- Security policy
- Violence and aggression policy
- Lone and off-site working policy

**Staff health and wellbeing group**

The CCG has a group of staff who promote national health campaigns and organise initiatives to improve staff health and wellbeing across the CCG, above and beyond the statutory requirements for any organisation. The group has organised several events and initiatives and these include:

- Staff flu vaccination clinic held at the CCG’s offices for staff wellbeing and to reduce sickness
- Events for mental health awareness week: bake off competition, mental health awareness quiz, supporting the ‘this is me’ green ribbon campaign and a lunchtime session on stress awareness and management
- Physical challenges to encourage staff to be more active both at an individual and team level, for example staff participated in ‘1000 miles for the NHS’ and designed and ran a ‘climb (the equivalent of) Mount Kilimanjaro’ challenge.
- Promoted national health initiatives to staff such as ‘dry January’, ‘fizz free February’ and ‘healthy eating week’
- Ensured that staff are aware of resources available to them such as GSTT gym and swimming pool, cycling facilities and mileage for travelling to meetings, Southwark Council’s free swim and gym.

The health and wellbeing group meets every two months with representatives across most departments, including hosted services, and with leadership from two clinical leads.
2.2.2.4 **Expenditure on consultancy and contingent labour**

The CCG has spent a total of £942,820 on consultancy. £575,537 relates to core CCG business with the remainder (£367,283) being attributable to spend relating to the Healthy London Partnership Transforming Primary Care programme for which NHS Southwark CCG is the host, and the CCG’s share of costs incurred as a part Our Healthier South East London Programme.

The CCG has spent a total of £1,166,388 on contingent labour (non-permanent staff) costs. 78% of this relates to core CCG business, with the remainder being mainly attributable to spend relating to the Healthy London Partnership Transforming Primary Care programme for which NHS Southwark CCG is the host, and the CCG’s share of costs incurred as a part Our Healthier South East London Programme.

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

2.2.2.5 **Off-payroll engagements**

**Table 1: Off payroll engagements longer than 6 months**

For all off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months.

<table>
<thead>
<tr>
<th>Number of existing arrangements as of 31 March 2019</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>For less than one year at the time of reporting</td>
<td>3</td>
</tr>
<tr>
<td>For between one and two years at the time of reporting</td>
<td>1</td>
</tr>
<tr>
<td>For between 2 and 3 years at the time of reporting</td>
<td>8</td>
</tr>
<tr>
<td>For between 3 and 4 years at the time of reporting</td>
<td>1</td>
</tr>
<tr>
<td>For 4 or more years at the time of reporting</td>
<td>0</td>
</tr>
</tbody>
</table>

**Table 2: New off-payroll engagements**

For all new off-payroll engagements between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than 6 months:

| Total number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019 | 3 |
| Of which:                                                                                             |   |
| Number assessed as caught by IR35                                                                     | 0 |
| Number assessed as NOT caught by IR35                                                                  | 3 |
| Number engaged directly (via PSC contracted to department) and are on departmental payroll             | 0 |
| Number of engagements reassessed for consistency/assurance purposes during the year                   | 0 |
| Number of engagements that saw a change to IR35 status following the consistency review                | 0 |
Table 3: Off payroll engagements / senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility between 1 April 2018 and 31 March 2019

<table>
<thead>
<tr>
<th>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

| Total number of individuals on payroll and off payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements | 26 |

2.2.3 Parliamentary Accountability and Audit Report

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

Andrew Bland
Accountable Officer
24 May 2019
2.2.4 Independent auditor’s report to the members of the governing body of NHS Southwark Clinical Commissioning Group

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Southwark Clinical Commissioning Group ("the CCG") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 3.2.1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer’s conclusions we considered the inherent risks to the CCG’s operations, including the impact of Brexit, and analysed how these risks might affect the CCG’s financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor’s report is not a guarantee that the CCG will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work
we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

Accountable Officer’s responsibilities

As explained more fully in the statement set out on page 74, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor’s responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor’s report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC’s website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

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

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 74, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made 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 CCGs arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General (‘the Code of Audit Practice’) to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Southwark CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Southwark CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

\[Signature\]

Neil Thomas
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL
3 ANNUAL ACCOUNTS

