Governing Body

14.00 – 17.30

Thursday 22 January 2015

Room M8
Cambridge House
1 Addington Square
London
SE5 0HF

souccg.southwark-ccg@nhs.net
www.southwarkccg.nhs.uk/about/ourboard/pages/ccgmeetingpapers

The best possible health outcomes for Southwark people
# AGENDA

<table>
<thead>
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<th>Time</th>
<th>Item</th>
<th>ENC</th>
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<tbody>
<tr>
<td>14.00</td>
<td>1 Chair’s Welcome</td>
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<td>Dr Heaversedge</td>
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<tr>
<td>14.05</td>
<td>2 Public Opening Space</td>
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**OPEN: Southwark CCG Governing Body – Meeting in Public**

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<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>14.15</td>
<td>3 Introductions and Apologies for Absence</td>
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<td>Dr Heaversedge</td>
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<td>4 Declaration of Interests</td>
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**Items for Assurance**

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<th>Time</th>
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<tbody>
<tr>
<td>14.20</td>
<td>5 Minutes of the Last Meeting: 13 November 2014</td>
<td>A (i-ii)</td>
<td>Dr Heaversedge</td>
</tr>
<tr>
<td>14.30</td>
<td>6 Integrated Governance &amp; Performance Committee Report – (November and December 2014)</td>
<td>B (i-v)</td>
<td>Robert Park Malcolm Hines</td>
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<td></td>
<td>CCG Performance Summary Report (M8)</td>
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<td>CCG Finance Report (M8)</td>
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<td>CCG BAF and Risk Report</td>
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<tr>
<td>14.45</td>
<td>7 Commissioning Strategy Committee Report – (November and December 2014)</td>
<td>C (i-ii)</td>
<td>Dr Heaversedge</td>
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<tr>
<td>15.00</td>
<td>8 Engagement &amp; Patient Experience Committee Report (November 2014)</td>
<td>D</td>
<td>Diane French</td>
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<tr>
<td>15.15</td>
<td>9 Update on South East London Strategy Programme</td>
<td>E (i-iii)</td>
<td>Andrew Bland</td>
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<tr>
<td>15.45</td>
<td>10 Director of Public Health Report</td>
<td>F</td>
<td>Ruth Wallis</td>
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<td>16.00</td>
<td>Break</td>
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### Items for Decision

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<tr>
<th>Time</th>
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<th>Chair/Officer</th>
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<tbody>
<tr>
<td>16.10</td>
<td>Arrangements for CCG Commissioning of Primary Care</td>
<td>Andrew Bland</td>
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<tr>
<td>16.25</td>
<td>Safeguarding Annual Review</td>
<td>Gwen Kennedy</td>
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### Items for Discussion

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>16.40</td>
<td>CCG Chief Officer Report</td>
<td>Andrew Bland</td>
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<tr>
<td>16.50</td>
<td>Strategic Commissioning Framework for Primary Care Transformation in London</td>
<td>Paul Roche</td>
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### Items for Reference and Information

<table>
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<tr>
<th>Time</th>
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<th>Chair/Officer</th>
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<tbody>
<tr>
<td></td>
<td>CCG Integrated Performance Report (M8)</td>
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<td>Minutes of the CCG Committees:</td>
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<td></td>
<td>Integrated Governance &amp; Performance Committee (November 2014)</td>
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<td>Commissioning Strategy Committee (November 2014)</td>
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<td>Engagement &amp; Patient Experience Committee (November 2014)</td>
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<td>Dulwich Programme Board (November 2014)</td>
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### Closing Items

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>17.10</td>
<td>Any Other Business: Items to be notified to the secretary at least 48 hours before the meeting in accordance with Standing Orders</td>
<td>Dr Heaversedge</td>
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**CLOSE: Southwark CCG Governing Body– Meeting in Public**

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<tr>
<th>Time</th>
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<tr>
<td>17.15</td>
<td>Public Open Space</td>
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<tr>
<td>18</td>
<td>Date of Next Meeting: 2-5.30pm, 12 March 2015 – Cambridge House, 1 Addington Square, SE5 0HF.</td>
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<td>17.30</td>
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CCG GOVERNING BODY
13th November 2014
160 Tooley Street London SE1 2QH

Minutes

GOVERNING BODY MEMBERS PRESENT:

Andrew Bland (AB) Chief Officer (items 301/14-317/14)
David Cooper (DC) Chair of Health Watch Southwark
Professor Ami David (AD) Registered Nurse Member
Dr Obi Ezeji (OE) Clinical lead
Diane French (DF) Lay Member (from item 305/14)
Dr Richard Gibbs (RG) Lay Member
Dr Jonty Heaversedge (JH) CCG Chair and Clinical Lead (Chair)
Malcolm Hines (MH) Chair (Chair)
Dr Patrick Holden (PH) LMC representative
Dr Sian Howell (SH) Clinical Lead
Paul Jenkins (PJ) Interim Director of Integrated Commissioning
Gwen Kennedy (GK) Director of Quality and Safety
Dr Nancy Kuchemann (NK) Clinical Lead
Dr Jacques Mizan (JM) Clinical Lead
Robert Park (RP) Lay Member
Dr Yvonneke Roe (YR) Clinical Lead
Dr Tushar Sharma (TS) Clinical Lead
Dr Tan Vandal (TV) Secondary Care Doctor Member

IN ATTENDANCE:*

Vicky Bradding (VB) CCG Corporate Secretary (Minutes)
Alison Furey (AF) Consultant in Public Health, Southwark LA
Patrick Harborow (PHa) Clinical Lead SE London NHS111
Janet Laylee (JL) Children and Young People’s Partnership
Dr Claire Lemar (CL) Children and Young People’s Partnership
Bimpe Oki (BO) Consultant in Public Health, Southwark LA
Niamh Wilson (NW) NHS111 Contract Manager, SECSU

*A list of attendees from the public seats are recorded at the end of the minutes

APOLOGIES:

Dr Noel Baxter (NB) Clinical Lead
Dr Adam Bradford (ABr) Clinical Lead
Dr Jane Cliffe (JC) LMC Representative
Linda Drake (LD) Practice Nurse Member
Professor John Moxham (JM) King’s Health Partners
Dr Ruth Wallis (RW) Director of Public Health, Lambeth and Southwark

The best possible health outcomes for Southwark people
The meeting commenced with a short film - a team leader from MEND talked about the motivations and barriers for families accessing services to promote healthy lifestyles for families.

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<tr>
<td><strong>301/14 Chairs Welcome</strong></td>
<td>JH welcomed everyone to the meeting. Members of the public introduced themselves.</td>
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| **302/14 Public Open Space** | Mrs Rylance-Watson welcomed the appointment of a Lay Member as chair of the Engagement and Patient Experience Committee (EPEC).  
Mrs Rylance-Watson raised a question to be addressed as part of item 307/14: Integrated Governance and Performance (IGP) Committee Report. She enquired about the role of mental health and the police in the urgent care performance measure and where issues relating to SLAM and their performance are discussed. This had been raised at a recent meeting of the Southwark Pensioners Action Group.  
AB explained that all SLAM performance is monitored at contract monitoring meetings and, in relation to urgent care performance, SLAM is a full member of the System Resilience Group and the Urgent Care Group. Mental health issues are discussed in these forums. |
| **303/14 Declaration of Interests** | JH asked RG, the Conflicts of Interest Panel Chair and Guardian, to give guidance on how to manage potential conflicts for agenda item 311/14: NHS111 procurement strategy, particularly for clinical members who provide out of hours services or are members of a GP Federation.  
RG highlighted the potential conflicts arise from the possibility of Southwark GPs benefitting should SELDOC be awarded the contract for 111, as most Southwark GP practices are members of SELDOC. However, the 111 paper is concerned with the overall approach to procurement including patient outcomes, not details of the service specification. Clinician input is important particularly for patient outcomes. He requested that members ensure discussions do not go beyond the remit of the paper. RG further highlighted that NHS Bromley CCG are leading 111 procurement.  
Clinical GB members declared their interests specifically in relation to this item as follows: |
There were no declarations from other GB members in relation to this item.

All members confirmed that there were no changes to the current register of interests.

304/14 The Governing Body approved the minutes of the meeting held on 11 September 2014 as an accurate record.

305/14 Matters Arising and Action Log

Updates and new actions are detailed in the Action log attached to the minutes.

306/14 Item for Information

Chief Officer’s Report

This item was brought forward in the agenda.

AB presented his report and outlined the main areas of work. He particularly thanked Tamsin Hooton/PJ and the Integrated Commissioning Team for their hard work in securing the successful implementation of extended primary care access following the bid to the PM Challenge Fund. The service went live on 11th November and PJ reported 21 patients who would have otherwise have attended A&E, were seen by the new service on the first day.

AB also reported that the application for funding to support both winter pressures and hospital waiting times for elective care has been successful.

The Governing Body noted the Chief Officer’s Report
Integrated Governance and Performance (IGP) Committee Report – September and October 2014

RP reported that the IGP Committee continues to closely monitor performance targets. The CCG Board Assurance Framework was reviewed and is recommended to the Governing Body for approval, including the highest risks of Referral to Treatment (RTT) target, A&E four hour wait target, Improving Access to Psychological Therapies (IAPT) target and implementation of the adult mental health model.

AB updated the Governing Body on KCH Performance. A&E four hour waits have consistently met the 95% target over the last six weeks. In response to a question, AB confirmed that only a small number of 52 week waiters at KCH are Southwark residents. There have also been no Mixed Sex Accommodation breaches and cancer targets have been achieved. AB was pleased to report these recent achievements but highlighted the importance of maintaining the improvements. JH commended the CCG management team for their hard work in achieving such a positive outcome.

NK asked what had led to the improvements in performance at KCH, particularly RTT. AB confirmed it was multifactorial. The Governing Body concluded a detailed analysis will inform the CCG’s management of future performance issues and requests a detailed analysis to be presented at CSC for discussion. - ACTION KS.

In answer to Mrs Rylance-Watson’s question relating to mental health involvement in urgent care performance, PJ reported that there has been significant investment into A&E services and the CCG is working with the local authority and SLAM for crisis management through a number of structures including the System Resilience Group. Part of this work includes effectively managing the 350 mental health patients who regularly attend KCH A&E (Denmark Hill). GK stated that the Mental Health and Parity of Esteem Programme board and the Mental Health Concordat are also supporting the development of this work.

PJ reported that London Ambulance Service is in a critical position regarding their current performance on response rates and hospital handover. Discussion is underway regarding understanding the issues and service improvements.

In response to a query from AD, JH confirmed that health visiting performance is included in the performance report presented to IGP.

AB highlighted Winterbourne View performance target. The new discharge target of 50 per cent is London-wide. The Governing Body accepted that it is unlikely the NHS Southwark CCG will meet it due to the complex needs of the clients. GK
assured the Governing Body that all clients have been identified and are regularly reviewed. However discharge will not be possible for many of the clients largely due to their incredibly complex needs and some clients require Ministry of Justice approval before discharge.

**Finance** – MH reported that the CCG is on target to achieve its key financial targets with a surplus of £6m. He outlined the position in the main areas and highlighted to the Governing Body that some reserves are not yet committed. He highlighted the importance of retaining some reserves to cover unanticipated cost pressures before April 2015.

The Governing Body received and accepted the IGP report including the Board Assurance Framework, month 6 Finance Report and Performance Summary Report.

<table>
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<tr>
<th>Commissioning Strategy Committee (CSC) Report – October 2014</th>
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<td>JH highlighted the development of commissioning intentions, demand management and, primary care transformation programme and the decommissioning of In Health diagnostics. The DXS programme is being introduced and the Governing Body supported agreed that this will be very useful in supporting primary care.</td>
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The Governing Body received and accepted the report from the Commissioning Strategy Committee

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<tr>
<th>Engagement and Patient experience committee report (EPEC) – September 2014</th>
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<td>EPEC received updates from Patient Participation Groups (PPG). The Governing Body noted the challenges of low attendance at PPG meetings. An update was received from Healthwatch. EPEC terms of reference were amended and the annual engagement report is in progress.</td>
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The Governing Body received and accepted the report from EPEC

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<th>Director of Public Health Report</th>
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<td>AF highlighted Public Health’s local approach to the Ebola threat. She stated that NHS England is responsible for the national response. AF will confirm whether simple awareness information is publically available on the website - <strong>ACTION AF</strong>.</td>
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The Governing Body discussed the role of primary care in promoting uptake of bowel screening which is currently lacking from the national approach. JH encouraged clinical leads to promote the importance of bowel screening to enable
early detection. YR highlighted the difficulty of requesting another testing kit. Public Health is already investigating this process with Public Health England.

In answer to a query from TV as to whether extending the age range for bowel screening will improve uptake, AF stated that uptake needs to be improved at all age levels. RP requested information about the critical factors in improving immunisations performance. This information will be appended to the Governing Body minutes. - **ACTION AF**

NK enquired about the quality of information sent to women about the Randomised Control Trial to extend the age range for breast screening. AF replied that best evidence is decided nationally and there is a limit to local adaptation. Details of the Breast Screening patient information to be appended to the Governing Body minutes - **ACTION AF**.

**The Governing Body received and accepted the contents of the report**

### NHS 111 Procurement Strategy

NW highlighted that NHS 111 is a key enabler in delivering the SE London strategy to improve urgent care pathways. The draft timescale is procurement in January for November 2015 start. NHS111 will be the main provider of out of hours care and the current Out of Hours service will need to be decommissioned. The procurement approach focuses on collaboration with all potential providers to enable outcomes based commissioning. NW stated that it will not be possible to introduce NHS111 without CCG support.

JH reminded members to ensure discussions remain within the remit of the paper, following the earlier conflicts of interest discussion.

**311/14**

SH welcomed the outcomes based approach and she emphasised the importance of NHS 111 to be responsive. PJ highlighted the importance of learning from other sites and the need for NHS111 to link into current Southwark pathways. There is also a need to reflect the developments from the Challenge Fund within the strategy. NW confirmed that the NHS 111 service can be bespoke for Southwark.

DF enquired about patient and public involvement in the process to date and plans to involve patients/public. NW replied that one workshop was held including a Healthwatch Southwark representative. It is intended to hold further workshops including patient representatives to develop the service specification.

AB concluded that the level of patient/public engagement described in the document should be changed to reflect NHS Southwark CCG’s commitment to patient/public engagement and co-commissioning. He assured NW support from
NHS Southwark CCG. NW accepted the need for robust engagement locally and she agreed to incorporate it in the plan of delivery. DC offered support from Healthwatch Southwark.

RP highlighted the specific health needs of inner London are different to outer London and should be acknowledged in any procurement process.

In answer to a question from PH, NW confirmed that it is not known who will provide procurement support and could be external to the NHS. PJ raised the issue of governance of the Programme Board and requested NHS Southwark CCG is represented.

PHa stated that patients currently receive multiple assessments and the NHS111 procurement will include redesigning the patient journey.

**The Governing Body received the report and endorsed the recommendations and approach in principle with the following caveats:**

- Southwark’s local needs are reflected in the procurement process to ensure the NHS 111 service meets the needs of Southwark patients, including changes to the local provider landscape, e.g. Extended access in primary care.
- Patient/public involvement is enhanced with a view to co-commissioning for Southwark.
- NHS Southwark CCG is represented on the NHS 111 Programme Board.

**Public Health Obesity Strategy**

BO outlined the development of the strategy and is based on the best available evidence for interventions. Funding was agreed by the Children’s Trust Board.

The Governing Body discussed the effectiveness of the interventions outlined in the strategy. BO confirmed that the evidence base is limited. Evidence shows individual uncoordinated interventions are not effective and therefore obesity needs a whole systems approach. BO stated that a similar approach had been adopted in Lambeth and early evaluation is promising.

DF challenged the value of the evaluation given its cost of over £100k. BO replied that it is important to recognise that combining interventions is new and to monitor it to inform the value of continuing to commission the service in future years. NICE recommend evaluating the effectiveness of all new interventions. The evidence base of individual interventions does not extend to the current Southwark population. It is important that any new services are fit for purpose and tailored as much as possible to the local population.
YR requested further information about the budgetary pressures in years 2 and 3. MH stated that the local authority had agreed significant further investment through the Health and Wellbeing Board. BO reassured the GB that there is a definite commitment to budget and the issues seem to be more a capacity issue.

JH stated that it would be useful to know whether there are broader supporting strategies e.g. fast food outlets.

Once the service is established an update to the Obesity Strategy will be discussed in detail to the CSC including interventions beyond healthcare - ACTION AF.

In response to a question from RP, BO confirmed that the obesity strategy has prioritised the younger age group rather than teenagers as the evidence base is stronger for this age group and they can use national screening to monitor effectiveness.

The Governing Body received and endorsed the Public Health Obesity Strategy noting its concerns about the limited evidence base of interventions and extending the service to older children.

Children and Young People’s Health Partnership

CL described the key elements of the partnership and stated that the partnership’s objective is to work towards improving the health and wellbeing of local children by ensuring care is co-ordinated and every day health and care services are appropriately delivered. She highlighted that the Partnership Application support document provides a focus for primary care. Using the public health data increases opportunities for public health nursing. The paper describes how the partnership links with new models of care and the opportunities for changes in Southwark. She stated that the partnership provides an exciting opportunity to test how services can be commissioned differently. There will be a focus on evaluation.

OE stated that the extent of the partnership is very broad and most of the work described is already being addressed. He said that it would be good to be clear of the unique differences. CL replied that the main difference is that services will be happening at scale.

JH highlighted the challenge of separating provision of primary and secondary care services. CL replied that skill sets are different in some areas resulting in lack of co-ordination. The partnership will provide the opportunity to be more flexible e.g. by using GP data services to focus on mild to moderate needs.

In answer to a question from DK, CL confirmed that linkage has been made with
young carers. The carer role is crucial and she would like to promote self-management. DF requested particular focus on young carers.

PH stated that the Local Medical Council is fully supportive. CL confirmed that this is an extension of revised work carried out previously. AF welcomed the application and particularly an approach to the strengthening of early prevention. AF highlighted the small budget to support the nursing workforce and enquired whether there will be opportunities for this to be increased. CL stated that work is on-going to iterate the document and all elements of spend will be included in the next version.