3.1 The primary statements

3.1.1 Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>Income from sale of goods and services</th>
<th>Other operating income</th>
<th>Total operating income</th>
<th>Staff costs</th>
<th>Purchase of goods and services</th>
<th>Depreciation and impairment charges</th>
<th>Provision expense</th>
<th>Other Operating Expenditure</th>
<th>Total operating expenditure</th>
<th>Comprehensive Expenditure for the year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>2</td>
<td>(13,857)</td>
<td>(13,327)</td>
<td>(13,872)</td>
<td>7,584</td>
<td>479,839</td>
<td>82</td>
<td>(175)</td>
<td>370</td>
<td>487,700</td>
<td>473,828</td>
</tr>
<tr>
<td>2</td>
<td>(15)</td>
<td>(7,669)</td>
<td>7,654</td>
<td>9,120</td>
<td>476,824</td>
<td>115</td>
<td>277</td>
<td>514</td>
<td>486,850</td>
<td>465,854</td>
</tr>
</tbody>
</table>

Comprehensive Expenditure for the year

<table>
<thead>
<tr>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>473,828</td>
<td>465,854</td>
</tr>
</tbody>
</table>
3.1.2 Statement of financial position as at 31 March 2019

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>7</td>
<td>411</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td></td>
<td>411</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>8</td>
<td>10,706</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td>10,728</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>11,139</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>10</td>
<td>(49,357)</td>
</tr>
<tr>
<td>Provisions</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td>(49,357)</td>
</tr>
<tr>
<td><strong>Non-Current Assets less Net Current Liabilities</strong></td>
<td></td>
<td>(38,218)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td></td>
<td>(38,218)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers' Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td>(38,217)</td>
</tr>
<tr>
<td><strong>Total taxpayers' equity:</strong></td>
<td></td>
<td>(38,217)</td>
</tr>
</tbody>
</table>

The notes on pages 127 to 156 form part of this statement.

The financial statements on pages 125 to 156 were approved by the Governing Body on 24 May 2019 and signed on its behalf by:

Chief Accountable Officer
Andrew Bland
24 May 2019

Chief Finance Officer
Usman Niazi
24 May 2019
# 3.1.3 Statement of changes in taxpayers’ equity for the year ended 31 March 2019

The notes on pages 125 to 156 form part of this statement.

## Changes in taxpayers’ equity for 2018-19

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2018</strong></td>
<td>(23,412)</td>
</tr>
<tr>
<td><strong>Adjusted NHS Clinical Commissioning Group balance at 31 March 2018</strong></td>
<td>(23,412)</td>
</tr>
</tbody>
</table>

## Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2018-19

### Impact of applying IFRS 9 to Opening Balances

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact of applying IFRS 9 to Opening Balances</strong></td>
<td>(99)</td>
</tr>
</tbody>
</table>

### Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(473,928)</td>
</tr>
</tbody>
</table>

### Net funding

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net funding</strong></td>
<td>459,122</td>
</tr>
</tbody>
</table>

### Balance at 31 March 2019

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td>(36,217)</td>
</tr>
</tbody>
</table>

## Changes in taxpayers’ equity for 2017-18

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2017</strong></td>
<td>(20,006)</td>
</tr>
<tr>
<td><strong>Adjusted NHS Clinical Commissioning Group balance at 31 March 2018</strong></td>
<td>(20,006)</td>
</tr>
</tbody>
</table>

## Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2017-18

### Net operating costs for the financial year

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net operating costs for the financial year</strong></td>
<td>(465,854)</td>
</tr>
</tbody>
</table>

### Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(485,861)</td>
</tr>
</tbody>
</table>

### Net funding

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net funding</strong></td>
<td>462,447</td>
</tr>
</tbody>
</table>

### Balance at 31 March 2018

<table>
<thead>
<tr>
<th>General fund £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 31 March 2018</strong></td>
<td>(23,413)</td>
</tr>
</tbody>
</table>
3.1.4 Statement of cash flows for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(473,828)</td>
<td>(465,854)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5</td>
<td>82</td>
</tr>
<tr>
<td>Non-cash movements arising on application of new accounting standards</td>
<td>(99)</td>
<td>0</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>8</td>
<td>348</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>10</td>
<td>14,553</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>11</td>
<td>(102)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>11</td>
<td>(175)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td>(459,221)</td>
<td>(462,119)</td>
</tr>
<tr>
<td><strong>Cash Flows from Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Payments) for property, plant and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Investing Activities</strong></td>
<td>(153)</td>
<td>(94)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) before Financing</strong></td>
<td>(459,374)</td>
<td>(462,213)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Funding Received</td>
<td>459,122</td>
<td>462,448</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td>459,122</td>
<td>462,448</td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td>9</td>
<td>(252)</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td>274</td>
<td>39</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td>22</td>
<td>274</td>
</tr>
</tbody>
</table>

The notes on pages 127 to 156 form part of this statement.
3.2  Notes to the financial statements

3.2.1  Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

3.2.1.1  Going Concern

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

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

- Our Healthier South East London Strategy
- Sustainability and Transformation Plan (STP)
- Five year financial plan
- Southeast London Estates Strategy
- Refreshed digital strategy
- Better Care Fund 2019/20
3.2.1.2 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.

3.2.1.3 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Southwark Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for commissioning purposes and the accounts provide details of the income and expenditure.

The pool is hosted by NHS Southwark CCG. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

3.2.1.4 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

3.2.1.5 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

NHS Southwark CCG’s main source of revenue is the revenue allocation it receives from NHS England. In addition, the CCG has successfully bid for additional monies for clinical transformation, and estates projects.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Page 128 of 162
Payment terms are standard reflecting cross government principles.

3.2.1.6 Employee Benefits

3.2.1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, 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.

3.2.1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

3.2.1.7 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.

3.2.1.8 Property, Plant & Equipment

3.2.1.8.1 Recognition

Property, plant and equipment is capitalised if:

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

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

3.2.1.8.2 Measurement

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

3.2.1.9 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

3.2.1.10 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.
Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

3.2.1.11 Leases

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

3.2.1.11.1 The Clinical Commissioning Group as Lessee

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

3.2.1.12 **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.

3.2.1.13 **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:

3.2.1.14 **Clinical Negligence Costs**

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

3.2.1.15 **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 Resolution 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.

3.2.1.16 **Contingent liabilities and contingent assets**

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, contingent liabilities and contingent assets are disclosed at their present value.

### 3.2.1.17 Financial Assets

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

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

#### 3.2.1.17.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

#### 3.2.1.17.2 Financial assets at fair value through other comprehensive income

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

#### 3.2.1.17.3 Financial assets at fair value through profit and loss

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.
3.2.1.17.4  Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

3.2.1.18  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.

3.2.1.19  Foreign Currencies

The clinical commissioning group’s functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. 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 in the period in which they arise.
3.2.1.20  **Losses & Special Payments**

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

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

3.2.1.21  **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

3.2.1.22  **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

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

3.2.1.23  **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
3.2.2 Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Income from sale of goods and services (contracts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>10,714</td>
<td>13,327</td>
</tr>
<tr>
<td>Other Contract income</td>
<td>3,143</td>
<td>-</td>
</tr>
<tr>
<td>Total Income from sale of goods and services</td>
<td>13,857</td>
<td>13,327</td>
</tr>
</tbody>
</table>

| Other operating income |         |         |
| Charitable and other contributions to revenue expenditure: non-NHS | 15      | 16      |
| Other non contract revenue | -       | 7,653   |
| Total Other operating income | 15      | 7,669   |

Total Operating Income | 13,872  | 20,996  |

3.2.3 Revenue

Disaggregation of Income - Income from sale of good and services (contracts):

<table>
<thead>
<tr>
<th>Source of Revenue</th>
<th>Non-patient care services to other bodies £'000</th>
<th>Other Contract income £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>684</td>
<td>1,310</td>
</tr>
<tr>
<td>Non NHS</td>
<td>10,030</td>
<td>1,833</td>
</tr>
<tr>
<td>Total</td>
<td>10,714</td>
<td>3,143</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timing of Revenue</th>
<th>Non-patient care services to other bodies £'000</th>
<th>Other Contract income £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point in time</td>
<td>10,714</td>
<td>3,143</td>
</tr>
<tr>
<td>Over time</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>10,714</td>
<td>3,143</td>
</tr>
</tbody>
</table>
### 3.2.4 Employee benefits and staff numbers

#### 3.2.4.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>6,155</td>
<td>1,218</td>
<td>7,635</td>
</tr>
<tr>
<td>Social security costs</td>
<td>719</td>
<td>0</td>
<td>719</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>739</td>
<td>0</td>
<td>739</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>22</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>6,417</td>
<td>1,218</td>
<td>7,635</td>
</tr>
</tbody>
</table>

Less: Employee costs capitalised

<table>
<thead>
<tr>
<th></th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>6,417</td>
<td>1,167</td>
<td>7,584</td>
</tr>
</tbody>
</table>

#### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>7,725</td>
<td>2,435</td>
<td>9,120</td>
</tr>
<tr>
<td>Social security costs</td>
<td>667</td>
<td>0</td>
<td>667</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>711</td>
<td>0</td>
<td>711</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>6,686</td>
<td>2,435</td>
<td>9,120</td>
</tr>
</tbody>
</table>