DC welcomed the partnership application. He suggested that it would be useful to include young people’s stories and the changes that have been affected. CL replied that there has been a great deal of work in listening to young people ensuring information is relevant and is alignment. Practices have been changed following what people have said. The main principle is that care must be accessed at the right time in the right place. Work with families has been carried out particularly in relation to diabetes.

PJ welcomed the way that the partnership connects to integrated care. CL stated that the vast majority of children presenting at Emergency Departments are with general malaise and it is important that this data is captured through surveys with parents. Child assessment referral services provide more flexibility and prompter attention.

The Governing Body received and accepted the Children and Young people’s health partnership application.

**Items for Information**

The Governing Body noted the following items:

Annual Engagement Report
Annual Audit Committee Report
CCG Integrated Performance Report – Month 5

Minutes of CCG Committees:
- IGP Committee (September 2014)
- Commissioning Strategy Committee (August 2014)
- EPEC (September 2014)
- Dulwich Programme Board (July 2014)
- Audit Committee (September 2014)
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<td><strong>315/14</strong></td>
<td><strong>Any Other Business</strong>&lt;br&gt;The Governing Body welcomed Aarti Gandesna, the newly appointed manager for Healthwatch Southwark Manager.</td>
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| **316/14** | **Public Open Space**<br>Mrs Rylance-Watson requested future reports on NHS 111 reflect a clear understanding of enhanced access in primary care.  
Mrs Rylance-Watson expressed concern that a member of Southwark Social Services Department was not present at the meeting. She reflected that social services input would have been very valuable when the Public Health Obesity Strategy and the Children’s and Young People’s Health Partnership application was being discussed.  
Mr Skelly suggested that there should be one designated hospital for diagnosed Ebola patients rather than reducing space at KCH to treat patients. YR explained that Ebola patients are assigned to the Royal Free Hospital but a designated area must be provided at local hospitals to see suspected patients. |
| **317/14** | **The next meeting** will be held on 22nd January 2015, 14:00 – 17:30 at Cambridge House |
Southwark Clinical Commissioning Group

Governing Body

Attendance Sheet

Thursday 13th November 2014

William Hervey          Health development worker/South carers
Aarto Gandesna          Healthwatch Southwark Manager
Ivy Douglas             Healthwatch member
Jacqueline Best-Vessau  Southwark and Lambeth
Dolly Mace              Age UK SPAG
R Doora                 
Elizabeth Rylance-Watson Southwark Resident
Ian Brown               NHSE
Bob Skelly              Southwark Resident
Catherine Worsfold      CCG Corporate Governance Manager
Omar Al-Ramadhani       CCG Planning and Assurance Manager
Rosemary Watts          CCG Head of Membership, Engagement and Equalities
### Outstanding Actions

<table>
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<tr>
<th>Agenda item</th>
<th>Action Point</th>
<th>Update</th>
<th>Date to be completed</th>
<th>Lead</th>
<th>Status</th>
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<tr>
<td>Matters Arising (June 2014)</td>
<td>Publicise the Quality Alert system and ensure Quality Alerts remain a rolling agenda item for Locality meetings. Investigate the feasibility of extending the Quality Alert system for reverse quality alerts.</td>
<td>Quality alerts are a standing item at Locality meetings. The process of responding to quality alerts is being reviewed with the Commissioning Support Unit. An algorithm and process for reverse quality alerts has been developed and is currently being consulted on and tested. Currently under review by clinical lead</td>
<td>January 2015</td>
<td>PJ</td>
<td>Action in progress</td>
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<td>Public Open Space</td>
<td>Publicise Plain English information regarding details of provision of core GMS contract to enable meaningful public involvement with developing enhanced services.</td>
<td>Action partially completed as the Primary Care Strategy explains it and the NHSE website addresses it. Report to be taken to EPEC for review November 2014.</td>
<td>September 2014</td>
<td>AB /RWatts</td>
<td>Action outstanding</td>
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<tr>
<td>Agenda item</td>
<td>Action Point</td>
<td>Update</td>
<td>Date to be completed</td>
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<tr>
<td>Any Other Business</td>
<td>Scheduling of meetings in 2015/16 to be reviewed</td>
<td>In progress for January review.</td>
<td>January 2015</td>
<td>JH</td>
<td>Action in Progress</td>
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<tr>
<td>Integrated Governance &amp; performance Committee report</td>
<td>A detailed analysis of the factors that led to KCH improvement in RTT and A&amp;E to inform the CCG’s management of future performance issues to be presented at CSC</td>
<td>New action</td>
<td>January 2015</td>
<td>JH/KS</td>
<td>Action outstanding</td>
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<tr>
<td>Director of Public Health report (November 2014)</td>
<td>Information about the critical factors in improving immunisations performance to be appended to the November Governing Body minutes.</td>
<td>New Action</td>
<td>January 2015</td>
<td>AF</td>
<td>Action outstanding</td>
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<td>Director of Public Health report (November 2014)</td>
<td>Details of the Breast Screening patient information to be appended to the Governing Body November minutes</td>
<td>New Action</td>
<td>January 2015</td>
<td>AF</td>
<td>Action outstanding</td>
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<tr>
<td>Public Health Obesity Strategy</td>
<td>Once the Obesity service is established an update to the Obesity Strategy will be discussed in detail at the CSC including interventions beyond healthcare</td>
<td>New Action</td>
<td>May 2015</td>
<td>AF/BO</td>
<td>Action outstanding</td>
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### Closed Actions since November 2014

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<tr>
<th>Agenda item</th>
<th>Action Point</th>
<th>Action Taken</th>
<th>Date Closed</th>
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<tr>
<td>CCG Quality Framework</td>
<td>Governing Body seminar to be run on the Quality framework. Action plan to be developed to implement recommendations of the Quality framework and shared with GB members</td>
<td>GK confirmed that the Quality Framework will be on the agenda of the next Quality, Safety and Outcomes Programme Board meeting.</td>
<td>November 2014</td>
<td>GK</td>
<td>Action complete</td>
</tr>
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<td>Director of Public Health report (November 2014)</td>
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<td>Information is posted on the website</td>
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# CCG Governing Body

**DATE OF MEETING:** 22 January 2015

## ENCLOSURE B

### Integrated Governance & Performance Committee Report

**November and December 2014**

<table>
<thead>
<tr>
<th>CCG DIRECTOR RESPONSIBLE:</th>
<th>Andrew Bland, Chief Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL LEAD RESPONSIBLE:</td>
<td>Robert Park, Lay Member</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Kieran Swann, Head of Planning &amp; CCG Assurance</td>
</tr>
</tbody>
</table>

### INVOLVEMENT REQUIRED FROM THE CCG GOVERNING BODY:

The Governing Body is asked to:

- Review the Committee report, consider the recommendations and approve if appropriate.

### SUMMARY:

The Committee Report includes the activities completed by the Committee for the stated period. This includes details of Committee discussion; a summary of actions agreed by the Committee; a consideration of items of business against quality, safety, performance & financial criteria; and a summary of engagement completed in support of the Committee’s business.

The Report includes the Committee’s recommendations to the CCG Governing Body.

### Attached for Reference:

- ENC Bi-ii – Integrated Governance & Performance Committee Report (Nov & Dec)
- ENC Bii – CCG Performance Summary Report (M8)
- ENC Biv – CCG Finance Report (M8)
- ENC Bv – CCG BAF
- ENC K - CCG Integrated Performance Report (M8)
IN Volvement
Detailed in the Committee Report

ReCommendations:
The Governing Body is asked to consider the Committee’s recommendations

Ccg Director’s Contact:
Name: Andrew Bland
E-Mail: andrewbland@nhs.net

Author Contact:
Name: Kieran Swann
E-Mail: omar.al-ramadhani@nhs.net
**Governing Body Meeting**  
**22 January 2015**

**NAME OF THE GOVERNING BODY COMMITTEE:**  
Integrated Governance & Performance Committee

**DATE OF COMMITTEE MEETINGS:** 27 November 2014

**PRINCIPLE FOCUS:**

The Integrated Governance and Performance Committee was established to provide oversight of the activities of the CCG and of commissioned providers in respect of Finance; QIPP; Performance; Quality and Safety.

The committee will act as the quality forum for the borough. To this end the Integrated Governance and Performance Committee will operate as the designated group for issues relating to the quality of commissioned care to be reviewed and acted upon.

The committee is additionally responsible for assuring the effective functioning of the following areas for both the activities of the CCG and, for the purpose of assurance, of its main contracted providers. In this the Committee will provide the CCG Governing Body with assurance relating to the effective functioning of CCG safeguarding; information governance; health and safety and equality and diversity management.

The Integrated Governance and Performance Committee will act as the leadership forum for the Board Assurance Framework and the Corporate Risk Register.

The November 2014 meeting of the Committee gave focus to:

- CCG Risk Register & BAF (M6)
- CCG Finance Report (M7)
- Acute Contract Demand and Capacity Summary Report (M6)
- CCG Performance Highlight Report (M6)
- Finance Report (M5)
- Report from the Quality and Safety Programme Board
- Updated Terms of Reference IGP Committee and Quality and Safety Programme Board
- CCG Training and Development Policy
- Extended Primary Care Service Risk Assessment
- Non-Recurrent Investment in London Ambulance Service
- Constitutional Amendment for Co-commissioning – NHSE Guidance
- CCG Procurement Policy
- Information Governance Steering Group Report and Minutes
ISSUES ARISING:

1. CCG Risk Register & BAF (M6)

The committee was presented with the report and noted that the Board Assurance Framework (BAF) had been revised with a focus on reviewing the descriptions of risk controls and assurances to fully describe the progress of risk management. It was noted that two new risks had been added to the risk register and the top six strategic risks are:

- quality and safety issues from contractual breach of London Ambulance Service (LAS) not achieving performance standards for response rates or hospital handover (new).
- failure to develop a joint strategy for prevention of ill-health, health promotion and wellbeing (new).
- QIPP savings are not realised through the Adult Mental Health model.
- failure to meet IAPT trajectories and targets.
- acute providers do not meet performance targets for Referral to Treatment (RTT).
- providers do not meet A&E 4 hour waiting time targets.

Assurances were provided that the CCG was making funds available to improve RTT and LAS performance and that significant improvements had been made to A&E performance at Denmark Hill. Assurances were also provided that senior CCG managers had discussed developing work matrices for programme boards to ensure that work is joined up and to reduce duplication.

2. CCG Finance Report (M7)

The committee was assured that the CCG was on track to meet its financial targets for 2014/15. It was noted that there was some risk of overspend on acute performance. King’s College Hospital NHS Foundation Trust (King’s) had received £1.97m tranche 1 winter resilience funding and £4.97m tranche 2 winter resilience funding.

The committee heard that a provisional year end agreement had been reached with South London and Maudsley NHS Foundation Trust (SLaM) and assurances were provided that the CCG was progressing the same set of discussions with King’s and Guy’s and St. Thomas’ NHS Foundation Trust (GSTT).

Assurances were provided that the CCG was providing King‘s some financial support and there are detailed plans about how the trust will use the money to improve performance.

3. CCG Performance Highlight Report (M6)

The committee was presented with the M6 Highlight Report which provides an overview of current CCG and provider performance across a range of priority national and local standards. The committee noted areas of performance variance including; RTT performance at King’s College Hospital NHS Foundation Trust (King’s); sustained backlog of patients at King’s, emergency care performance and 62 days cancer waits performance at Guy’s & St. Thomas’.

An update was provided on RTT performance and it was noted that King’s was aiming to reach a sustainable position in December in order to consistently deliver the 95% admitted target. Diagnostics performance was also discussed and the committee heard that Southwark’s performance variance...
was being driven by performance at GSTT.

GSTT performance variance was discussed further as the committee expressed concerns that GSTT was under performing on a number of targets. Assurances were provided that RTT performance at the trust would return to target in December and that the trust has a trajectory in place to meet the 1% diagnostic target in December although this was rated as high risk. Assurances were provided that the South East Commissioning Support Unit (SECSU) would continue to closely monitor performance at GSTT.

For further assurance, the committee asked that reports are provided at the next meeting on A&E recovery plans at Denmark Hill.

An update was provided on Improving Access to Psychological Therapies (IAPT) and the committee was assured that the CCG was on track to meet its year end activity target.

4. Report from Quality and Safety Programme Board

The committee received updates from Clinical Quality Review Group (CQRG) meetings with the CCG’s main providers. For King’s, assurances were provided that the trust’s approach to acting upon Duty of Candour was seen as particularly good practice and that quality and safety in the emergency department had not been affected by high activity levels.

5. Acute Contract Demand and Capacity Summary Report (M6)

The committee heard that the M6 position showed the same trend as previous months. It was noted that pressure ulcer incidence was increasing at King’s and assurances were provided that improvement plans were in place and were having an impact in some areas of the trust. Assurances were also provided that the number of bariatric surgery long waiters at King’s were reducing.

6. Updated Terms of Reference

The committee approved revised IGP Committee and Quality and Safety Programme Board terms of reference.

7. CCG Training and Development Policy

The committee approved the CCG Training and Development policy noting that it also applies to Governing Body members.

8. CCG Sustainable Development Strategy and Management Plan 2014-2018

The committee was presented with the plan which defines sustainability; details the CCG’s aims and commitments to sustainability; provides examples of sustainability in existing strategies and plans; and sets out a series of actions to ensure Southwark CCG acts to improve sustainability.

9. Extended Primary Care Service Risk Assessment

A paper was presented which provided an update on the mobilisation of the Extended Primary Care Service in south Southwark; an outline of the CCG assurance process in place to authorise service
mobilisation; and the risks raised during the assurance process and agreed mitigations in place.

It was agreed that all risks should be clearly documented within the CCG and project risk registers and a further update would be brought to the next meeting.

10. Non-Recurrent Investment in London Ambulance Service

The committee was presented with a report which recommended the CCG invest £650k as part of the London funding request on non-recurrent resilience funding on London Ambulance Service (LAS) workforce, recruitment and safety. It was noted that South East London CCGs had accepted the proposals with a number of conditions.

The investment was approved and the committee noted that it would help LAS stabilise its performance in 2014/15 but further recovery planning was required.

11. Constitutional Amendment for Co-commissioning – NHSE Guidance

The committee noted the constitutional amendment for Co-commissioning guidance.

12. CCG Procurement Policy

The committee noted the updated CCG procurement policy which included suggested amendments made at the October meeting.

13. Information Governance Steering Group Report and Minutes

The minutes were noted by the committee.

SUMMARY OF ACTIONS UNDER DELEGATION:

1. More information on bariatric clock stops at King’s will be brought to the next meeting.

2. Issues around the follow-up of endoscopy results at GSTT will be reviewed at the CQRG meeting.

3. The committee should review a commissioner evidence document at a future meeting and feed recommendations to the Governing Body

4. All the extended primary care service risks will be clearly documented within the CCG and project risk registers.

5. A further update on the extended primary care service risks assessment will be brought back to a future meeting.
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<tr>
<td><strong>Quality and Safety</strong></td>
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<tr>
<td>Assurance was provided on quality and safety issues through the report from the Quality and Safety Programme Board, the Performance Highlight Report and the Integrated Performance Report.</td>
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<tr>
<td><strong>Performance</strong></td>
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<td>Performance was reviewed in the Performance Highlight Report, the Integrated Performance Report and the Non-Reccurrent Investment in London Ambulance Service report.</td>
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<td>The Extended Primary Care Service Risk Assessment was reviewed.</td>
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<td>3. Integrated Performance Report M8</td>
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<tr>
<td>5. Actions undertaken by the committee outlined above.</td>
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To agree:

1. CCG Risk Register and Board Assurance Framework

To receive updates on:

No further updates

RELATED REPORTS RECEIVED AT THE GOVERNING BODY MEETING:

1. CCG Chief Officer’s Report

ACRONYMS

IG&P  Integrated Governance & Performance Committee
GSTT  Guy’s & St. Thomas’ NHS Foundation Trust
GSTCHS Guy’s & St. Thomas’ NHS Foundation Trust Community Health Services
KCH  King’s College Hospital NHS Foundation Trust
SLaM  South London & Maudsley NHS Mental Health Foundation Trust
SLCSU South London Commissioning Support Unit
SMT  Senior Management Team

COMMITTEE CHAIR:
Name: Robert Park
E-Mail: southwark.ccg@nhs.net

LEAD CCG OFFICER:
Name: Kieran Swann
E-Mail: kieranswann@nhs.net
### Governing Body Meeting
22 January 2015

<table>
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<th>NAME OF THE GOVERNING BODY COMMITTEE:</th>
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| DATE OF COMMITTEE MEETINGS: | 18 December 2014 |

### PRINCIPLE FOCUS:  
The Integrated Governance and Performance Committee was established to provide oversight of the activities of the CCG and of commissioned providers in respect of Finance; QIPP; Performance; Quality and Safety.  
The committee will act as the quality forum for the borough. To this end the Integrated Governance and Performance Committee will operate as the designated group for issues relating to the quality of commissioned care to be reviewed and acted upon.  
The committee is additionally responsible for assuring the effective functioning of the following areas for both the activities of the CCG and, for the purpose of assurance, of its main contracted providers. In this the Committee will provide the CCG Governing Body with assurance relating to the effective functioning of CCG safeguarding; information governance; health and safety and equality and diversity management.  
The Integrated Governance and Performance Committee will act as the leadership forum for the Board Assurance Framework and the Corporate Risk Register.  
The December 2014 meeting of the Committee gave focus to:  
- Emergency Planning, Response and Resilience (EPRR) Assurance  
- CCG Risk Register and BAF (M7)  
- Performance and Quality Benchmarking Analysis  
- Winterbourne View Concordat Update  
- King’s Recovery Plan for A&E Performance  
- CCG Quality Report Q2 2014/15
ISSUES ARISING:

1. Emergency Planning Response and Resilience (EPRR) Assurance

A paper was presented which focused on a submission to NHS England on business continuity and how the CCG would cope during an emergency or serious incident. The committee heard that the submission had received substantial assurance, but the CCG was aiming to achieve full assurance. Assurances were provided that the Lambeth and Southwark Pandemic Flu Plan was approved by Senior Management Team and was in operation.

2. CCG Risk Register & BAF (M7)

The committee were presented with the report and noted that the new format of the Board Assurance Framework (BAF) was working well. It was noted that the CCG has the following six extreme risks:

- quality and safety issues from contractual breach of London Ambulance Service not achieving performance standards for response rates or hospital handover (new).
- failure to develop a joint strategy for prevention of ill-health, health promotion and wellbeing (new).
- QIPP savings are not realised through the Adult Mental Health model.
- failure to meet IAPT trajectories and targets.
- acute providers do not meet performance targets for Referral to Treatment (RTT).
- providers do not meet A&E 4 hour waiting time targets.

Assurance was provided that there will be an internal audit in January to review all risks.

The committee was advised to monitor the A&E and referral-to-treatment (RTT) risk scores as performance was beginning to improve in November and early December.

3. Performance and Quality Benchmarking Analysis

The committee was presented with a report which provided a benchmarking analysis of Southwark CCG’s performance for a number of performance and quality indicators against the national/regional average and against comparable CCGs.

It was noted that the report highlighted ‘Carers Reported Quality of Life’ and ‘People With Long Term Conditions Feeling Well Supported’ as areas where the CCG was an outlier against comparable CCGs. Assurances were provided that services were being procured to support carers from April 2015 and carer helpers had been recruited and tasked to identify and signpost carers for assessment.

It was agreed that joint working with the Local Authority would be required to improve performance in childhood obesity and alcohol related admissions.

4. Winterbourne View Concordat

The committee was presented with a paper which provided an update on the CCG’s Winterbourne View status. The committee noted that in October 2014, NHS England advised the CCG of a new combined target for London which requires 50% of individuals who were in assessment and treatment units in April 2014 to be discharged to community placements by March 2015.
It was noted that the CCG still has four clients who meet the criteria for the London target of 50% and these clients are not identified for discharge before the target date of 31 March 2015. Assurances were provided that the CCG was working with the Local Authority to review all clients through a steering group and all clients have discharge plans in place, care co-ordinators and management plans.

5. King’s Recovery Plan for A&E Performance

A slide pack was presented which provided an overview of King’s Denmark Hill’s A&E performance and recovery plan. It was noted that admissions from Southwark were flat despite increases in admissions from non-local activity. It was also noted that performance at Denmark Hill was above the 95% target in October and November but had fallen back to below target in December; in line with a dip in London-wide performance.

Assurances were provided that implementation of recovery plans would be accelerated in January 2015 and there was system-wide consensus that out of hospital initiatives in Southwark were having an impact on stemming attendance rates.

The committee was assured that quality and safety of the Denmark Hill ED was being monitored. It was noted that quality and safety indicators for Denmark Hill were monitored at a recent Clinical Quality Review Group (CQRG) meeting and Quality Board meeting and there was no cause for concern.

6. CCG Quality Report, Q2 2014/15

The committee was presented with the report which provides a qualitative repository for intelligence about quality issues in the local health economy.

Safeguarding training compliance was discussed and assurances were provided that the issue had been monitored at recent CQRG meetings at King’s and GSTT and more detail would be brought to the next meeting.

Assurances were also provided around provision of physical health checks and accommodation at SLaM and pressure ulcers and falls at King’s.
SUMMARY OF ACTIONS UNDER DELEGATION:

1. More details will be provided on assurance for risks IC-15 and IC-16 and that the wording for these risks is reviewed.

2. To check that the current version of the Carers Strategy is on Southwark CCG’s website.

3. Provide more detail about safeguarding performance.

4. Review safeguarding risk scores in the next BAF update

5. Provide an update on progress on carrying out the programme of clinical visits.

6. All committee members will be emailed reminding them of their responsibilities to attend the meeting and asking for apologies in advance if they are unable to be at a meeting.

IMPLICATIONS:

Quality and Safety

Quality and safety was reviewed in the Q2 CCG Quality report, the Performance and Quality Benchmarking Analysis and Winterbourne View Concordat Update.

Performance

The committee reviewed performance in the King’s Recovery Plan for A&E Performance and the Performance and Quality Benchmarking Analysis.

Financial

King’s performance recovery plan.
**ENGAGEMENT:**

**Membership**
CCG Quality Report, Q2 2014/15

**Patients and the public**
CCG Quality Report, Q2 2014/15

**Stakeholders**
Winterbourne View Concordat Update and King’s Recovery Plan for A&E Performance

**RECOMMENDATIONS MADE TO THE GOVERNING BODY:**

**To note:**
1. CCG Summary Performance Report M8
2. CCG Finance Report M8
3. Integrated Performance Report M8
5. Actions undertaken by the committee outlined above.

**To agree:**
1. CCG Risk Register and Board Assurance Framework

**To receive updates on:**
No further updates

**RELATED REPORTS RECEIVED AT THE GOVERNING BODY MEETING:**

1. CCG Chief Officer’s Report
### ACRONYMS

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>IG&amp;P</td>
<td>Integrated Governance &amp; Performance Committee</td>
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<td>GSTCHS</td>
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<td>South London Commissioning Support Unit</td>
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### COMMITTEE CHAIR:
Name: Robert Park  
E-Mail: southwark.ccg@nhs.net

### LEAD CCG OFFICER:
Name: Kieran Swann  
E-Mail: kieranswann@nhs.net
This document is a highlight report, which is written to provide the Governing Body with an overview of current CCG and provider performance across a range of priority national and local standards. The highlight report focuses on areas of performance variance and covers Q3 2013/14 up to November 2014; the period for which we have the most recent validated data.

**CCG Performance Highlight Report Contents**

1. Urgent care
2. London Ambulance Service
3. Referral-to-Treatment
4. Diagnostic waiting times
5. Cancer waiting times
6. IAPT
7. Winterbourne view
8. Dementia
9. Health visiting
10. Serious Incidents & Never Events
11. Healthcare acquired infections (MRSA and *clostridium difficile*)
12. Friends & Family
## Urgent Care Performance – A&E Waits

### A&E waits all types (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

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### A&E waits type 1 (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

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### Weekly A&E waits all types (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

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<tr>
<td>KCH (Trust wide)</td>
<td>88.4</td>
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<td>KCH (Den Hill)</td>
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<td>90.5</td>
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</table>
Reported Performance Position

- GSTT have met the performance standard in all three quarters of 2014/15.

- King’s (Denmark Hill) failed the last four quarters including quarter 3 2014/15. There are a number of issues which caused this performance including; bed capacity issues and discharge management fluctuations in demand, acuity of patients, mental health pathways, and repatriation delays. However, Denmark Hill did meet performance for the month of October and November but failed the target in December.

- The Lambeth, Southwark and Bromley System Resilience Group have developed a System Resilience Plan which details all actions that all organisations within the system are taking to improve performance and return to fulfilment of national performance standards. These plans draw on existing recovery plans from KCH.

- Ernst and Young conducted a Demand and Capacity review. This has been used to drive an appraisal of options aimed at closing the bed gap through securing the optimal utilisation of the Trust’s Denmark Hill, PRUH, QMS and Orpington sites alongside improvements in internal and external productivity and efficiency to enable the delivery of sustained performance across A&E and RTT targets. Many of these recommendations have now been implemented with further options currently under active consideration by the trust, Commissioners from both CCGs, NHS England and Monitor through regular Tripartite meetings.

- Next steps are: monitoring of performance trajectories and recovery plans, providing certainty for the year; implementation of internal recovery plan; continued commissioner led action on whole system support focusing on discharge, mental health, repatriations and rehab; completing the winter review process, and ensuring lessons learnt are taken forward; Strategic Review, including review of balance and capacity resource across King’s sites.
Urgent Care Performance – Summary of Q2 and Q3 Actions

1. **Denmark Hill site capacity:** Commissioners worked with all trusts across SE London to do a demand and capacity analysis for each site. This work was a specialty-by-specialty review on how many beds are likely to be needed to meet demand on a quarter by quarter basis. For Denmark Hill, a bed gap of 68 was identified. As a result a number of actions were initiated, including transferring work to Orpington and PRUH from Denmark Hill, improving internal efficiency, and making full use of increased community capacity in order to decompress the site.

2. **Mental Health:** Additional bed capacity commissioned as part of 2013/14 contract and psychiatric liaison nurse post funded by CCG. Additional investment has also been identified for SLaM through the winter funding process to provide additional support to A&E.

3. **Southwark & Lambeth Integrated Care (SLiC) Simplified Discharge Workstream Programme:** Identification of priorities following stocktake in Q1.

4. **Primary care access:** The CCG agreed to commission primary care access, 8am-8pm, 7 days a week. The CCG was notified that it’s application for the Prime Minister’s Challenge Fund had been successful. This funding (approx. £1million) will be used for setup and infrastructure costs. The CCG has also invested a further £2.1m recurrently to support enhanced access to primary care.

5. **MDT Assessment/social Care:** Evaluation of weekend social care worker pilot at GSTT to support seven day working.

6. **Repatriations:** A South London Wide repatriation coordination project has been funded for six months to support improved management of repatriation of patients across South London and identify any underlying issues which impact on the effective repatriations of patients in a timely manner. The role commenced part way through October and has since then successfully improved the level of data and information being supplied around those patients awaiting repatriation, this has led to a greater awareness and in turn increased support in escalating repatriation delays.

7. **Guy’s Urgent Care Centre:** Change in provider from Q1, with service now delivered by GSTT. Primary care partner secured for initial phase.
1. **Development and agreement of System Resilience Plans:** These cover both elective and non-elective across Lambeth, Southwark and Bromley. We have received confirmation that these plans for non elective have been assured for both the initial and secondary tranches of winter funding allocations. A new Head of System Resilience for SE London is now in post.

2. **Denmark Hill site:** Plans are in place to release capacity throughout the year, with several service moves taking place in the next two months. Representatives of the CCGs and KCH have met with Lewisham and Greenwich NHS Trust to discuss repatriation protocols as these have proved to be problematic over the last 12 months and have disrupted patient flows at Denmark Hill. The Lewisham and Queen Elizabeth Stroke Units have now consolidated onto one site for several months which is enabling repatriations to be accepted back in a more timely manner.

3. **Mental Health:** Three month audit of mental health presentations are now being considered. In addition, significant bids have been put forward as part of the winter funding process which would extend support to both St Thomas’ and Denmark Hill EDs in and out of hours, and help ensure more timely responses and assessments of patients presenting. Further schemes are also under active consideration.

4. **Southwark & Lambeth Integrated Care (SLiC):** Simplified Discharge Workstream programme: options appraisal for unified point of access is currently being considered by the Operations board. A new post, Head of Transformation – Integration has now been recruited to Southwark CCG and started on 20 November.

5. **Extended Primary care access:**
   - Mobilisation of first site (Lister Health Centre) on 11 November with positive initial feedback from patients and practices
   - Pathway in place to allow patient re-direction from King’s ED: a meeting will take place between the service provider and trust during February to review progress.
   - Ongoing work around staffing, practice readiness, IT and premises to mobilise second site (Bermondsey Spa) in February 2015
London Ambulance Service

8 minutes red 1 (75%) – May be life threatening and the most time critical conditions - emergency response within 8 mins irrespective of location

8 minutes red 2 (75%) – May be life threatening but less time critical than Red 1 - emergency response within 8 mins irrespective of location

19 minutes (95%) - May be life threatening - receive an ambulance response at the scene within 19 mins irrespective of location

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<td>76.7%</td>
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<td>8 mins red 2</td>
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<td>90.5%</td>
<td>91.6%</td>
<td>89.2%</td>
<td>92.0%</td>
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Reported Performance Position

• During 2014/15 delivery against national standards has become increasingly challenged with all category performance declining. The Regional Tripartite commissioned a diagnostic review of the key drivers of underperformance (December 2014, the Tripartite consists of NHS England, NHS Trust Development Authority and Monitor).

• The review found that utilisation of the service had increased significantly impacting on the operational capability of the service. Utilisation levels are driven by the number of Category A incidents, the job cycle time and the number of vehicle hours. In 2014/15 the level of Category A incidents has risen, available vehicle hours have reduced and the nominal net turnover rate is rising. When utilisation rates rise, calls to the Trust are held; when this number reaches a certain agreed level the Trust raises the threshold at which it will respond to a call at Demand Management Plan level. Clinically, this means that there is an increasing risk of harm associated with those delays.

Actions Agreed to Meet Performance Standard

• London CCGs have supported a system-wide response to LAS performance and patient safety issues with additional £13m investment in 14/15 to support immediate remedial action plans and contribute to more sustainable performance.

• LAS has made good progress with a major recruitment campaign with an expected 215 new frontline staff in post by March 2015. Category C calls (those deemed to be the least serious) are no longer being conveyed to hospital, with patients advised to seek medical assistance from a more appropriate source, with calls being transferred to 111 as necessary.

• Diagnostic review commissioned by NHSE being used to develop remedial and sustainable 24 month action plan.
Referral-to-Treatment: 18 Weeks Performance

RTT admitted (target 90%) - The percentage of admitted pathways completed within 18 weeks

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<td>84.9</td>
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King's DH is below the performance threshold. The Trust has an agreed planned failure to Q3 in order to reduce current backlog.

Reported Performance Position

- Southwark's performance was below the threshold in November and is driven by patients being treated at KCH and GSTT. For Q1 - Q3 KCH Denmark Hill had a planned failure of the admitted target with the Trust working to expected monthly performance positions and reduced backlog targets.

- The backlog at King’s Denmark Hill has been reducing every month since May 2014 and was 1,180 in November.
**Actions Agreed to Meet Performance Standard and Clear Backlog**

- During November both GSTT and KCH were implementing additional national RTT monies designed to clear long waiter backlogs further. Additional monies have run from July - Nov with both GSTT and KCH expected to perform below the 90% target for that period.

- Consequently Southwark’s performance will also be below 90% for the period. KCH have not been able to reduce their trust-wide backlog to the desired level over this period and now expect to fail the admitted target trust-wide and for Denmark Hill until March.

- Agreed transfer to Guys and St Thomas’ of Orthopaedic patients for the first two quarters of 2014/15 with a review in Q3.

- Maximising internal trust capacity across Denmark Hill, PRUH and Orpington sites, to support the overall decompression of the KCH acute hospital sites and the effective management of available emergency and elective capacity across the trust. Key elective proposals cover: Orthopaedics - consolidation of the trust’s elective adult Orthopaedic activity at Orpington; Gynaecology - consolidation of all elective inpatient Gynaecology activity at the PRUH site; Non complex cataract surgery - consolidation of simple cataract activity at QMS; and General Surgery - consolidation of the trust elective adult General Surgery activity at Orpington. Assumption is changes will be implemented over 2014/15 in a phased way beginning with Orthopaedics and Gynaecology from start Q2.

- At KCH outsourcing to the private sector was stepped up from July with the receipt of tranche one of additional national RTT monies. The trust has now begun additional work at a number of private providers (King Edward VII, Cromwell, HCA, Shirley oaks, Sloane hospital, Lister, London Bridge).

- Providing more information to primary care referrers to support conversations with patients and enabling informed choice in relation to waiting times.
Referral-to-Treatment: 52 + week waits

Cause of Reported Performance Position

- Southwark had two long waiters in November, one was at KCH in colorectal and this patient has now been TCI'd. The other was at GST under Paediatrics.

Actions Agreed to Meet Performance Standard

The number of over 52 week waiters at KCH has fallen dramatically over the last 6 months. As part of 2014/15 contract the CSU agreed revised trajectories to reduce 52 week waiters to 0 by end Q1 2014/15. This trajectory was missed and Southwark CCG wrote to the trust on behalf of all commissioners raising concerns in this area. The trust has instigated a number of actions to improve the position including:

- Outsourcing to the private sector - following agreed additional RTT funding from NHSE, KCH will be outsourcing patients in Neurosurgery and Bariatric Surgery.
- Increased use of the Orpington site as an elective Orthopaedic centre for KCH including Saturday lists.
- Capacity changes and site services moves across KCH site to decompress DH and free up capacity such as opening of the Centenary Wing (Infill Block 4) and Orpington.
- KCH expect to have three long waiters trust-wide at the end of December. Based on weekly information, as at 5/1/15 Southwark had 2 patients who if untreated will have waited beyond 52 weeks by the end of January without a TCI.
Diagnostic Waits

**Diagnostic wait less than 6 weeks (target <1%)** - The % of patients waiting 6 weeks or more for a diagnostic test

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<tr>
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<th>Dec</th>
<th>Jan</th>
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<td>2.15</td>
<td>1.97</td>
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<tr>
<td>KCH (Den. Hill)</td>
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<td>3.54</td>
<td>3.85</td>
<td>2.52</td>
<td>2.31</td>
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**Cause of Reported Performance Position**

- Southwark CCG’s performance is below target at 1.51% in November - waits at GSTT are the main driver for this under performance. The majority of the patients waiting over 6 weeks at GSTT are in endoscopy.

**Actions Agreed to Meet Performance Standard**

- Within gastroscopy and urodynamics, GST have specialised diagnostics, such as capsule endoscopy and video fluoroscopy studies and also some groups of patients with complex conditions. There has been an increase in demand for these services and the Trust is working to increase capacity, but this involves a complex combination of staff and equipment.

- The trust is seeking to improve the booking of endoscopy patients’ appointments to ensure efficient use of all available capacity. GSTT aims to recover the standard from April 2015.
Cause of Reported Performance Position

- Southwark performance relates to six patients not treated within the required time frame from 37 pathways. Two patients waited over 100 days, all breaches over 100 days have RCA’s completed at both GST and KCH. Three patients were categorised as unavoidable breaches due to patient choice and three were categorised as avoidable.

Actions Agreed to Meet Performance Standard

- Avoidable delays were picked up in the recommendations from the IST review undertaken at the end of 2013. All trusts in SEL have action plans to address these issues which are monitored through regular performance meetings both on an individual trust basis, and a pan provider/commissioner basis.
- Good progress has been made in implementing the actions identified following the IST review, however across SEL this has yet to result in the level of improved performance to attain the required performance standard.
- KCH are expecting improvements in performance over the course of Q3 and draft figures show that they have met the target for Q3 on both sites.
- GST hope to meet performance for internal referrals from Q4.
Improving Access to Psychological Therapies (IAPT)

Cause of Reported Performance Position

- Growth in demand for IAPT services in Southwark and capacity limits in IAPT provision from SLaM. Performance has improved significantly in 2014/15 and currently the CCG is on track to meet the year end activity target.
- Identified variation from practice-based counsellors completing psychological therapy interventions.
- The number of long waiters (over 14 weeks) has been decreasing since June. In June 2014, 200 patients were waiting over 14 weeks; in October 2014, 99 patients were waiting over 14 weeks.