Less: Employee costs capitalised

<table>
<thead>
<tr>
<th></th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>6,686</td>
<td>2,435</td>
<td>9,120</td>
</tr>
</tbody>
</table>
### 3.2.4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>Permanently employed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>103.52</td>
<td>15.13</td>
<td>118.65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Permanently employed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>96.29</td>
<td>15.10</td>
<td>111.39</td>
</tr>
</tbody>
</table>

Of the above:

- Number of whole time equivalent people engaged on capital projects

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Number</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-</td>
<td>0.67</td>
<td>0.67</td>
</tr>
</tbody>
</table>

### 4.3 Exit packages agreed in the financial year

<table>
<thead>
<tr>
<th></th>
<th>Compulsory redundancies</th>
<th>Other agreed departures</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£25,001 to £50,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Compulsory redundancies</th>
<th>Other agreed departures</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017-18</td>
<td>2017-18</td>
<td>2017-18</td>
</tr>
<tr>
<td>Number</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>-</td>
<td>1</td>
<td>19,916</td>
</tr>
<tr>
<td>£25,001 to £50,000</td>
<td>1</td>
<td>25,212</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>25,212</td>
<td>19,916</td>
</tr>
</tbody>
</table>

### Analysis of Other Agreed Departures

<table>
<thead>
<tr>
<th></th>
<th>Other agreed departures</th>
<th>Other agreed departures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018-19</td>
<td>2017-18</td>
</tr>
<tr>
<td>Number</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</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.

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 Agenda for Change.

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

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

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

### 3.2.4.3 Pension costs

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

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

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

### 3.2.4.4 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.2.4.5 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For 2018-19, employers’ contributions of £373,063 were payable to the NHS Pensions Scheme (2017-18: £787,151) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.
### 3.2.5 Operating expenses

#### 5. Operating expenses

<table>
<thead>
<tr>
<th>Description</th>
<th>2018-19 Total £’000</th>
<th>2017-18 Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purchase of goods and services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>4,850</td>
<td>10,771</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>310,482</td>
<td>301,909</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>26,368</td>
<td>26,629</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>52,927</td>
<td>49,720</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>30,946</td>
<td>32,080</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>47,138</td>
<td>48,075</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>178</td>
<td>64</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>943</td>
<td>697</td>
</tr>
<tr>
<td>Establishment</td>
<td>1,625</td>
<td>2,697</td>
</tr>
<tr>
<td>Transport</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Premises</td>
<td>2,730</td>
<td>3,708</td>
</tr>
<tr>
<td>Audit fees</td>
<td>54</td>
<td>52</td>
</tr>
<tr>
<td>Other non statutory audit expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal audit services</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Other professional fees</td>
<td>697</td>
<td>-</td>
</tr>
<tr>
<td>Legal fees</td>
<td>65</td>
<td>292</td>
</tr>
<tr>
<td>Education, training and conferences</td>
<td>904</td>
<td>224</td>
</tr>
<tr>
<td><strong>Total Purchase of goods and services</strong></td>
<td><strong>475,839</strong></td>
<td><strong>475,824</strong></td>
</tr>
<tr>
<td><strong>Depreciation and impairment charges</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>82</td>
<td>115</td>
</tr>
<tr>
<td><strong>Total Depreciation and impairment charges</strong></td>
<td><strong>82</strong></td>
<td><strong>115</strong></td>
</tr>
<tr>
<td><strong>Providing expense</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>(175)</td>
<td>277</td>
</tr>
<tr>
<td><strong>Total Provision expense</strong></td>
<td><strong>(175)</strong></td>
<td><strong>277</strong></td>
</tr>
<tr>
<td><strong>Other Operating Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>145</td>
<td>87</td>
</tr>
<tr>
<td>Research and development (excluding staff costs)</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Expected credit loss on receivables</td>
<td>225</td>
<td>426</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Other Operating Expenditure</strong></td>
<td><strong>370</strong></td>
<td><strong>515</strong></td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td><strong>480,117</strong></td>
<td><strong>477,730</strong></td>
</tr>
</tbody>
</table>

**Notes:**

* The audit fee for the year consists of the audit plan fee of £44,566 plus a £500 additional charge in relation to the extra work required for the adoption of new accounting standards. The total audit fee is thus £45,066 plus VAT leaving a total of £45,078.