Actions Agreed to Meet Performance Standard

- Audit and review of all practice-based counselling completed.
- Additional administrative staff funded within SLaM to register referrals to counsellors and remove administration tasks from counsellors.
- Programme to increase IAPT-accredited activity being completed by practice-based counsellors.
- The recruitment of ten additional high intensity workers has been approved with 8 WTE additional workers now in place.
- Mental Health commissioners have agreed for SLaM to use SilverCloud; an online therapy programme. Licences for up to 500 people have been bought and provides another therapy option for patients. This will be operational from January 2015.
Reported Performance Position

Winterbourne View reporting is required on a fortnightly basis. At the end of December 2014 Southwark CCG reported on eight clients meeting the reporting criteria i.e. people in in-patient beds for mental and/or behavioural healthcare who have either learning disability and/or autistic spectrum disorder (including Asperger’s syndrome). This submission includes three clients admitted during November and December 2014 and one client recently transferred to the CCG from NHS England.

Reviews

Of the eight clients reported in Quarter 2 all have been reviewed within the last six months and have robust care management plans in place.

Care Treatment Reviews

NHS England have introduced Care Treatment Reviews (CTRs) for clients meeting the London target criteria (50% of individuals who were in assessment and treatment units in April 2014 need to be transferred by March 2015) where a discharge date has not been set before end of March 2015. Southwark CCG have four clients meeting this criteria and CTRs have been scheduled for three of these clients in January 2015. The CTRs are designed to look more closely at the care management plans and to explore opportunities for earlier discharges.
## Dementia Diagnosis Rate

### 2013/14 estimate prevalence = 1,600 and 2014/15 estimated prevalence = 1,664.

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<tr>
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<td><strong>Trajectory – diagnoses</strong></td>
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Data extracted from EMIS Web and subject to further validation. *Green = above target; Amber = <1% below target; Red = >1% below target.*

### Reported Performance Position

- 27 patients were transferred from the Southwark dementia register to the Lambeth dementia register due to a transfer of care home responsibility from a Southwark GP practice to a Lambeth GP practice. This transfer of patients occurred between April and May 2014 and contributed to a large drop in patients on the Southwark register at the beginning of the year.

- Waiting times from GP referral to initial baseline assessment at SLMS are down to 10.1 weeks in December 2014 from 16 weeks in April 2014. There have been further reductions to length of wait from assessment to diagnosis (7.4 weeks) and SLMS are closely monitoring the waiting list.

- The CCG is below trajectory as of 31 December. The number of patients on the dementia register increased by only five in December 2014, however this may have been due to a seasonal dip in activity. SLMS diagnosed 12 patients in December so there are at least seven more patients that need to be added to the dementia register.
Dementia Diagnosis Rate – Action plans

**Actions recently completed**

1. A detailed briefing has gone out to Southwark GP practices communicating comparative performance and providing support for each practice to improve performance.

2. SLMS have provided patient level information of patients who have been diagnosed with dementia directly to practices to facilitate better data coding. SLMS have also carried out a review of the last 12 months activity by the Community Mental Health teams to ensure all patients with a diagnosis of dementia are registered.

3. The CCG has secured a dedicated weekly scanning slot that will provide an additional four MRI slots per week and reduce overall diagnosis times resulting in higher throughput and lower waiting times. All the slots have been used since late October.

**Planned actions**

1. On-going engagement with GP practices to offer support to improve performance and coding. By 9 January, 79.6% of practices in Southwark have undertaken a coding clean up exercise.

2. The CCG team will work alongside NHSE with practices which have a consistent decrease in their register to understand what is driving the decrease and support them to resolve identified issues. Support will include; communicating the importance of early detection of dementia; workforce development; providing a GP coding exercise; practice specific action plans; providing an updated EMIS referral form for the Memory Service; increase screening of at risk patients through the DES; ensuring a full set of bloods are requested by GPs and sent along with Memory Service referral.

3. SLMS recruited an additional band 6 nurse assessor in December 2014 to increase capacity.

4. SLMS are also recruiting to a band 7 Dementia Lead Nurse Specialist to diagnose dementia within Primary Care and a further band 6 nurse assessor to diagnose dementia in care homes and target patients with Mild Cognitive Impairment (MCI) who may have deteriorated since their diagnosis.
Health Visitors

Southwark Health Visitor establishment 1 October 2014

Note: The Health Visiting service is commissioned by NHS England

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<th>Locality</th>
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</table>

Reported performance position

- GSTT are on track to fill their vacancies by March 2015. Vacancies have dropped from 9 in July to 5 in October.

Planned actions

- GSTT have increased their training placements and hope to recruit from these posts as soon as students qualify.
Q3 Serious Incidents & Never Events requiring investigation

Points to Note

SIs logged at the PRUH have not been included in the below figures as NHS Bromley CCG review and assure these incidents. None of the PRUH SIs were for Southwark residents. **The CCG was notified of six never events in Q3 - 5 at King’s and 1 at GSTT**

<table>
<thead>
<tr>
<th>Provider SIs (EXCL NEs)</th>
<th>Q3 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>October</td>
</tr>
<tr>
<td><strong>KCH – All SIs (Southwark patients in brackets)</strong></td>
<td>11 (2)</td>
</tr>
<tr>
<td><strong>GSTT hospital and community</strong> - Southwark patients only</td>
<td>1</td>
</tr>
<tr>
<td><strong>SLaM</strong> - Southwark patients only</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other Commissioned Provider</strong> - Southwark patients only</td>
<td>1</td>
</tr>
</tbody>
</table>
**Healthcare Acquired Infections – MRSA**

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>13/14</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCCG</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- This table only shows cases assigned to the CCG following Post Infection Review (PIR).
- All MRSA bacteraemia cases reported via the HCAI Data Capture System (DCS) are assigned to either an acute Trust or a CCG through the completion of a PIR. A case is deemed to be CCG assigned where the completed PIR indicates that a CCG is the organisation best placed to ensure that any lessons learned are completed.

**Actions Agreed with Providers to Meet Performance Standard**

- Infection control (including MRSA) cases are discussed at the monthly Clinical Quality Review meetings at King’s and GSTT. These meetings are chaired by CCG Clinical Leads in Southwark and Lambeth. King’s and GSTT undertake a Root Cause Analysis (RCA) on all MRSA cases and all CDI cases attributed in their organisation.

- The Lambeth and Southwark Public Health Team review local HCAI data regularly. Post Infection Reviews of MRSA bacteraemias are producing information on the detail of local cases and learning. Most cases are very complex with numerous healthcare contacts.
### Healthcare Acquired Infections – c.difficile

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>13/14</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Q1</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Q2</th>
<th>Oct</th>
<th>Nov</th>
<th>14/15 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCCG</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>36</td>
<td>4</td>
<td>1</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>15</td>
<td>4</td>
<td>2</td>
<td>42</td>
</tr>
<tr>
<td>KCH DH</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>49</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>22</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>GSTT</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>43</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>18</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>15</td>
<td>2</td>
<td>2</td>
<td>37</td>
</tr>
</tbody>
</table>

**Actions Agreed with Providers to Meet Performance Standard**

- Infection Control including MRSA and *Clostridium difficile (CDI)* information is made available at the monthly Clinical Quality Review Group (CQRG) meetings at King's and GSTT. These meetings are chaired by CCG Clinical Leads in Southwark and Lambeth. King's and GSTT undertake a Root Cause Analysis (RCA) on all MRSA cases and all CDI cases attributed to their organisation.

- KCH Denmark Hill has carried out a number of improvement actions including: deep clean and use of hydrogen peroxide vapour on a number of wards; ongoing review of every case of CDI at weekly meetings; increased level of discharge cleaning; re-training of staff; and daily review of side rooms to facilitate appropriate bed placement of CDI patients. Additional measures have now been put in place including spot-checks of clinical departments by the Director for Infection Prevention and Control (DIPC) and Deputy DIPC, and weekly reporting to Kings Executive.
The 2014-15 National Patient Experience CQUIN focuses predominantly on response rates and extending the test to outpatient and day case areas in the Autumn.

### Friends & Family Test – Response Rates

#### Inpatient Response Rates (target: Q1 25%; Q4 higher than Q1 and higher than 30%)

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KCH – Den. Hill</strong></td>
<td>43%</td>
<td>41%</td>
<td>46%</td>
<td>35%</td>
<td>40%</td>
<td>35%</td>
<td>48%</td>
<td>50%</td>
<td>33%</td>
<td>45%</td>
<td>42%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>GSTT</strong></td>
<td>26%</td>
<td>27%</td>
<td>35%</td>
<td>35%</td>
<td>40%</td>
<td>37%</td>
<td>40%</td>
<td>34%</td>
<td>31%</td>
<td>30%</td>
<td>35%</td>
<td>39%</td>
</tr>
</tbody>
</table>

#### A&E Response Rates (target: Q1 15%; Q4 higher than Q1 and higher than 20%)

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KCH – Den. Hill</strong></td>
<td>9.6%</td>
<td>16.8%</td>
<td>15.1%</td>
<td>17.6%</td>
<td>21.8%</td>
<td>26.0%</td>
<td>27.8%</td>
<td>24.7%</td>
<td>25.2%</td>
<td>26.7%</td>
<td>27.2%</td>
<td>25.3%</td>
</tr>
<tr>
<td><strong>GSTT</strong></td>
<td>16.1%</td>
<td>14.8%</td>
<td>27.7%</td>
<td>10.1%</td>
<td>11.0%</td>
<td>6.1%</td>
<td>17.6%</td>
<td>12.7%</td>
<td>10.6%</td>
<td>5.1%</td>
<td>14.2%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

**Reported Performance Position**

- A&E response rate at GSTT has been below the 15% target since July. The trust needs to achieve a response rate of at least 20% in Q4.
- The trust has continued to focus on promoting A5 response postcards by Band 2 UCC Receptionist and hours extended to late shifts and weekends. Trial of clinical staff handing A5 response cards to patients in Majors cubicles and Reception staff handing out cards on arrival to boost coverage.
CCG Finance Report 2014/15

Month 8
(Period to end of November 2014)

CCG Governing Body

22nd January 2015
Financial Performance Duties

<table>
<thead>
<tr>
<th>Duty</th>
<th>YTD Target</th>
<th>YTD Performance</th>
<th>RAG</th>
<th>Annual Target</th>
<th>Forecast Performance</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve planned surplus (Expenditure not to exceed income)</td>
<td>£3,981k</td>
<td>£4,182k</td>
<td>✔</td>
<td>£5,972k</td>
<td>£6,272k</td>
<td>✔</td>
</tr>
<tr>
<td>Capital resource does not exceed the allowance</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Revenue resource does not exceed the allowance</td>
<td>£246,717k</td>
<td>£242,535k</td>
<td>✔</td>
<td>£383,675k</td>
<td>£377,403k</td>
<td>✔</td>
</tr>
<tr>
<td>Capital Resource use on specified matters does not exceed the allowance</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Revenue resource use on specified matters does not exceed the allowance</td>
<td>£241,852k</td>
<td>£237,871k</td>
<td>✔</td>
<td>£376,460k</td>
<td>£370,488k</td>
<td>✔</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the allowance</td>
<td>£4,865k</td>
<td>£4,665k</td>
<td>✔</td>
<td>£7,215k</td>
<td>£6,915k</td>
<td>✔</td>
</tr>
</tbody>
</table>

Notes:

1. The above duties correspond to those reported in Note 42 of the Annual accounts, and represent the statutory duties of the CCG.

2. To support the delivery of the above, an in-year QIPP programme of £15,591k has been established. QIPP monitoring information is included on page 17.
• Southwark CCG was underspent at the end of Month 8 by £4,182k for the year to date.

• This is marginally above the planned pro rata effect of £3,981k, and the CCG is on track to achieve the annual target surplus of £5,972k.

• The CCG has utilised £329k of reserves to achieve this ytd position. This is mainly to offset adverse variances in the ytd reported position for Community & Primary Health Services.

• There is £1.87m of reserves currently uncommitted in the likely forecast position.

• In the worst case projection, we would need to utilise the balance of reserves. This would still enable the CCG to meet its financial targets but would require the use of all of the CCG’s reserves.

• The CCG is currently forecasting successful achievement of the £15.59m QIPP programme.
Summary of Position (2 of 2)

Data available for this report:
- Acute data is available for seven months.
- Prescribing data is available for six months.
- Mental Health data is available for six months.

Southwark CCG “Running Costs” are treated as a separate allocation so shown as separate in the summary. Cross subsidisation of Running Costs by underspend on Programme Budgets is not permitted.
<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best Case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>218,777</td>
<td>0</td>
<td>-251</td>
<td>464</td>
<td>-1,475</td>
</tr>
<tr>
<td>Client Groups</td>
<td>70,894</td>
<td>367</td>
<td>0</td>
<td>159</td>
<td>-200</td>
</tr>
<tr>
<td>Community and Primary Health Services</td>
<td>35,280</td>
<td>-795</td>
<td>-750</td>
<td>-710</td>
<td>-914</td>
</tr>
<tr>
<td>Prescribing</td>
<td>31,046</td>
<td>-200</td>
<td>0</td>
<td>240</td>
<td>-251</td>
</tr>
<tr>
<td>Corporate Costs</td>
<td>6,227</td>
<td>300</td>
<td>407</td>
<td>465</td>
<td>375</td>
</tr>
<tr>
<td>Earmarked Budgets and Reserves</td>
<td>8,264</td>
<td>329</td>
<td>594</td>
<td>0</td>
<td>2,464</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>5,972</td>
<td>3,981</td>
<td>5,972</td>
<td>5,972</td>
<td>5,972</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>376,460</strong></td>
<td><strong>3,982</strong></td>
<td><strong>5,972</strong></td>
<td><strong>6,590</strong></td>
<td><strong>5,972</strong></td>
</tr>
</tbody>
</table>

**Reserves not utilised in above position (netted off for MFF & other commitments)**

|                        |                    |                          |                            | 1,870          | 2,464           | 0              |

**Reserves not yet utilised in above position (Month 7 for comparison)**

|                        |                    |                          |                            | 4,418          | 6,639           | 1,830          |
# CCG Running Costs Summary 2014/15 - Month 8

## Notes:

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

2. The reason for the underspend at Month 8 relates to the fact that the CCG has already put into effect plans to make large savings that are required of the CCG in 2015/16 (additional 10% savings). Such savings include renegotiated contracts for Commissioning Support Unit services and accommodation. The new staffing structure is now in place and budgeted accordingly.

### Table: Running Costs Summary

<table>
<thead>
<tr>
<th>Running Costs</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running costs</td>
<td>7,215</td>
<td>200</td>
<td>300</td>
<td>400</td>
<td>200</td>
</tr>
<tr>
<td>Month 7 (for comparison)</td>
<td>7,215</td>
<td>175</td>
<td>300</td>
<td>400</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note: a red negative sign indicates budget overspend*
### Acute Financial Position 2014/15

<table>
<thead>
<tr>
<th>Acute Contract</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best Case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guys and St Thomas’ FT</td>
<td>82,492</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-894</td>
</tr>
<tr>
<td>Kings College Hospital FT</td>
<td>87,707</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham and Greenwich NHS Trust</td>
<td>3,554</td>
<td>244</td>
<td>254</td>
<td>367</td>
<td>188</td>
</tr>
<tr>
<td>University College London Hospital</td>
<td>1,592</td>
<td>-116</td>
<td>-201</td>
<td>-174</td>
<td>-236</td>
</tr>
<tr>
<td>London Ambulance</td>
<td>11,012</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other contracts and non-contracted activity</td>
<td>32,421</td>
<td>-129</td>
<td>-304</td>
<td>272</td>
<td>-532</td>
</tr>
<tr>
<td><strong>Total Acute</strong></td>
<td><strong>218,777</strong></td>
<td><strong>0</strong></td>
<td><strong>-251</strong></td>
<td><strong>464</strong></td>
<td><strong>-1,475</strong></td>
</tr>
<tr>
<td><strong>Month 7 (for comparison)</strong></td>
<td><strong>209,842</strong></td>
<td><strong>-1,273</strong></td>
<td><strong>-2,479</strong></td>
<td><strong>-521</strong></td>
<td><strong>-2,949</strong></td>
</tr>
</tbody>
</table>

**Note:** a red negative sign indicates budget overspend
The position at month 8 shows a breakeven position. This is based on month 7 monitoring information from providers and is adjusted to reflect where provider reporting does not yet reflect contractual arrangements or doesn't yet include agreed challenges.

GSTT – the ytd position shows performance in line with plan. There is an underlying small overspend position, driven by underspends on the following PODs: non-elective (£265k), maternity pathway (£285k), and “other” (£478k). These underspends are offset against overspends on emergency (£543k), A&E (£223k), out patient follow up (£393k), out patient procedure (£210k), and Critical Care (£218k). However, at the current time, the value of the underlying overspend is within the contract tolerances, and therefore the reported position is break-even.

King’s – the ytd position shows performance in line with plan. There is an underlying underspend position, driven by underspends on the following PODs: elective (£676k), maternity pathway (£202k), out patient procedure (£220k), direct access (£182k), and “other” (£695k). However, at the current time, the value of the underlying underspend is within the contract tolerances, and therefore the reported position is break-even.
• The predicted year end position has been based on the adjusted Month 7 provider information, adjusted where appropriate for a realistic assessment of challenges and financial adjustments.

• The Acute budget has increased in Month 8 due to the allocation of £6.93m Winter Resilience funding which was received in Month 7 and had been held within CCG Reserves.
## Client Group Financial Position 2014/15

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Contracts</td>
<td>52,976</td>
<td>-664</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>1,794</td>
<td>290</td>
<td>100</td>
<td>150</td>
<td>50</td>
</tr>
<tr>
<td>Older Adults</td>
<td>5,183</td>
<td>691</td>
<td>200</td>
<td>250</td>
<td>150</td>
</tr>
<tr>
<td>Palliative care</td>
<td>1,735</td>
<td>64</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Children Services</td>
<td>1,702</td>
<td>201</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>YPD</td>
<td>3,982</td>
<td>-219</td>
<td>-300</td>
<td>-241</td>
<td>-400</td>
</tr>
<tr>
<td>Reablement</td>
<td>1,877</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Client Groups</td>
<td>1,646</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Client Groups</strong></td>
<td>70,894</td>
<td>367</td>
<td>0</td>
<td>159</td>
<td>-200</td>
</tr>
<tr>
<td><strong>Month 7 (for comparison)</strong></td>
<td>73,636</td>
<td>760</td>
<td>0</td>
<td>159</td>
<td>-1,500</td>
</tr>
</tbody>
</table>

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

- The CCG has agreed a settlement with SLaM with regard to the funding issue over specialist commissioning relating to invoices issued by SLaM in 2013-14.
- The CCG has reached agreement with SLaM with regard to the 2014-15 contract value, which includes an investment of £1m relating to expected activity levels for the year.
- QIPP savings of £2m have been applied to the contract and the CCG and SLaM are working closely to ensure effective delivery of the savings.
- Specialist CAMHs services are underspending by 3% (£10k). This is offset against Specialist Adults which are overspending by £85k. Systems are now in place to monitor the appropriateness of referrals.
- There is an underlying overspend position of £584k on Residential placements as at the end of September (the latest month for which data is available).
- Dementia - Funding to enhance the capacity of the memory service has been agreed. Part year funding of £91k was added to the Mental Health budget in Month 6.
- Children’s continuing care is currently overspending by 33%. The full year forecast overspend is £350k.
- Expenditure on all other continuing care services remain within budget.
- Other Client Groups includes Children’s Community Nursing Team, Home Enteral Nutrition and Clinical Assessment Service.
### Community and Primary Health Services 2014/15

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Contract</td>
<td>27,035</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Access/Urgent Care/WIC</td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Extended Access Services</td>
<td>1,205</td>
<td>109</td>
<td>164</td>
<td>164</td>
<td>0</td>
</tr>
<tr>
<td>Other Primary Health Services</td>
<td>6,540</td>
<td>-904</td>
<td>-914</td>
<td>-914</td>
<td>-914</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35,280</strong></td>
<td><strong>-795</strong></td>
<td><strong>-750</strong></td>
<td><strong>-710</strong></td>
<td><strong>-914</strong></td>
</tr>
<tr>
<td>Month 7 (for comparison)</td>
<td>34,363</td>
<td>64</td>
<td>92</td>
<td>200</td>
<td>0</td>
</tr>
</tbody>
</table>

- The contract for the UCC has changed this year with GSTT taking over the contract and Southwark CCG paying the trust directly for activity incurred by Southwark residents. £710k was transferred in Month 3 to the Acute budget for the above.
- As reported in Month 6, the CCG is now invoicing NHS England directly for the funding for the Prime Minister’s Challenge Fund Improving Access to General Practice.
- The overspend on “Other Primary Health Services” is due to a commitment of £1.2m to Southwark Council relating to creating a risk reserve against emergency activity reductions in the Better Care Fund. This is overspend is partially offset by an underspend on the 111 LAS contract.

**Note:** A red negative sign indicates budget overspend
### Prescribing Financial Position 2014/15 (1 of 2)

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best Case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bermondsey &amp; Rotherhithe</td>
<td>7,356</td>
<td>309</td>
<td>457</td>
<td>550</td>
<td>288</td>
</tr>
<tr>
<td>Borough &amp; Walworth</td>
<td>8,649</td>
<td>139</td>
<td>205</td>
<td>300</td>
<td>129</td>
</tr>
<tr>
<td>South Southwark</td>
<td>14,511</td>
<td>100</td>
<td>148</td>
<td>200</td>
<td>143</td>
</tr>
<tr>
<td>Admin and Other Prescribing</td>
<td>530</td>
<td>-748</td>
<td>-810</td>
<td>-810</td>
<td>-810</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31,046</strong></td>
<td><strong>-200</strong></td>
<td><strong>0</strong></td>
<td><strong>240</strong></td>
<td><strong>-251</strong></td>
</tr>
<tr>
<td><strong>Month 7 (for comparison)</strong></td>
<td><strong>31,046</strong></td>
<td><strong>151</strong></td>
<td><strong>0</strong></td>
<td><strong>425</strong></td>
<td><strong>-426</strong></td>
</tr>
</tbody>
</table>

### Notes

- The data for prescribing is released two months in arrears. The ytd and forecast positions have been based on the month 6 data.
- The £200k adverse ytd variance relates to £273k prior year spend over and above the accrual entered at year end and an overspend on Locally Enhanced Services. These adverse variances are being offset by underspends on current year prescribing as reported by NHS Prescription Services.

**Note:** a red negative sign indicates budget overspend
• The adverse variance reported within Admin & Other Prescribing Includes the difference between the practice level report from Prescribing Services and charges to Southwark CCG from NHS Business Services Authority. As at Month 6 (the last month for actual data), this difference was £154k.

• There is a cost pressure for the second half of the year due to DoH agreed price increases of low cost, high volume drugs. The new prices were are effective from October 2014.
## Corporate Costs 2014/15

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best Case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP IT</td>
<td>814</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Development Costs for Dulwich Health Centre and Other Projects</td>
<td>694</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Estates Costs</td>
<td>1716</td>
<td>183</td>
<td>275</td>
<td>275</td>
<td>275</td>
</tr>
<tr>
<td>Medicine Management</td>
<td>450</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>Payments to Southwark Council incl- GUM and Public Health</td>
<td>1337</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Corporate</td>
<td>1216</td>
<td>117</td>
<td>132</td>
<td>150</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6227</strong></td>
<td><strong>300</strong></td>
<td><strong>407</strong></td>
<td><strong>465</strong></td>
<td><strong>375</strong></td>
</tr>
<tr>
<td><strong>Month 7 (for comparison)</strong></td>
<td><strong>6227</strong></td>
<td><strong>140</strong></td>
<td><strong>166</strong></td>
<td><strong>240</strong></td>
<td><strong>66</strong></td>
</tr>
</tbody>
</table>

### Notes:
- These costs are **not** counted against the £25 per head CCG Running Costs allocation.
- ‘Other Corporate’ includes South East London PMO, and local CCG PMO.
- There is an underspend of £183k on Estates charges from NHS Property Services (mainly Dulwich) and Community Health Partnerships. The favourable swing in month is due to a change in the methodology of calculating charges used by Community Health Partnerships. Charges are now based on actual cost.

**Note**: a red negative sign indicates budget overspend
## Earmarked Budgets and Reserves 2014/15

### Programme Budget

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best Case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Contingency (0.5%)</td>
<td>1,264</td>
<td>279</td>
<td>544</td>
<td>0</td>
<td>1,264</td>
</tr>
<tr>
<td>Non-Recurrent Expenditure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General Risk Reserve</td>
<td>4050</td>
<td>50</td>
<td>50</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>SEL Collaborative Risk Pool</td>
<td>1,150</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,150</td>
</tr>
<tr>
<td>MFF re - Merger Kings/Pru</td>
<td>1,800</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>8,264</td>
<td>329</td>
<td>594</td>
<td>0</td>
<td>2,464</td>
</tr>
</tbody>
</table>

**Month 7 (for comparison)**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>15,374</td>
<td>159</td>
<td>2,221</td>
<td>0</td>
<td>4,809</td>
</tr>
</tbody>
</table>

**Reserves not utilised in overall position (netted off for MFF & other commitments)**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,870</td>
<td>2,464</td>
<td>0</td>
</tr>
</tbody>
</table>

### Planned Surplus

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Surplus</td>
<td>5,972</td>
<td>3,981</td>
<td>5,972</td>
<td>5,972</td>
<td>5,972</td>
</tr>
</tbody>
</table>

**Month 7 (for comparison)**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5,972</td>
<td>3,484</td>
<td>5,972</td>
<td>5,972</td>
<td>5,972</td>
</tr>
</tbody>
</table>

**Note:** A red negative sign indicates budget overspend
### Running Costs 2014/15 (Separate Allocation)

<table>
<thead>
<tr>
<th>Programme Budgets</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 8 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best case (£k)</th>
<th>Worst Case (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>2564</td>
<td>-22</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CSU Recharge</td>
<td>2122</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Office Accommodation</td>
<td>402</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>2127</td>
<td>222</td>
<td>300</td>
<td>400</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7215</strong></td>
<td><strong>200</strong></td>
<td><strong>300</strong></td>
<td><strong>400</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Month 7 (for comparison)</strong></td>
<td><strong>7215</strong></td>
<td><strong>200</strong></td>
<td><strong>300</strong></td>
<td><strong>400</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

- This is the separate allocation of £25 per patient for running costs.

- The ‘Other’ costs include Southwark’s share of Office costs, various Levies and Audit Fees.
## QIPP Monitoring

### SOUTHWARK CCG QIPP 2014-15

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan</th>
<th>Year to Date</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QIPP Target 2014-15 (Post-RAG-Rating) (£k)</td>
<td>YTD Plan (£k)</td>
<td>YTD Actual (£k)</td>
</tr>
<tr>
<td>Acute</td>
<td>10,000</td>
<td>6,667</td>
<td>6,667</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,500</td>
<td>1,667</td>
<td>1,667</td>
</tr>
<tr>
<td>Primary Care Prescribing</td>
<td>2,241</td>
<td>1,494</td>
<td>1,494</td>
</tr>
<tr>
<td>Community Services</td>
<td>500</td>
<td>333</td>
<td>333</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>250</td>
<td>167</td>
<td>167</td>
</tr>
<tr>
<td>Corporate</td>
<td>100</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td><strong>Southwark CCG QIPP Target 2014/15</strong></td>
<td><strong>15,591</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Total QIPP savings plans of £16,388k are in place for 2014/15. However, in order to achieve the plans, an investment of £797k has been made. This includes £455k on Mental Health QIPP schemes and £342k on Acute schemes. This leaves the net QIPP value at £15,591k.**
- **The CCG is forecasting to deliver the QIPP programme in full in 2014/15.**

**Note:** a red negative sign indicates budget overspend
## Financial Risks & Mitigations (1 of 2)

### Risks

<table>
<thead>
<tr>
<th>Risks</th>
<th>Full Risk Value £m</th>
<th>Probability of risk being realised %</th>
<th>Potential Risk Value £m</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute SLAs</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Community SLAs</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Mental Health SLAs</td>
<td>1.00</td>
<td>50.00%</td>
<td>0.50</td>
<td>bed usage and outplacements</td>
</tr>
<tr>
<td>Continuing Care SLAs</td>
<td>0.50</td>
<td>50.00%</td>
<td>0.25</td>
<td>risk of increase being above population levels of 2% pa</td>
</tr>
<tr>
<td>QIPP Under-Delivery</td>
<td>0.50</td>
<td>50.00%</td>
<td>0.25</td>
<td>most QIPP has been secured in contract negotiations - low risk</td>
</tr>
<tr>
<td>Performance Issues</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Other Risks</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL RISKS</strong></td>
<td><strong>2.00</strong></td>
<td><strong>1.00</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Mitigations

<table>
<thead>
<tr>
<th>Mitigations</th>
<th>Full Mitigation Value £m</th>
<th>Probability of success of mitigating action %</th>
<th>Expected Mitigation Value £m</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncommitted Funds (Excl 2% Headroom)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency Held</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Contract Reserves</td>
<td>1.87</td>
<td>100.00%</td>
<td>1.87</td>
<td>further reserves not specifically earmarked</td>
</tr>
<tr>
<td>Investments Uncommitted</td>
<td>0.90</td>
<td>100.00%</td>
<td>0.90</td>
<td>holding back on some service redesign in mental health and acute</td>
</tr>
<tr>
<td><strong>Uncommitted Funds Sub-Total</strong></td>
<td><strong>2.77</strong></td>
<td></td>
<td><strong>2.77</strong></td>
<td></td>
</tr>
<tr>
<td>Actions to Implement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further QIPP Extensions</td>
<td>0.50</td>
<td>50.00%</td>
<td>0.25</td>
<td>short term measures</td>
</tr>
<tr>
<td>Non-Recurrent Measures</td>
<td>1.00</td>
<td>50.00%</td>
<td>0.50</td>
<td>short term measures</td>
</tr>
<tr>
<td>Delay/ Reduce Investment Plans</td>
<td>0.50</td>
<td>50.00%</td>
<td>0.25</td>
<td>further reductions in acute and community investment</td>
</tr>
<tr>
<td>Other Mitigations</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Mitigations relying on potential funding</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td><strong>Actions to Implement Sub-Total</strong></td>
<td><strong>2.00</strong></td>
<td></td>
<td><strong>1.00</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL MITIGATION</strong></td>
<td><strong>4.77</strong></td>
<td></td>
<td><strong>3.77</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Net Risk / Headroom

| Forecast Outturn Surplus/Deficit |                          | 6.27                             |
| RISK ADJUSTED CONTROL TOTAL     |                          | **9.04**                         |
The value of the potential risks reported on the previous page is in addition to the forecast outturn position. The purpose of this table is to report on risks and mitigations that are not included in the forecast – i.e. to illustrate anything that puts the reported forecast outturn at risk.

- The best case impact is £2.77m: no risks materialise and funds remain uncommitted.
- The worst case impact is £0.77m: all risks occur, further actions are unsuccessful and uncommitted funds all used to mitigate risks.
- Contract Reserves reported in the “Mitigations” table (page 19) excludes the MFF and other committed reserves (including the reserves utilised to achieve the target position). This is consistent with the unutilised reserves figure reported within the Earmarked Budgets & Reserves 2014/15 table (page 16).
Under the Better Payments Practice Code (BPPC), CCGs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. This is measured both in terms of the total value of invoices and the number of invoices by count. Current month and cumulative performance as well as comparison to the previous month are shown in the table above.
### Revenue Resource Limit (1 of 2)

<table>
<thead>
<tr>
<th></th>
<th>Admin £m</th>
<th>Programme £m</th>
<th>Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial CCG Allocation 2014/15</strong></td>
<td></td>
<td>362.47</td>
<td>362.47</td>
</tr>
<tr>
<td><strong>Running Costs Allowance 2014/15</strong></td>
<td>7.22</td>
<td></td>
<td>7.22</td>
</tr>
<tr>
<td><strong>Brought forward surplus from 2013/14</strong></td>
<td></td>
<td>3.97</td>
<td>3.97</td>
</tr>
<tr>
<td><strong>2014/15 Opening Allocations</strong></td>
<td>7.22</td>
<td>366.44</td>
<td>373.66</td>
</tr>
<tr>
<td><strong>In year Allocations:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP IT – Month 3</td>
<td></td>
<td>0.77</td>
<td>0.77</td>
</tr>
<tr>
<td>1415 RTT Funding – Month 5</td>
<td></td>
<td>1.61</td>
<td>1.61</td>
</tr>
<tr>
<td>GP IT Transitional Allocation – Month 5</td>
<td></td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>2014-15 CEOV and non-rechargeable services allocation adjustment – Month 6</td>
<td></td>
<td>0.67</td>
<td>0.67</td>
</tr>
<tr>
<td>Winter Resilience Funding Tranche 1 &amp; 2</td>
<td></td>
<td>6.94</td>
<td>6.94</td>
</tr>
<tr>
<td><strong>Total Confirmed Allocation at Month 8</strong></td>
<td>7.22</td>
<td>376.46</td>
<td>383.68</td>
</tr>
</tbody>
</table>
There has been no change to the Confirmed Allocation in Month 8.

There are anticipated adjustments due in Month 9, including:
- NHS England South Region Specialist Commissioning baseline re-opening (expected funding outflow of £20k).
- Additional Mental Health Allocation (expected funding inflow of £174k).
- RTT Tranche 2 (expected funding inflow of £2.7m).

Further allocation adjustments are expected. These include:
- MFF Allocation adjustment (expected funding outflow of £1.8m) . Expected in Month 10.
- The allocation adjustment for Specialist Commissioning misattributions included in 2014/15 contract plans (highlighted in previous Finance Reports), may also come through in Month 10, but this adjustment is awaiting a decision with regard to timing.

Adjustments are not reflected in the table on page 22 until such time as they have been agreed and confirmed through the NHSE standard process.
Recommendations

1. To note the budgets and position for the ‘Programme Budgets’ and the ‘Running Costs’ as at end November 2014.

2. To note the risks on specialised commissioning.

Malcolm Hines
Chief Financial Officer
NHS Southwark CCG
15th December 2014
## CCG CORPORATE OBJECTIVES 2014-15

### QUALITY, SAFETY & EFFECTIVENESS

<table>
<thead>
<tr>
<th>Risk Title &amp; Description (Cause &amp; Effect)</th>
<th>Director / Risk Owner</th>
<th>Programme Board</th>
<th>Score Likelihood x Impact</th>
<th>Risk Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability to achieve improvement in the quality of care delivered in residential and nursing homes</td>
<td>Gwen Kennedy</td>
<td>Baker, Quality &amp; Safety</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Effective governance: Children's Safeguarding Policy in place, which has been updated in October 2014 and agreed by IG&amp;P Committee. The group responsible for the CCG’s Safeguarding Children and Children’s Executive Committee, which runs to monthly meetings. Health Sub-Group of Southwark Safeguarding Children’s Board has been in place since October 2014. Safeguarding specialists in place: Specialist Designated Nurse for Child Protection and Designated Doctor for Safeguarding Children are both in place. The CCG has a changes Child Protection - clinical lead eligible for safeguarding. Robust risk management and monitoring: Continual monitoring of Child Protection Action Plans in partnership with the local authority. Training and development of members and staff: PLT events for child safeguarding have been run and these are attended by clinicians from all GP practices in Southwark. Safeguarding training is part of annual mandatory training for all CCG staff and has been completed by 100% of staff in 2014. CCG staff involved in attending safeguarding networking meetings organized by the SSSR and GCS surveillance - able to meet the requisite standards</td>
<td>Gwen Kennedy</td>
<td>Baker, Quality &amp; Safety</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Development of effective systems, in conjunction with Adult Safeguarding, for care homes within Southwark.</td>
<td>Gwen Kennedy</td>
<td>Baker, Quality &amp; Safety</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### SUSTAINABLE DELIVERY & GOVERNANCE

<table>
<thead>
<tr>
<th>Risk Title &amp; Description (Cause &amp; Effect)</th>
<th>Director / Risk Owner</th>
<th>Programme Board</th>
<th>Score Likelihood x Impact</th>
<th>Risk Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaps in mitigation/assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SYSTEM TRANSFORMATION

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### INVOLVEMENT

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### SMART Actions with name of Risk Actions & deadline for completion of action

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### Direction of Travel

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**CCG Objectives**

1. **Quality, Safety & Effectiveness**
   - Ensure effective involvement of member practices and other partners in decision making.
   - Improve the quality and safety of local health services.
   - Secure delivery of the NHS Constitutional rights and pledges for all Southwark residents.
   - Ensure good governance, financial stability of the local health economy, VFM and delivery of statutory responsibilities.