The CCG will be required to obtain assurance from the external auditors over reported compliance with the requirements of the Mental Health Investment Standard. The CCG has received £10,000 of resource allocation in relation to this work. The final fee is not yet confirmed.*
3.2.5.1 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>9435</td>
<td>101,637</td>
<td>10325</td>
<td>132,101</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>8939</td>
<td>99,763</td>
<td>9957</td>
<td>130,160</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>94.74%</td>
<td>98.16%</td>
<td>96.44%</td>
<td>98.53%</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>3242</td>
<td>340,922</td>
<td>3122</td>
<td>340,111</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>3206</td>
<td>340,254</td>
<td>3075</td>
<td>339,253</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>98.89%</td>
<td>99.60%</td>
<td>98.49%</td>
<td>99.75%</td>
</tr>
</tbody>
</table>

3.2.5.2 Property, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>Information technology</th>
<th>Total</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2018</td>
<td></td>
<td>395</td>
<td>395</td>
<td></td>
</tr>
<tr>
<td>Additions purchased</td>
<td>213</td>
<td></td>
<td>213</td>
<td></td>
</tr>
<tr>
<td>Cost or Valuation at 31 March 2019</td>
<td>608</td>
<td></td>
<td>608</td>
<td></td>
</tr>
<tr>
<td>Depreciation 01 April 2018</td>
<td>115</td>
<td></td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>Charged during the year</td>
<td>82</td>
<td></td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>Depreciation at 31 March 2019</td>
<td>197</td>
<td></td>
<td>197</td>
<td></td>
</tr>
<tr>
<td>Net Book Value at 31 March 2019</td>
<td>411</td>
<td></td>
<td>411</td>
<td></td>
</tr>
<tr>
<td>Purchased</td>
<td>411</td>
<td></td>
<td>411</td>
<td></td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>411</td>
<td></td>
<td>411</td>
<td></td>
</tr>
</tbody>
</table>

Asset financing:

|                        | 411     |                        | 411   |

7.1 Economic lives

<table>
<thead>
<tr>
<th></th>
<th>Minimum Life</th>
<th>Maximum Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information technology</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Page 142 of 162
### 3.2.5.3 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2018-19 £'000</th>
<th>Non-current 2018-19 £'000</th>
<th>Current 2017-18 £'000</th>
<th>Non-current 2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>3,390</td>
<td>-</td>
<td>2,406</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,807</td>
<td>-</td>
<td>1,407</td>
<td>-</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>250</td>
<td>-</td>
<td>2,057</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>4,819</td>
<td>-</td>
<td>5,169</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>520</td>
<td>-</td>
<td>228</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>356</td>
<td>-</td>
<td>65</td>
<td>-</td>
</tr>
<tr>
<td>Expected credit loss allowance-receivables</td>
<td>(750)</td>
<td>-</td>
<td>(426)</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>40</td>
<td>-</td>
<td>128</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>274</td>
<td>-</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>10,706</strong></td>
<td><strong>-</strong></td>
<td><strong>11,053</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

**Total current and non current**

<table>
<thead>
<tr>
<th></th>
<th>10,706 £'000</th>
<th>11,053 £'000</th>
</tr>
</thead>
</table>

### 3.2.5.4 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2018-19 DHSC Group Bodies £'000</th>
<th>2018-19 Non DHSC Group Bodies £'000</th>
<th>2017-18 DHSC Group Bodies £'000</th>
<th>2017-18 Non DHSC Group Bodies £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>573</td>
<td>1,774</td>
<td>893</td>
<td>5,029</td>
</tr>
<tr>
<td>By three to six months</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>53</td>
</tr>
<tr>
<td>By more than six months</td>
<td>167</td>
<td>394</td>
<td>134</td>
<td>161</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>740</strong></td>
<td><strong>2,168</strong></td>
<td><strong>1,080</strong></td>
<td><strong>5,191</strong></td>
</tr>
</tbody>
</table>
### 3.2.5.5 Impact of Application of IFRS 9 on financial assets at 1 April 2018

<table>
<thead>
<tr>
<th>Classification under IFRS 9 as at 1st April 2018</th>
<th>Cash and cash equivalents</th>
<th>Trade and other receivables - NHSE bodies</th>
<th>Trade and other receivables - other DHSC group bodies</th>
<th>Trade and other receivables - external</th>
<th>Other financial assets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assets held at Amortised cost</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Total at 31st March 2018</td>
<td>274</td>
<td>4,463</td>
<td>-</td>
<td>5,234</td>
<td>19</td>
<td>9,990</td>
</tr>
<tr>
<td>Classification under IFRS 9 as at 1st April 2018</td>
<td>Financial Assets measured at amortised cost</td>
<td>274</td>
<td>4,463</td>
<td>-</td>
<td>5,333</td>
<td>19</td>
</tr>
<tr>
<td>Total at 1st April 2018</td>
<td>274</td>
<td>4,463</td>
<td>-</td>
<td>5,333</td>
<td>19</td>
<td>10,089</td>
</tr>
<tr>
<td>Changes due to change in measurement attribute</td>
<td></td>
<td></td>
<td></td>
<td>(99)</td>
<td></td>
<td>(99)</td>
</tr>
<tr>
<td>Change in carrying amount</td>
<td></td>
<td></td>
<td></td>
<td>(99)</td>
<td></td>
<td>(99)</td>
</tr>
</tbody>
</table>
### 3.2.5.6 Movement in loss allowances due to application of IFRS 9