2. **Sustainable Delivery & Governance**
   - Commission proactive care focused upon the prevention and the early detection of illness.
   - Improve outcomes for Southwark patients and achieve better value, integrated care through transformation programmes delivered in partnership with stakeholders and our residents.

3. **System Transformation**
   - Ensure the CCG’s commissioning resource and organisational capability are effectively aligned to deliver its objectives.

4. **Involve patients and the public** in the commissioning of the services they receive.

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Implementation of the CCG Quality Framework: The document reviews the CCG's progress on its ambition to become a ‘quality-focused’ organisation. The framework sets out a series of recommendations to enhance the quality of commissioned care and patient outcomes. These recommendations are to be taken forward by the CCG’s programme boards and committees. It was signed off for implementation by the CCG Governing Body in June 2014.

Dedicated committees and programme board established: IGP & Committee and Governing Body receive assurance from CQRGs and lead directors on quality issues, including complaints and Serious Incidents and key quality indicators. The newly convened Quality and Safety Programme Board as a sub-committee of IGP, chaired by GB lead to provide oversight and scrutiny of all aspects of quality and patient safety with contracted providers. The CCG completes monthly quality and contract monitoring meetings with all main providers (SlAM; KHG, SST; SELDOC).

Provision of information and data on quality: The CCG produces a quarterly Quality Report, which summarises key quality issues and provides assurance that action is being taken to address them. This is reviewed by the Quality and Safety Programme Board and by the IGP Committee. Data and information on acute and community quality issues is provided by SECSU. The CCG has also established a Primary Care Quality Alerts system so local GPs can flag concerns, which can then be addressed with local providers.

Leadership and accountability for quality: Governing Body clinical leads assigned to each provider and chair (or attend as a minimum) CQRG meetings with providers. Clinical leaders are involved in the development of CQUINS.

Site visits: The CCG completes regular site visits at local providers. CCG governing body members and management conduct biannual visits to all CCG member practices and discuss quality and performance issues highlighted by the CCG’s primary care dashboard, which compares practice performance with peers.


Mobilisation readiness: Ensures effective two-way communication with all stakeholders, including providers.

Variable quality monitoring processes and systems in smaller providers.

Risk Actionee & deadline for Risk Control

Risk owner: Nigel Smith

Programme: IAPT

Risk: Implement mobilisation and communication - Variable quality monitoring processes and systems in smaller providers.

Impact: Variable quality monitoring processes and systems in smaller providers.

Probability: 3

Assurance: Regular monitoring and reporting of South East Extended Primary Care Service, including on-going programme of support and training to ensure continued care and patient messaging at all practice level - on-going, H5

Travel: Programme of Clinical Site Visits being scheduled for 2015 addressing key clinical risk priority areas. GJ, January 2015

Programme of future client reviews in place. HM-B, ongoing, review in March 2015.

CCG

Risk of not meeting the Winterbourne View performance target: Winterbourne View is a specialist care home for people with a learning disability. A number of challenges and concerns were identified during the Winterbourne View scandal: The facility was not meeting the required standards for the care of people with a learning disability and the scandal led to a significant reconfiguration of care for people with a learning disability.

Risk owner: Paul Jenkins

Programme: Winterbourne View

Risk: Implementation of the CCG Quality Framework - Variable quality monitoring processes and systems in smaller providers.

Impact: Variable quality monitoring processes and systems in smaller providers.

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IC-13
QUALITY, SAFETY & EFFECTIVENESS
Low staff levels of Community Nurses impacts on preventative and community nursing (also on Lambeth BAP)
Pam Jenkins
Primary & Community Delivery
3 4 5

Governance structures in place to work with NHS Lambeth CCG, the lead commissioners for the provider of community nursing (GSTI) including performance monitoring through contract and CQFG meetings. Qualitative quality issues are raised by GPs and monitored by the CCG through the Quality Walt system.

Commissions have agreed GSTTI action plan to improve staff levels. This includes: recruitment and retention plan; monthly meetings of the Head of and Deputy Head of Community Nursing to monitor implementation of task action plan which includes recruitment and retention plan; District Nurse Vascular Conference 19 November 2019.

Commissions have agreed additional funding for 2014/15 for extra staff and clinical supervision.

IC-17
QUALITY, SAFETY & EFFECTIVENESS
Low rates of diagnostic imaging services leads to CCG missing national Dementia targets and lack of treatment for those people not diagnosed
Paul Jenkins
Mental Health & Party of Education
4 4 5

A range of measures have been implemented to support SLAM and primary care to identify dementia patients including: funding for a dementia nurse; a bespoke support package for GP practices (August 2014) containing practice level data, a coding clean up exercise, DES and SLMS referral form. MRI scanning capacity at SLMS has been increased to support quick diagnosis.

CCG is working with GPs’ neighbourhoods (QHS and IHL) to improve dementia diagnosis and it has been discussed at Locality meetings.}

IC-18
QUALITY, SAFETY & EFFECTIVENESS
Delivery of Integrated Commissioning Strategies: Reducing the impact on contract negotiations for the 2015/16 outpatient reductions, A&E reductions, UCC, prescribing reductions, mental health
Paul Jenkins
Nigel Smith
N/A
4 4 5

Strong risk-share arrangement in place with acute providers. Provider delivery of QIPP for 2014/15 is included within contracts to mitigate risk for 2014/15. Performance against all QIPP projects is monitored against targets on a monthly basis as part of contract monitoring with on-going discussions with providers to agree actions to improve performance.

QIPP risk sharing agreement for main acute providers and for the SLAM contract guarantees risk-capped delivery of QIPP efficiencies in 2014/15.

IC-20
SUSTAINABLE DELIVERY AND EFFECTIVE GOVERNANCE
Failure to deliver financial targets and Service Planning Implementation
Malcolm Hines
Julian Knott
N/A
4 4 5

Risk share arrangements in place: SE London has a financial risk share agreement, which is embedded in the CCG consolidation. Partnership working is also well established with monthly CFO meetings in both SEL and across London to address generic financial pressures and opportunities.

Robust monitoring of CCG financial position: CCG financial plan is scrutinised and approved by CoM and GB at the beginning of the year. The CCG has in place strong internal systems to regularly monitor progress, including monthly reports to IGP Committee, bi-monthly reviews of finance at the CCG Governing Body and regular updates to SMT. The Audit committee reviews the completeness and accuracy of information provided to the GB and is responsible for systems of financial reporting to the Governing Body, including those of budgetary control. Annual systematic internal audit review of financial management takes place as well as regular external monitoring through the NHSE quarterly assurance process.

There is an annual financial reporting process which the CCG adheres to and this includes scrutiny sign off of annual accounts by external auditors.

Specific resolution of key financial risks. A number of key challenges for 2014/15 have now been concluded. These include: a formal year-end agreement negotiated and agreed with both KCH and SLAM. NHSE Specialised Commissioning contracts successfully transferred with a broadly neutral impact on the CCG, the Better Care Fund financial planning and risk assessment completed.

Risk-share on QIPP delivery in place with trusts, which limits CCG risk significantly.

Further reserves have been identified to mitigate in-year slippage on QIPP delivery. Effective monitoring of QIPP delivery with management. The CCG completes close in-year monitoring through SMT and IGP Committee to enable early identification of risks, variances and oversight of mitigating action implementation. Specific delivery risks captured in Directorate Risk Registers.

IC-24
SUSTAINABLE DELIVERY AND EFFECTIVE GOVERNANCE
Failure to achieve full delivery of £15.5m (net) QIPP. Programmes for 2014/15 led to risk delivery of the CCG financial plan.
Malcolm Hines
N/A
4 4 5

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IC-27
SUSTAINABLE DELIVERY AND EFFECTIVE GOVERNANCE
Failure to deliver financial targets and Service Planning Implementation
Malcolm Hines
N/A
4 4 5

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Fully-functional governance structure in place. SIRO and Caldicott Guardian are members of CCG Governing Body with support from a designated Corporate Governance Manager and specific IG advice contracted from the CSU Information Governance team. The Information Governance Steering Group (IGSG) has been established to oversee issues relating to IG and regulated by IGSSG as a co-ordinated provider. This consists of SIRO, Caldicott Guardian and key leads from all Directories. The IGSSG meets every 6 weeks and oversees implementation of Information Governance within the CCG. The CCG has agreed a number of key performance indicators and strategies including the Information Governance Framework, Information Governance Policy, Information Quality Policy, Information Security Policy, and Information Management Policy.

Staff training. Information Governance is mandatory training for all the members of the CCG and 100% staff have completed it. Southwark CCG staff attend workshops and networking meetings organised by the CSU on PSD data, information sharing agreements; contracts; and risk stratification.

Actions to address areas of risk. The first iteration of Information Asset register Info flows, PID and ISG have been completed with SECSU support in PID data flows and access issues. Administrative arrangements are now in place for the Continuing Care Team. CCG is advancing a route for invoice validation and risk stratification of acute data. SECSU provides a Controlled Environment for invoice validation.

CCG has a dedicated team responsible for the assurance of clinical governance (3 WTEs).

Close oversight of provider clinical governance: CCG Clinical Governance Manager oversees all tissues with a range of claims and with a role to assure the IG&P Committee that main processers are consistently meeting SLA on SECSU. IG&P Committee receives monthly update on SECSU and Next Events, and reviews the quarterly Quality Report, which looks more broadly at quality and clinical governance issues. The CCG Clinical Governance Programme Board in place will be used to provide extra oversight and scrutiny of these matters.

CCG challenges providers on clinical governance: CCG clinical governance team and designated CCG clinical leads attend commissioner and provider quality (CQRG) and SI meetings and liaise with NHS England for updated guidance.

Involving partners in quality assurance: CCG clinical governance teams are involved in regular review meetings with colleagues from Southwark, Lambeth and Bromley CCG and have established effective working relationships with provider and with the Patient Safety Team at NHS South London (England), South London Quality Surveillance Unit.

The CCG has implemented the Clinical Associates system allowing potential future GP leads to gain experience in the clinical governance functions.

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Comprehensive approach to performance management with partner organisations. Led by Tripartite Panel through acute contract management reviews by CCG G&Q Commissioning Strategy Committee. There are a number of other working groups leading the development of integration of care pathways. HIV/ICCDP steering group for risk stratification; Primary Care and Neighbourhoods group leading development of integration in primary care.

Additional resources made available to trusts. KCH and GSST capacity increased through new central funding; winter resilience funding agreed to address capacity and oversee by system resilience group convened across Southwark, Lambeth and Bromley.

Emergency Care Intensive Support Team (ECIST) recommendations are being implemented.

LAS recruitment, 162 additional paramedics have been recruited to start in February 2015.

Centralised commissioning arrangements. Led by North West London Commissioning Alliance on behalf of London CCGs, enabling a single commissioner voice to be represented. A London-wide Strategic Commissioning Board is in place chaired by the Chief Officer of Brent CCG. Tripartite approach also in place with NHS England and Monitor.

A diagnostic external review of LAS performance has been commissioned. Review event took place on 19th November to understand LAS current situation and begin to identify an immediate and medium-term recovery plan.

CCGs in London have committed to invest in LAS to support an agreed recovery plan.

The CCG works with member practices to support ‘right first time’ referrals. This includes: a clinical assessment tool to support referral management, referral trend monitoring at GP locality meetings, and individual practice visits include monitoring, discussing and agreeing actions of referral patterns. A training programme is in place in key care areas to ensure appropriateness and effectiveness of referrals.

CCG-Provider contractual risk share agreed. This reduces the financial impact of over performance on the CCG with a budget contingency in place.

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A diagnostic review into LAS. Strategic Commissioning Board oversight.

CN9

CCG and commissioned providers are not ready for contractural changes and clinical pathways with Outpatients.

Sustainable and efficient performance for emergency and elective referrals including Outpatients.

Gwen Kennedy Jean Young Quality & Safety

CGG Provider contractual risk share agreed. This reduces the financial impact of over performance on the CCG with a budget contingency in place.

CCG Governance structure is in place. A designated Director and Officer leads to coordinate the CCG's preparation and response. Formal CCG Emergency Resilience Planning and Preparedness and Business Continuity plans in place and self-assessed.

CGG has taken steps to ensure local providers have completed emergency preparations. CCG has sought assurance that acute providers are prepared for an outbreak and received this verbally at October CCGP. CCG is working in partnership with public health colleagues to draft an Ebola plan. CCG is working with public health to support GP practices prepare for Ebola including support documentation, additional training and information.

CCG’s robust demand and capacity planning and monitoring is in place.

A diagnostic exercise only just complete and implementation of agreed action plan on use of additional resources has yet to commence.

LAS to implement agreed action plan following diagnostic review Mar 2015. PJ to oversee.

CN14

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Andrew Brand Malcolm Hines Karen Swann

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CCG Governance structure is in place. A designated Director and Officer leads to coordinate the CCG's preparation and response. Formal CCG Emergency Resilience Planning and Preparedness and Business Continuity plans in place and self-assessed.

CCG has taken steps to ensure local providers have completed emergency preparations. CCG has sought assurance that acute providers are prepared for an outbreak and received this verbally at October CCGP. CCG is working in partnership with public health colleagues to draft an Ebola plan. CCG is working with public health to support GP practices prepare for Ebola including support documentation, additional training and information.

CCG’s robust demand and capacity planning and monitoring is in place.

A diagnostic exercise only just complete and implementation of agreed action plan on use of additional resources has yet to commence.

LAS to implement agreed action plan following diagnostic review Mar 2015. PJ to oversee.

CN14

CGG and commissioned providers are not ready for contractural changes and clinical pathways with Outpatients.

Sustainable and efficient performance for emergency and elective referrals including Outpatients.

Andrew Brand Malcolm Hines Karen Swann

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<tr>
<th>Risk Title &amp; Description</th>
<th>Assurance</th>
<th>Residual Risk (Likelihood x Impact)</th>
<th>Gaps in mitigation/assurance</th>
<th>SMART Actions with name of Risk Actionee &amp; deadline for completion of action</th>
<th>Direction of Travel</th>
</tr>
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<tbody>
<tr>
<td>Delivering system change with additional stakeholder engagement planned through several task and finish groups to consider individual elements of the programme including mental health in primary care, crisis and responsive community teams. Reconfiguring the adult mental health pathways to reduce the number of CEDs and demand on inpatient services has been identified as one of the commissioning intentions and priorities of the mental health team and a key priority in the Joint Mental Health Strategy to provide more integrated, person-centred community-based services that intervene early and reduce the need for hospital-based care.</td>
<td>Government has approved new structure with CCG-SMT retaining oversight of establishment. Management response to consultation for Phase 1 of Fit for Purpose review. Management response to administration review consultation.</td>
<td>1 3 3</td>
<td>Recruit to new posts in CCG structure, Dec 2014, MH</td>
<td></td>
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<tr>
<td>Additional investment agreed for 2014/15. On-going financial investment requested as part of the 15/16 planning programme to support the transformation of local services.</td>
<td>Successful implementation of the Enhanced Assessment and Liaison Service. This will ensure responsive, high quality assessment services ensuring the right care at the right time and preventing escalation of need.</td>
<td>4 4</td>
<td>Review SLAM proposals and agree 14/15 areas for investment and implementation by December 14</td>
<td></td>
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<tr>
<td>Further CCG's position on delivering BCF plans.</td>
<td>Delivering BCF plans.</td>
<td></td>
<td>Agree with SLAM 2015/16 funding arrangements and expected QIPP outcomes</td>
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</tbody>
</table>
| CCG has established Prevention 
CCG group with LA reps to help ensure integration work streams are well managed. Other CCG programmes also reflect integration requirements e.g. Prevention and Mental Health. | Health and Social Care Partnership Board minutes, Integrated working group minutes | | CCG has established Prevention Programme Board to identify the CCG’s position on delivery prevention. | Develop, implement and maintain CCG’s position on delivery prevention. |  |
<p>| Protecting service provision to ensure CCG is able to continue service provision through this time of transition. | None identified | 3 3 | Lack of clinical associate | JV to develop commissioning intentions with local authority and mental health colleagues, Dec 2014 |  |
| CCG has a Clinical lead and Officer Lead assigned to Children’s with Director oversight. The substantive support role has been recruited to support CCG and Local Authority to share joint commissioning intentions. The CCG has senior leadership input into the south east London Children and Young People programme. | | | | PJJ to recruit clinical associate lead, December 2014 |  |
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<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Date reviewed</th>
<th>Strategic Objective alignment</th>
<th>Risk Title &amp; Description (Cause &amp; Effect)</th>
<th>Director &amp; Risk Owner</th>
<th>Programme Board</th>
<th>Initial Risk Score (Likelihood x Impact)</th>
<th>Risk Controls</th>
<th>Assurance</th>
<th>Residual Risk Score (Likelihood x Impact)</th>
<th>Gaps in mitigation/assurance</th>
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<tr>
<td>FM-12</td>
<td>06/11/2014</td>
<td>INVOLVEMENT</td>
<td>Public and Patient Engagement programmes do not inform commissioning decisions leading to risk of legal challenge of commissioning decisions</td>
<td>Malcolm Hines, Rosemary Watts</td>
<td>Engagement</td>
<td>4 3 12</td>
<td>Publication of resources and support to support engagement. Engagement Programme Board set up October 2014: Locally Patient Participation Groups (PPGs): - papers published on website and CCG support function to locally PPGs with a range of further support in place for PPG members: - glossary of terms, information pack, templates, training in place, workshop as part of national PPG week, practice membership of NAPPI (National Association of Patient Participation).</td>
<td>EPEC oversight</td>
<td>NHS England and EPEC approved Annual Consultation Report 2013/14 reflected in domain 2 of CCG Assurance Framework and addressed by NHS England at CCG Assurance meetings. See minutes.</td>
<td>Clear plans to be developed to implement all recommendations of CCG’s Quality Framework relating to engagement and involvement.</td>
<td>Implement membership and engagement annual work plan, RW, March 2015</td>
<td>GB DD session on public and patient engagement planned in 2015.</td>
</tr>
</tbody>
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ENCLOSURE C
Commissioning Strategy Committee Report
November and December 2014

<table>
<thead>
<tr>
<th>CCG DIRECTOR RESPONSIBLE:</th>
<th>Andrew Bland, Chief Officer</th>
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<tbody>
<tr>
<td>COMMITTEE CHAIR:</td>
<td>Dr Jonty Heaversedge, CCG Chair</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Kieran Swann, Head of Planning and CCG Assurance</td>
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INVolVEMENT REQUIRED FROM THE CCG GOVERNING BODY:
The Governing Body is asked to:
1. Receive assurance that the Committee is acting to the full scope of its responsibilities and conforms to the agreed structure of delegation

SUMMARY:
The report includes the activities completed by the Commissioning Strategy Committee for the stated period. It includes details of Committee discussion and a summary of actions agreed.