<table>
<thead>
<tr>
<th></th>
<th>Trade and other receivables - NHSE bodies</th>
<th>Trade and other receivables - other DHSC group bodies</th>
<th>Trade and other receivables - external</th>
<th>Other financial assets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Impairment and provisions allowances under IAS 39 as at 31st March 2018</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assets held at Amortised cost (ie the 1718 Closing Provision)</td>
<td>-</td>
<td>-</td>
<td>(426)</td>
<td>-</td>
<td>(426)</td>
</tr>
<tr>
<td>Financial assets held at FVOCI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total at 31st March 2018</strong></td>
<td>-</td>
<td>-</td>
<td>(426)</td>
<td>-</td>
<td>(426)</td>
</tr>
<tr>
<td><strong>Loss allowance under IFRS 9 as at 1st April 2018</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assets measured at amortised cost</td>
<td>-</td>
<td>-</td>
<td>(525)</td>
<td>-</td>
<td>(525)</td>
</tr>
<tr>
<td><strong>Total at 1st April 2018</strong></td>
<td>-</td>
<td>-</td>
<td>(525)</td>
<td>-</td>
<td>(525)</td>
</tr>
<tr>
<td>Change in loss allowance arising from application of IFRS 9</td>
<td>-</td>
<td>-</td>
<td>(99)</td>
<td>-</td>
<td>(99)</td>
</tr>
</tbody>
</table>
### 3.2.6 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2018</strong></td>
<td>274</td>
<td>39</td>
</tr>
<tr>
<td><strong>Net change in year</strong></td>
<td>(252)</td>
<td>234</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td>22</td>
<td>274</td>
</tr>
</tbody>
</table>

Made up of:

- **Cash with the Government Banking Service**
  - 22
  - 274

- **Cash and cash equivalents as in statement of financial position**
  - 22
  - 274

**Balance at 31 March 2019**

- 22
- 274
### 3.2.7 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: Revenue</td>
<td>7,111</td>
<td>-</td>
<td>5,693</td>
<td>-</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>10,122</td>
<td>-</td>
<td>9,013</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>8,185</td>
<td>-</td>
<td>2,850</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Capital</td>
<td>61</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>23,115</td>
<td>-</td>
<td>16,676</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>126</td>
<td>-</td>
<td>116</td>
<td>-</td>
</tr>
<tr>
<td>Tax</td>
<td>136</td>
<td>-</td>
<td>118</td>
<td>-</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>501</td>
<td>-</td>
<td>275</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td>49,357</td>
<td>-</td>
<td>34,743</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td>49,357</td>
<td></td>
<td>34,743</td>
<td></td>
</tr>
</tbody>
</table>

Other payables include £373k outstanding pension contributions at 31 March 2019; 31 March 2018 = £438k.
3.2.8 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

<table>
<thead>
<tr>
<th>Classification under IAS 39 as at 31st March 2018</th>
<th>Trade and other payables - NHSE bodies £000s</th>
<th>Trade and other payables - other DHSC group bodies £000s</th>
<th>Trade and other payables - external £000s</th>
<th>Other borrowings (including finance lease obligations) £000s</th>
<th>Other financial liabilities £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Liabilities held at FVTPL</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Financial Liabilities held at Amortised cost</td>
<td>14,707</td>
<td>-</td>
<td>19,802</td>
<td>-</td>
<td>-</td>
<td>34,509</td>
</tr>
<tr>
<td>Total at 31st March 2018</td>
<td>14,707</td>
<td>-</td>
<td>19,802</td>
<td>-</td>
<td>-</td>
<td>34,509</td>
</tr>
</tbody>
</table>

Changes due to change in measurement attribute

| Change in carrying amount | - | - | - | - | - | - |

| - | - | - | - | - | - |

Page 148 of 162
3.2.9 Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2018-19 £'000</th>
<th>Non-current 2018-19 £'000</th>
<th>Current 2017-18 £'000</th>
<th>Non-current 2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td></td>
<td>-</td>
<td>277</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>-</td>
<td>277</td>
<td>-</td>
</tr>
<tr>
<td>Total current and non-current</td>
<td></td>
<td>277</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Other £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2018</td>
<td>277</td>
<td>277</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>(102)</td>
<td>(102)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>(175)</td>
<td>(175)</td>
</tr>
<tr>
<td>Balance at 31 March 2019</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

3.2.10 Financial instruments

3.2.10.1 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.

3.2.10.2 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.
3.2.10.3 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.

3.2.10.4 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes from 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.

3.2.10.5 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.

3.2.10.6 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England’s expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

3.2.10.7 Financial assets

<table>
<thead>
<tr>
<th>Financial Assets measured at amortised cost</th>
<th>Total</th>
<th>2018-19</th>
<th>2019-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other receivables with NHSE bodies</td>
<td>2,999</td>
<td>2,999</td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables with other DHSC group bodies</td>
<td>1,294</td>
<td>1,294</td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables with external bodies</td>
<td>4,520</td>
<td>4,520</td>
<td></td>
</tr>
<tr>
<td>Other financial assets</td>
<td>274</td>
<td>274</td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>22</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>9,109</td>
<td>9,109</td>
<td></td>
</tr>
</tbody>
</table>
3.2.10.8 Financial liabilities

<table>
<thead>
<tr>
<th>Financial Liabilities measured at amortised cost</th>
<th>Total 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-19 £’000</td>
<td>2018-19 £’000</td>
</tr>
<tr>
<td>Trade and other payables with NHSE bodies</td>
<td>2,366</td>
</tr>
<tr>
<td>Trade and other payables with other DHSC group bodies</td>
<td>20,885</td>
</tr>
<tr>
<td>Trade and other payables with external bodies</td>
<td>25,343</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>501</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td><strong>49,095</strong></td>
</tr>
</tbody>
</table>

3.2.10.9 Operating segments

NHS Southwark CCG considers it has only one segment: Commissioning of Healthcare Services.
3.2.11 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

3.2.11.1 Interests in joint operations

<table>
<thead>
<tr>
<th>Name of arrangement</th>
<th>Parties to the arrangement</th>
<th>Description of principal activities</th>
<th>Amounts recognised in Entities books 2017-18</th>
<th>Amounts recognised in Entities books 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Care Fund</td>
<td>NHS Southwark CCG and London Borough of Southwark</td>
<td>Health and Social Care</td>
<td>(5,393)</td>
<td>5,393</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>NHS Southwark CCG and London Borough of Southwark</td>
<td>Health and Social Care</td>
<td>(5,242)</td>
<td>5,242</td>
</tr>
</tbody>
</table>

There were no assets and liabilities in joint operations.
### 3.2.12 Related party transactions

The transactions listed below are in relation to interests declared by the Governing Body members (excluding transactions with practices, department of health bodies and other government departments):

<table>
<thead>
<tr>
<th>Related Party</th>
<th>2018-19 Payments to Related Party £'000</th>
<th>2018-19 Receipts from Related Party £'000</th>
<th>2018-19 Amounts owed to Related Party £'000</th>
<th>2018-19 Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridge House</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equinox Brook Drive</td>
<td>270</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ICA</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kings College London</td>
<td>43</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Paxton Green Time Bank</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Priory Group</td>
<td>81</td>
<td>0</td>
<td>33</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Party</th>
<th>2017-18 Payments to Related Party £'000</th>
<th>2017-18 Receipts from Related Party £'000</th>
<th>2017-18 Amounts owed to Related Party £'000</th>
<th>2017-18 Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridge House</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equinox Brook Drive</td>
<td>360</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ICA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kings College London</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Paxton Green Time Bank</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Priory Group</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
These transactions relate to business as usual trading activities. There are no provisions for doubtful debts.

The transactions listed below are in relation to those practices where one of the GPs of that practice is or has been a member of NHS Southwark CCG’s Governing Body during the financial year:

<table>
<thead>
<tr>
<th>Practice</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>Elm Lodge Surgery</td>
<td>935</td>
<td>0</td>
<td>174</td>
<td>0</td>
</tr>
<tr>
<td>Villa Street Medical Centre</td>
<td>1,003</td>
<td>0</td>
<td>134</td>
<td>0</td>
</tr>
<tr>
<td>Quay Health Solutions Ltd</td>
<td>3,252</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Improving Health Ltd</td>
<td>1,927</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nunhead Surgery</td>
<td>1,201</td>
<td>0</td>
<td>223</td>
<td>0</td>
</tr>
<tr>
<td>Nexus</td>
<td>9,198</td>
<td>0</td>
<td>1,406</td>
<td>0</td>
</tr>
<tr>
<td>Park Medical Practice</td>
<td>847</td>
<td>0</td>
<td>62</td>
<td>0</td>
</tr>
<tr>
<td>SELDOC</td>
<td>644</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

2018-19
These transactions relate to business as usual trading activities. There are no provisions for doubtful debts.