November and December 2014 meetings of the Committee gave focus to:
- Minutes and Reports from Locality Groups
- IAPT Procurement
- PM's Challenge Fund Implementation
- Evelina Integration Programme
- Special Educational Needs & Disabilities (SEND) update
- Summary of Programme Boards' Activities and Updates
- Fitness for Surgery Update.
- Committee Terms of Reference
- Development of CQuINS 2015/16
- Crisis Care Concordat
- CCG Evidence for King's CQC Assessment
- Update on Primary Care Co-commissioning
<table>
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<tbody>
<tr>
<td>Membership</td>
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<tr>
<td>CCG Locality Group Meetings</td>
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<tr>
<td>Patients and the public</td>
</tr>
<tr>
<td>A Healthwatch representative is a member of the Commissioning Strategy Committee</td>
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<tr>
<td>Stakeholders</td>
</tr>
<tr>
<td>The CCG will work collaboratively with partners on all of the above referenced topics.</td>
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<tr>
<th>RECOMMENDATIONS:</th>
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<tbody>
<tr>
<td>The Governing Body are asked to note:</td>
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<tr>
<td>The Commissioning Strategy Committee report for November and December 2014.</td>
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<tr>
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<tr>
<td>Name: Andrew Bland</td>
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<tr>
<td>E-Mail: <a href="mailto:andrewbland@nhs.net">andrewbland@nhs.net</a></td>
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<td>Name: Kieran Swann</td>
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<td>E-Mail: <a href="mailto:kieranswann@nhs.net">kieranswann@nhs.net</a></td>
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Governing Body Meeting
22 January 2015

NAME OF THE GOVERNING BODY COMMITTEE:
Commissioning Strategy Committee

DATE OF COMMITTEE MEETINGS: 13 November 2014

PRINCIPLE FOCUS:
The Commissioning Strategy Committee has oversight of the development of strategic plans and priority setting on behalf of the CCG. It is the Committee where service developments are identified and where business cases and proposals are reviewed. The Committee scrutinises the on-going efficacy of commissioned services by receiving evaluations and reviews of local pathways or commissioned services.

The Commissioning Strategy Committee receives reports and proposals for development from Member Practice Locality Groups and also engages with these groups and locality management groups to support the delivery of commissioning strategy in Southwark.

The Commissioning Strategy Committee will recommend the CCG Integrated Plan, Operating Plan and commissioning budgets to the CCG Governing Body for their endorsement and submission to the Council of Members for their approval.

The Committee meets monthly and reports to the CCG Governing Body.

The November 2014 meeting of the Committee gave focus to:
- Minutes and Reports from Locality Groups
- IAPT Procurement
- PM's Challenge Fund Implementation
- Evelina Integration Programme
- Special Educational Needs & Disabilities (SEND) update
- CCG Programme Board Updates
- Fitness for Surgery Update.
1. Minutes and Reports from Locality Groups
   Feedback was received on the items of business discussed at north and south locality meetings in September and October 2014.

2. IAPT Procurement
   The committee reviewed an update on the procurement of IAPT services and agreed with a recommendation to defer the tender process for a period of six months in order to enable Southwark practices offering counseling services a period of time to review the employment status of these counselors. This would enable the CCG to fully understand TUPE requirements and then describe these within the tender process.

3. PM’s Challenge Fund Implementation
   An update was received on the roll-out of this programme of work. The development of Improving Health in south Southwark was discussed as was the CCG’s process for reviewing the risks associated with the new model of extending access to primary care. There was discussion about communications to support the service changes and assurance was received that this had been properly planned.

4. Evelina Integration Programme
   Information was received on the proposed model and approach by the Children and Young People’s Health Partnership (CYPHP) to improve the health and wellbeing of local children and young people. Comments were made on the draft business case with some consensus that the further inclusion of out-of-hospital care and prevention would be beneficial. It was agreed that committee members think about questions for the Evelina team as they would present the business case at the Governing Body meeting later in November.

5. Special Educational Needs & Disabilities (SEND) update
   Members considered a paper updating them on progress with SEND multi-agency work in Southwark. The committee noted the progress report.

6. CCG Programme Board Updates
   Lead directors and programme board chairs feedback on the work their respective programme boards had completed to date. Leads described the direction of travel of their boards and outlined some of the areas they plan to look at in the course of their work. Feedback was received from the Engagement; Primary Care; Community Resilience and Prevention; Quality and Safety; Mental health and integrated care boards.

7. Fitness for Surgery Update.
   An update on progress with the implementation of Fitness for Surgery was received. Members reflected on the importance of secondary care involvement in smoking cessation pathways.
### SUMMARY OF ACTIONS UNDER DELEGATION:

1. Primary care risk assessments will be shared with committee members once complete.
2. Legal advice on IAPT shared with practices in Lambeth and to share with the LMC.

### IMPLICATIONS:

**Quality and Safety**
- Fitness for Surgery update received.
- Delay to IAPT procurement.
- Progress made on delivery of PM’s Challenge Fund.

**Performance**
None

**Financial**
None

### ENGAGEMENT:

**Membership**
- Locality Reports
- IAPT

**Patients and the public**
- Will be engaged by Evelina Children and Young People’s Health Partnership and as part of the IAPT procurement.

**Stakeholders**
- CCG member practices with IAPT and PM’s Challenge Fund
- Collaboration with southwark Local Authority on SEND work.
- Evelina Children and Young People’s Health Partnership
RECOMMENDATIONS MADE TO THE GOVERNING BODY:

To note:
- The report made by the Commissioning Strategy Committee.

To agree:
- None required.

RELATED REPORTS RECEIVED AT THE GOVERNING BODY MEETING:
None

ACRONYMS
IG&P Integrated Governance & Performance Committee
GSTT Guy’s & St. Thomas’ NHS Foundation Trust
GSTCHS Guy’s & St. Thomas’ NHS Foundation Trust Community Health Services
KCH King’s College Hospital NHS Foundation Trust
SLaM South London & Maudsley NHS Mental Health Foundation Trust
SLCSU South London Commissioning Support Unit
SMT Senior Management Team

COMMITTEE CHAIR:
Name: Jonty Heaversedge
E-Mail: jonty.heaversedge@nhs.net

LEAD CCG OFFICER:
Name: Kieran Swann
E-Mail: kieranswann@nhs.net
Governing Body Meeting  
22 January 2015

<table>
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| DATE OF COMMITTEE MEETINGS: | 4 December 2014 |

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- Committee Terms of Reference
- Summary of Programme Boards’ Activities
- Development of CQuINS 2015/16
- Minutes and Reports from Locality Groups
- Crisis Care Concordat
- CCG Evidence for King’s CQC Assessment
- Update on Co-commissioning
1. Committee Terms of Reference
The updated ToRs were agreed and included changes to accurately describe the new reporting arrangements for the CCG’s programme boards and that LMC representative should be invited to the committee ‘in attendance’

2. Summary of Programme Boards’ Activities
Lead directors and programme board chairs gave updates on their work to date. The primary care board looked at workforce development; CQC inspections and practice visits. The prevention board explained they had received presentations on health inequalities; smoking and had spent time looking at outcomes measures. They had also agreed to work up a plan for obesity and alcohol harm reduction. The mental health and parity of esteem board considered the interface between mental health services and primary care. The board also looked at outcomes and the development of a strategic framework for mental health commissioning. The integration board reported that it has been working on examining different models of locality integration including Local Care Networks.

3. Development of CQuINs 2015/16
A draft of the CQuINs programme was presented for comment. The committee discussed the importance of clinical engagement in further refining CQuINs and also that trusts would need to ‘buy-in’ to the priorities identified. Assurance was provided that this engagement was taking place. The inclusion of a CQuIN on alcohol was endorsed and a further briefing was requested for the January 2015 committee meeting.

4. Minutes and Reports from Locality Groups
Locality chairs described actions and discussion points from the most recent meetings. The north locality discussed GP-referral to St Thomas’ emergency department and also discussed dementia diagnosis and the actions they should take to ensure rates improve. The south Southwark meeting looked at the CQC inspection regime in primary care and community physiotherapy. Full reports and minutes were made available to committee members.

5. Crisis Care Concordat
The CCG agreed to endorse the concordat, which highlights the need for excellence in crisis care for patients with mental health conditions. It was agreed that development work in this area would lead by the mental health and parity of esteem programme board, with progress reported to the CSC.

6. CCG Evidence for King’s CQC Assessment
The CQC had planned to inspect King’s College Hospital in January 2015 and had requested evidence from commissioners on the quality of King’s care. A summary of commissioner evidence was made available to committee members. The date of this inspection had subsequently been changed and is likely to now take place later in 2015.

7. Update on Co-commissioning
The application and engagement process for CCGs to take on co-commissioning of primary care was described to the committee. The benefits and risk of the different models were discussed by the committee. The committee also discussed the governance process for sign-off and the implications of the change on conflict of interest arrangements.
### SUMMARY OF ACTIONS UNDER DELEGATION:

1. Further information to be presented to the next CSC meeting on CQuINs.
2. Waiting times for patients accessing community/practice physiotherapy services are reviewed and shared with member practices (action arose from south Southwark locality report).
3. Two monthly update on progress with IAPT procurement.

### IMPLICATIONS:

#### Quality and Safety
- Summary of Programme Boards’ Activities
- Development of CQuINS 2015/16
- Crisis Care Concordat
- CCG Evidence for King’s CQC Assessment
- Update on Co-commissioning

#### Performance
None

#### Financial
- Update on Co-commissioning
- Development of CQuINS 2015/16

### ENGAGEMENT:

#### Membership
- Locality Reports
- Update on Co-commissioning
- CQC feedback shared with member practices

#### Patients and the public
None

#### Stakeholders
- Development of CQuINs with providers
- Co-commissioning with NHS England and south east London CCGs
**RECOMMENDATIONS MADE TO THE GOVERNING BODY:**

To note:
- The report made by the Commissioning Strategy Committee.

To agree:
- None required.

**RELATED REPORTS RECEIVED AT THE GOVERNING BODY MEETING:**

Primary Care Co-Commissioning

**ACRONYMS**

<table>
<thead>
<tr>
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<th>Description</th>
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<tr>
<td>IG&amp;P</td>
<td>Integrated Governance &amp; Performance Committee</td>
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<tr>
<td>GSTT</td>
<td>Guy’s &amp; St. Thomas’ NHS Foundation Trust</td>
</tr>
<tr>
<td>GSTCHS</td>
<td>Guy’s &amp; St. Thomas’ NHS Foundation Trust Community Health Services</td>
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<tr>
<td>KCH</td>
<td>King’s College Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>SLaM</td>
<td>South London &amp; Maudsley NHS Mental Health Foundation Trust</td>
</tr>
<tr>
<td>SLCSU</td>
<td>South London Commissioning Support Unit</td>
</tr>
<tr>
<td>SMT</td>
<td>Senior Management Team</td>
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</table>

**COMMITTEE CHAIR:**

Name: Jonty Heaversedge  
E-Mail: jonty.heaversedge@nhs.net

**LEAD CCG OFFICER:**

Name: Kieran Swann  
E-Mail: kieranswann@nhs.net
**ENCLOSURE D**

**Engagement and Patient Experience Committee Report**  
**November 2014**

<table>
<thead>
<tr>
<th>CCG DIRECTOR RESPONSIBLE:</th>
<th>Malcolm Hines, Chief Financial Officer</th>
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<tbody>
<tr>
<td>COMMITTEE CHAIR:</td>
<td>Diane French, Lay Member</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Rosemary Watts, Head of Membership, Engagement and Equalities</td>
</tr>
</tbody>
</table>

**INVOLVEMENT REQUIRED FROM THE CCG GOVERNING BODY:**

The Governing Body is asked to:

Receive assurance that the Committee is acting to complete the full scope of its responsibilities and conform to the agreed structure of delegation.

**SUMMARY:**

The Committee Report includes the activities completed by the Committee for the stated period. This includes details of Committee discussion; a summary of any actions agreed by the Committee; a consideration of items of business against engagement, patient engagement and quality, safety, performance & financial criteria; and a summary of engagement completed in support of the Committee’s business.

The Report includes the Committee’s recommendations to the CCG Governing Body.

**INVOLVEMENT**

Detailed in the Committee Report

**RECOMMENDATIONS:**

The Governing Body is asked to consider the Committee’s recommendations

**CCG DIRECTOR’S CONTACT:**

Name: Malcolm Hines  
E-Mail: malcolm.hines@nhs.net

**AUTHOR CONTACT:**

Name: Rosemary Watts  
E-Mail: rosemary.watts@nhs.net
The Engagement and Patient Experience Committee has been established to ensure that the CCG acts on patient experience feedback and that the CCG engages patients in all aspects of the commissioning process, thereby ensuring its statutory duties are met and the CCG is effectively involving patients and members of the public in its work.

EPEC draws upon the patient engagement pyramid that has been established in Southwark. Practice PPGs will feed into locality PPG groups, who subsequently provide verbal reports to EPEC. This ensures that issues from patients and members of the public inform the work of EPEC and the CCG.

The November 2014 meeting of EPEC focused on:

1. Patient Experience deep dive report
2. Engagement Programme Board Update
3. Engagement in commissioning intentions
4. Co-commissioning primary care

ISSUES ARISING:

1. Matters Arising
   
   Primary and secondary care interface – that a discharge audit is presently being conducted at King’s which will be discussed at the forthcoming south Southwark Locality Patient Participation Group.

   Developing the patient voice in Southwark - the Committee was informed that new training dates will be put in place for the new year an advertised via the engagement mailing list and via PPGs. A number of suggestions were received from Blackfriars Advice Centre about innovative ways to outreach to young people, such as the use of local radio stations, youth programmes and art projects such as Peckham Platform. CCG will meet with Blackfriars Advice Centre to explore these options in more detail.

2. Feedback from Locality Patient Participation Groups (PPGs) and Healthwatch:

   South Southwark Locality PPG
   
   1. The last meeting was not very well attended
   2. The group had a presentation from Improving Health on progress to date with the extended access service.
3. The key issue for the locality is increasing its EPEC representation from south Southwark are there are two patient representative vacancies
4. There was a long discussion about whether practices inform patients as a matter of course when test results come back negative. The Committee was informed that Patient Online will rolled out in Southwark which will allow patients to access their results online, although the committee cautioned about patients who do not have online access.

North Southwark Locality PPG
1. The two north locality PPGs have started to meet as one and have decided to meet four times a year.
2. Low turnouts at practice PPGs remain a prime concern for participants.
3. Strategies for increasing participation at PPGs were discussed.
4. Alternative methods of engaging were also debated e.g. utilising social and electronic media and that this might encourage participation from a younger age range.
5. Carol McPaul, from Quay Health Solutions gave an update on neighbourhood working and the progress of the extended access service in north Southwark.

Healthwatch
1. Aarti Gandesha has started as the Healthwatch manager
2. Healthwatch Southwark are hosting a public forum on 22 November to mark ‘Healthwatch One Year on’ at which both the CCG and Southwark Council are speaking and hosting information stalls.
3. Moving forward Healthwatch is focussing on the following priority areas:
   o Mental health with a focus on the Child and Adolescent MH service (CAMHS)
   o Sexual health and HIV testing and care
   o Social care
4. Future engagement will include weekly engagement events, quarterly focus groups and Public Forums.

3. Patient Experience Deep Dive
The Planning and CCG Assurance Manager presented and led discussion on the final draft of the patient experience deep dive report that went to the Integrated Governance and Performance committee (IGP). He advised that the aim of the report is to review how the CCG uses patient experience information to inform service design and improve the quality and safety of NHS services used by Southwark patients. He drew the Committee’s attention to the report’s recommendations (p 24) and asked for the Committee’s endorsement of these recommendations and its suggestions on how to take these forward.

He also updated the meeting that a patient experience dashboard is presently being developed across London to bring together a range of patients experience information in one place and also informed that quality review meetings are carried out.

4. Engagement Programme Board Update
The Committee was updated on the development of the programme board and received an update on the outcomes of the first meeting of the engagement programme board which were to develop outreach engagement mechanism to those people who are seldom heard and have most health need and to develop more digital engagement opportunities.

5. Engagement in Commissioning Intentions
The Committee was presented with a paper outlining the process for the development of
commissioning intentions, the linkages with the programme boards and inviting comments to ensure that intentions are well informed by patient engagement and experience. It was highlighted that once the programme boards have developed their commissioning intentions and work programme the engagement programme board will advise and support engagement to further develop these. The Committee agreed that language used need to be simplified and ideas presented in a straightforward manner to facilitate conversations with local people.

6. Co-commissioning of primary care
The Committee were updated on the proposals and options for co-commissioning and the engagement that has taken place with member practices.