The Department of Health is regarded as a related party. During the year 2018-19 (and 2017-18), NHS Southwark CCG has had a significant number of material transactions with entities for which the Department is regarded as being the parent department, for example:

- Guy's and St Thomas' NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- The Lewisham and Greenwich NHS Trust
- London Ambulance Services NHS Trust
- University College London Hospital NHS Foundation Trust
- Moorfield's Eye Hospital NHS Foundation Trust
- Barts Health NHS Trust
- St George's Healthcare NHS Foundation Trust

<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>Elm Lodge Surgery</td>
<td>1,750</td>
<td>0</td>
<td>132</td>
<td>0</td>
</tr>
<tr>
<td>Villa Street Medical Centre</td>
<td>1,455</td>
<td>0</td>
<td>115</td>
<td>0</td>
</tr>
<tr>
<td>Quay Health Solutions Ltd</td>
<td>2,367</td>
<td>0</td>
<td>677</td>
<td>0</td>
</tr>
<tr>
<td>Improving Health Ltd</td>
<td>1,701</td>
<td>0</td>
<td>679</td>
<td>0</td>
</tr>
<tr>
<td>Nunhead Surgery</td>
<td>2,402</td>
<td>0</td>
<td>222</td>
<td>0</td>
</tr>
<tr>
<td>Nexus</td>
<td>16,514</td>
<td>1,266</td>
<td>64</td>
<td>0</td>
</tr>
<tr>
<td>Park Medical Practice</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SELDOC</td>
<td>544</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

2017-18
NHS Southwark CCG has also had a number of material transactions with other government departments and other central and local government bodies in 2018-19. Most of these transactions have been with the London Borough of Southwark.

A financial Risk-Share agreement is in place across the six CCGs in south east London. It was agreed through the governance of each CCG that the Risk-Share agreement be enacted in 2018-19. The final revenue resource limit values included in the 2018-19 annual accounts of each CCG reflect the outcome of the Risk-Share agreement.

### 3.2.13 Events after the end of the reporting period

The CCG has considered this and there are no material events, adjusting or non-adjusting, which will affect the 2018/19 accounts.

### 3.2.14 Financial performance targets

NHS Clinical Commissioning Group have 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>2018-19 Target</th>
<th>2018-19 Performance</th>
<th>2017-18 Target</th>
<th>2017-18 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>489,177</td>
<td>487,912</td>
<td>488,480</td>
<td>486,900</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>216</td>
<td>214</td>
<td>69</td>
<td>50</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>475,104</td>
<td>473,828</td>
<td>467,415</td>
<td>465,854</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>6,581</td>
<td>6,510</td>
<td>6,500</td>
<td>6,457</td>
</tr>
</tbody>
</table>

### 3.2.15 Effect of application of IFRS 15 on current year closing balances

The impact of IFRS 15 is not material and hence no disclosure is made.
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).

**GP Federation**: A network of GP practices which have put in place formal arrangements for working together to share responsibility for delivering patient-focused services specifically to suit local needs. There are two in Southwark – Improving Health in south Southwark and Quay Health Solutions in the north.

**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

Integrated Care Systems: A network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in the hope of limiting unnecessary spending.

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

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

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

KCH: King’s College Hospital NHS Foundation Trust.

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

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

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

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

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

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

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

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

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

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

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

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

Planned Care: where a patient is referred for treatment and there is a pre-determined pathway of care.

Primary Care: Sometimes used to describe the services provided by GPs, NHS dentists, optometrists (opticians) and community pharmacists. This may also include other community health services.

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

Proactive care: care that actively seeks to prevent ill health or 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 per cent of non-admitted (outpatient/day case) patients should start consultant-led treatment within 18 weeks of referral. In order to sustain delivery of these standards, 92 per cent of patients who have not yet started treatment should have been waiting no more than 18 weeks.
Secondary care: More specialised care, usually after referral from GP (primary care). This can be provided in a hospital or in the community.

SEL: south east London

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

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

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

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

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

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

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

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

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

UCC (Urgent Care Centre): a centre which provides care and treatment for minor illnesses and injuries that require urgent attention but that are not critical or life-threatening.

Unplanned Care: is care that is not planned or pre-booked with your GP or hospital.

Voluntary and Community Sector / Organisations: not-for-profit organisations set up to offer services to specific groups in society. These can be run and staffed by paid professionals as well as volunteers.