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<td>2. EPEC discussed engagement in developing commissioning intentions</td>
</tr>
<tr>
<td>3. EPEC discussed engagement in co-commissioning</td>
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<thead>
<tr>
<th>IMPLICATIONS:</th>
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<tbody>
<tr>
<td>Quality and Safety</td>
</tr>
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<th>ENGAGEMENT:</th>
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<tr>
<td>Membership</td>
</tr>
<tr>
<td>There are three clinical leads named for this Committee.</td>
</tr>
<tr>
<td>Patients and the public</td>
</tr>
<tr>
<td>The membership of this committee comprises patient representatives from the locality patient participation groups.</td>
</tr>
<tr>
<td>Stakeholders</td>
</tr>
<tr>
<td>Healthwatch, Blackfriars Advice Centre and the Forum for Equality and Human Rights Southwark are members of this Committee</td>
</tr>
</tbody>
</table>
RECOMMENDATIONS MADE TO THE GOVERNING BODY:

To note:
1. The issue of waiting times at King’s raised by patients
2. Low numbers of patients attending practice and locality PPGs and the need to develop a wider range of methods of engaging including social and electronic media
3. The need to test with patients whether they understand the extended access care pathway
4. The need for the voluntary sector to shape the integration agenda and the need to explore social prescribing models.

To decide:
No matters for decision required of the CCG Governing Body

RELATED REPORTS RECEIVED AT THE GOVERNING BODY MEETING:
None

ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>EPEC</td>
<td>Engagement and Patient Experience Committee</td>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency Department</td>
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<td>PPG</td>
<td>Patient Participation Group</td>
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<tr>
<td>GSTT</td>
<td>Guy’s &amp; St. Thomas’ NHS Foundation Trust</td>
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<td>KCH</td>
<td>King’s College Hospital NHS Foundation Trust</td>
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<tr>
<td>SLaM</td>
<td>South London &amp; Maudsley NHS Mental Health Foundation Trust</td>
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<tr>
<td>CSU</td>
<td>Commissioning Support Unit</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
</tr>
</tbody>
</table>

COMMITTEE CHAIR:
Name: Diane French
E-Mail: souccg.southwark-ccg@nhs.net

LEAD CCG OFFICER:
Name: Rosemary Watts
E-Mail: rosemary.watts@nhs.net
ENCLOSURE E

Our Healthier South East London: programme update

CLINICAL LEAD: Jonty Heaversedge, CCG Chair

CCG DIRECTOR LEAD: Andrew Bland, Chief Officer

AUTHOR: Caroline Taylor, Programme Director

RECOMMENDATIONS:
The Governing Body is asked to:
1. Note the progress of the Our Healthier South east London programme
2. Identify areas where further work is required to develop the strategy

SUMMARY:
The six Clinical Commissioning Groups (CCGs) across south east London published a draft of a joint five-year commissioning strategy in June 2014. The strategy was presented to and approved by the CCG Governing Body, prior to its submission to NHS England for a national deadline of 20 June. The Governing Body made a number of comments and identified areas for further work, which were incorporated into the strategy programme’s work plan. The governing body has received updates on progress since June. This more detailed report summarises the progress made on the strategy in the last six months and the next steps.

The strategy is being developed by the six CCGs working with NHS England and in partnership with local authorities, NHS providers, patients, local people and other key stakeholders. Its development is overseen by a programme board, the Clinical Commissioning Board, comprising the chairs and chief officers of the six Clinical Commissioning Groups, with colleagues from NHS England and representation from Healthwatch and patient and public voices. The Clinical Commissioning Board reports to the Clinical Strategy Committee of the six CCGs. The Clinical Commissioning Board is, in turn, supported by a Partnership Group, bringing together local authorities, NHS providers and other partners. Clinical leadership from CCGs, providers and local authorities is provided by the Clinical Executive Group and six Clinical Leadership Groups.
The strategy complements and builds on local work and has a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working collectively. It seeks to respond to local needs and aspirations, to improve the health of people in south east London, to reduce health inequalities and to deliver a health care system which is clinically and financially sustainable. It also meets the NHS England requirement that all CCGs develop a commissioning strategy.

The strategy is being developed through an iterative process, so this report reflects the progress to date. It sets out the progress in developing a whole system model for south east London and the six priority areas for intervention: community-based care, children, maternity services, cancer, urgent and emergency care and planned care. Each of these priority areas has a Clinical Leadership Group drawn from local NHS organisations, local authorities and members of the public. This paper describes the current position in relation to the development of whole system outcomes and modelling the impact of the strategy across health and social care. The strategy is broadly consistent with the recommendations of the London Health Commission and the NHS Five Year Forward View, but further work will be undertaken to ensure alignment and to take account of further national and London wide policies as they develop.

There is further work required to develop the models in more detail and to engage widely in this, then to consider the implications in practice, again with extensive engagement in each borough and across south east London. Feedback from this engagement and involvement will continue to inform development of the strategy and will be published in a series of regular ‘You Said, We Did’ reports. Should any significant service changes be proposed as a result of the further development by the clinicians, patients and local people working on the strategy, consultation on these would take place in the second half of 2015. In the meantime, each CCG is continuing to develop its operational plans and local strategies, including working with its local authority to develop/refresh the Health and Wellbeing Strategy. The south east London strategy had been tested to ensure consistency with local strategies and plans, and to identify the progress already made towards implementation, so as to inform the operational plans and the further development of the strategy.
OUR HEALTHIER SOUTH EAST LONDON
The South East London Commissioning Strategy

1. Introduction

Our strategy:
- is local commissioner led and clinically driven
- aims to improve health, reduce health inequalities and ensure the provision of health services across south east London that meet safety and quality standards consistently and are sustainable in the longer term
- is based on local needs and aspirations, listens to local voices and builds on plans and work at borough level, whilst taking into account national and London-wide policies
- focuses on those issues which need collective action by south east London’s health system and local authorities’ working in partnership to address successfully
- focuses on the most important health issues for people in south east London, as identified in the south east London “case for change” developed by local clinicians and social care colleagues and tested with partners, local people and other stakeholders
- runs for five years – from 2014 to 2019 – to give plenty of time to plan and deliver improvements

Borough-level Joint Strategic Needs Assessments, CCGs’ commissioning plans and Health and Wellbeing Strategies continue to be produced locally, to identify borough-specific issues and challenges and the plans to address them. The clinical case for change identified a number of issues across south east London which are reflected in the health of local people and which impact on the safety, quality, effectiveness and accessibility of health services, which can be best addressed by collective action across the health and integrated care system or where working together will add value.

2. Summary of issues

Health outcomes in south east London are not as good as they could be and the longer we leave these problems, the worse they will get. We all need to change what we do and how we do it.
- Too many people live with preventable ill health or die too early
- The outcomes from care in our health services vary significantly and high quality care is not available all the time
- We don’t treat people early enough to have the best results
- People’s experience of care is very variable and can be much better
- Patients tell us that their care is not joined up between different services
- The money to pay for the NHS is limited and need is continually increasing
• We all pay for the NHS and we have a responsibility to spend the money wisely

3. Our approach to tackling these challenges

NHS Southwark CCG is working on this joint strategy as a member of the Strategic Planning Group for south east London, together with the other five CCGs and NHS England. The strategy is being developed by local clinicians, social care leads and other experts, CCG commissioning leads, Healthwatch representatives and patient and public voices from across south east London. It focuses on six key areas:

• Community Based Care*
• Urgent and Emergency Care
• Maternity
• Children and Young People
• Planned Care
• Cancer

(*This group merges two previous workstreams set out in previous reports – Primary and Community Care and Long Term Conditions – Physical and Mental Health).

Development work on the strategy to date has identified the following key characteristics which would underpin a future integrated system for south east London:

• Build strong, confident communities
• Promote health and wellbeing
• Provide accessible and easy to navigate services
• Join up services from different agencies and disciplines
• Deliver early diagnosis and intervention
• Raise the quality of services to the same high standard
• Support people to manage their own health and wellbeing

Further details are available in the strategy documentation, which is available on each CCG website and on the programme website.

4. Development of the ‘Whole System Model’

Each of the six Clinical Leadership Groups has made excellent progress over the last six months and their work has been brought together in an over-arching Whole System Model, which describes how we would propose to deliver health and care services in future. The model is underpinned by Local Care Networks in each borough. This work is still in development and is being tested against the Five Year Forward View and recently received planning guidance, and the London Health Commission recommendations.
The Whole System Model and Local Care Networks are represented diagrammatically in Appendix A.

5. Progress of Clinical Leadership Groups (CLGs)
Each CLG has discussed and agreed the case for change in its clinical area and developed initial proposals for change which are now being discussed and developed further.

5.1 Community-Based Care

The case for change
- Patients and carers tell us that care is not joined up between different services
- Older people often have more than one health problem and need support and treatment from many different services and professions
- Barriers exist between the current arrangement of service providers in health and social care leading to disjointed service provision for those who need it
- Many people would like to have greater involvement and control of their own care and be facilitated to do more to care for themselves
- Some patients find it hard to get a GP appointment when needed, reverting to accessing other urgent and emergency services or deterioration in their health

How we propose to improve services
- We are developing a new model of community based care for South East London in order to ensure everyone has equitable access to consistently high quality, joined up care
- Community Based Care will be coordinated with improved communication between services that inter-link with or are integrated within a future model of Local Care Networks
- Local Care Networks will bring together general practice, primary, community (physical and mental health), social care and voluntary sector colleagues to provide holistic patient-centred care for a designated geographically coherent population
- Local Care Networks will be proactive, supporting people to live healthier lives and focusing on prevention, as well as advice and treatment, to empower people to look after their own health and reduce the possible onset of future health conditions. The services available will respond to the varied needs and characteristics of the population they serve with the flexibility to meet the needs of individuals
- Access to GP services and other community based services will be available 8am to 8pm, with additional local access to more specialised care and expertise outside of hospital
- Services will be proactive, accessible, coordinated and provide continuity of care; with a flexible, holistic approach to make sure that every contact counts
- Community based care will deliver a more rehabilitative approach to supporting people with long term conditions, enabling people to take control of
their own care, avoiding deterioration and episodes of crisis, with a focus on recovery

- Multi-disciplinary teams and named care workers will provide support to people with complex and multiple health and social care needs, their carers and families, to enable them to continue to lead as full and active life as possible for as long as possible

5.2. Maternity

The case for change

- Not all maternity services meet the needs of our population and rising birth rate. There are not enough trained midwives and obstetricians with the right skills to provide 24/7 care
- The rate of complex pregnancies is increasing due to health issues such as obesity and diabetes, and more women giving birth at an older age

How we propose to improve services

- Mums to be will receive a personalised service, continuity of care and a range of birthing options
- 24/7 consultant presence on labour wards and more midwives
- Enabling women to have a healthy natural birth in a setting of their choice
- Children and Young People

5.3 Children and young people

The case for change

- A growing population of young people with a significant number from deprived families
- Greater than average instance of childhood obesity, undiagnosed mental health issues and teenage pregnancies in south east London

How we propose to improve services

- Children and young people will be able to access more joined up care in the community through children’s integrated community teams
- Ensuring access to right services in the right place, with no ‘wrong door’
- Better management of long term conditions in the community

5.4 Cancer

The case for change

- Biggest cause of premature and avoidable deaths in London
- Some people with cancer wait longer than they should do for their first hospital treatment
- There are differences in patient outcomes and experiences

How we propose to improve services
• Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer
• Promoting healthy lifestyle choices, making sure that health services take a holistic approach in every contact
• Improving carer support
• Enabling people to die with dignity and improve their and their families experiences at end of life

5.5 Planned care

The case for change
• There are sometimes delays between diagnosis and treatment and to diagnostic procedures
• Services are not always as joined up as they should be

How we propose to improve services
• Ensure that all patients who need planned care across south east London will receive the same quality and outcomes regardless of the setting
• Better direct access to diagnostics for GPs
• Better communication between services, especially between acute and community services, to avoid unnecessarily repeated appointments and procedures

5.6 Urgent and Emergency Care

The case for change
• No hospital in south east London fully meets the London standards for safety and quality in emergency care. Not all our hospitals have their most senior doctors working at night and weekends
• Many people are going to A&E unnecessarily when other more suitable care is available

How we propose to improve services
• A rapid response team, which would make sure patients who need urgent and emergency care receive the treatment they need in the right place at the right time (including in their own homes) and would support the rapid return of patients to their homes, moving back to local health and care services outside hospital
• Urgent Care and Emergency Care services to be available in the same place, with patients being directed to the right department for their needs by an Emergency Nurse Practitioner or other appropriately qualified clinician
• Local Care Networks, which will have extended opening hours linking in to rapid access services to support the frail, elderly and those patients with long term conditions
• Mental health liaison services to work within the Local Care Networks for patients in crisis - for example, patients using or requiring perinatal, drugs and


alcohol, children and young people's and older people's and dementia services

6. The modelling of impacts

The impacts of the future model of care will be modelled in a number of ways to assess the financial, outcome and qualitative changes expected as a result of implementation. The outcome and qualitative changes will be measured through public health analysis, based on evidence from elsewhere and using a variety of techniques and outcome frameworks. The approach to assessing the financial consequences of the changes will be based on a four stage approach:

1. **Services offered in 2013/14**: Understanding the services delivered last year will allow for comparison against the financial baseline (necessarily based on the last complete financial year).

2. **Current (2014/15) services**: It is then important to understand the changes to the 2013/14 services this year. This will give a revised baseline (based on a partial year of financial data).

3. **Changes due to existing programmes**: There are a number of existing programmes of work within South East London (including, but not limited to, the Better Care Fund, Community Based Care, and Southwark and Lambeth Integrated Care). Understanding how these will change services will allow for a forecast position before the application of the commissioning strategy proposals.

4. **Future model of care**: These end states (likely to be consistent across CCGs) are as developed by the Clinical Leadership Groups.

The overall approach, given that the future model will be new, will be to build up the indicative cost of provision, based on the interventions and inputs such as workforce, training, estate costs and IT. This will be an iterative process and will be based on activity impacts (in terms of percentage changes in activity for each activity metric) by combing benchmarking with the assessment of the Clinical Leadership Groups as to whether the impacts will be high, medium or low (e.g. we might identify that outpatient appointments will reduce by 10% for children). These activity assumptions will be compared with other similar schemes elsewhere and tested through both the Clinical Leadership Groups and the Finance Leads’ Group. Once these activity impacts have been agreed, the financial impacts associated with the activity changes will be modelled. This will be modelled both for the cost of commissioning (i.e. tariff impact) and, for activity taking place in South East London, the cost of provision for local trusts. This latter output is important as it allows for an assessment of the releasable costs associated with the change, which will impact the sustainability of the system. Following the initial financial assessment, it may be necessary to iterate the Clinical Leadership Group proposals (e.g. they may not be affordable). Once the designs have been re-worked further financial modelling will take place to estimate revised impacts for use in the further development of the strategy.
In order to evaluate the correct level of impact across south east London as a consequence of the strategy, it is important to make sure that impact assumptions arising from the changes proposed through the Clinical Leadership Groups are not duplicated and in effect double or even triple counted. This is a particular issue for urgent and emergency care because one of the key areas of impact expected will be a reduction in non-elective admissions and A&E attendances. This is likely to be an impact arising from changes identified within the Urgent & Emergency Care Clinical Leadership Group, but also from number of the others. In addition, changes outside the acute setting, including strong and confident communities and local care networks, should also impact on this activity. In order to reduce the risk of double counting benefits in reductions, we have requested a baseline data set by Clinical Leadership Group, which separates out activity distinct to the group eg the A and E and non-elective paediatric activity is within the children and young people data set and excluded from the volumes within urgent and emergency care. From a modelling perspective these baselines will be used as the start point and refreshed periodically. We will need to update for actual outturn and changes in this financial year and also for planned changes, such as the Better Care Fund, to ensure that these are taken into account prior to calculating the scale of the impact. As the strategy develops and the system wide model is developed, the emerging impact identified by the respective groups will be tested back at Clinical Leadership Group level and also at system wide level. It will be broken down to CCG and also indicative volumes per GP will be identified so that this can be tested through for reasonableness and coherence. It is often that case that a number of factors are required to achieve a particular impact and so validation of the total change will be undertaken by testing against evidence such as national and international examples and review by clinicians. In some areas, the impact will need to be estimated, if the models have not been tried elsewhere and there is therefore limited direct evidence as to impact. The estimates will therefore be tested through sensitivity analysis to ensure that they are reasonable.

Local authority colleagues are engaged in the work to model the impact of the strategy and the intention is to include the impact on social care as well as health, in order to have as full an understanding as possible of the system wide position.

7. Whole System Outcomes

Alongside the progress made over the last six months with the Whole System Model, commissioners and providers have identified system level outcomes which the strategy aims to achieve in order to deliver greater value to health service users and the population of south east London. The proposed Whole System Outcomes are set out below:
<table>
<thead>
<tr>
<th>Domain</th>
<th>Outcome/Impact</th>
<th>Example Indicator(s)</th>
<th>Metric/Target</th>
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</thead>
</table>
| Population Health | Preventing people from dying prematurely and supporting them to live longer and healthier lives | • Extended years of life  
• Potential years of life lost (PYLL) from causes considered amenable to healthcare for both adults and children & young people  
• Life expectancy at 75 for both males and females  
• Levels of confidence  
• Feeling empowered to make healthy decisions  
• Reduction in obesity  
• Reduction in alcohol misuse  
• Reduction in smoking  
• Reduction in emergency admissions |               |
|                   | Reducing differences in life expectancy and healthy life expectancy between communities- starting with quality early childhood education and care | • Reduced gap in life expectancy at birth  
• Improvements in wider factors which affect health and wellbeing and health inequalities |               |
| Quality of Life   | Supporting people feel independent, in control of their health, and able to access personalised care to suit their needs | • Population reported outcome measures (not patient)  
• Living in my own home  
• Reduction in permanent admissions to residential and nursing care homes, per 100,000 population  
• Number supported to die at home if they wish |               |
|                   | Provision of health and care that enables people to live a good quality of life with their long term condition | • Health-related quality of life for people with long-term conditions  
• Quality of extended years of life  
• Patient activation |               |
<table>
<thead>
<tr>
<th>Effective-ness of Care</th>
<th>Treatment that is effective, efficient and delivers the best results for patients including rapid reablement</th>
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<tr>
<td></td>
<td>• Reduction in the variation of service quality and clinical outcomes</td>
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<tr>
<td></td>
<td>• 1 year survival rate for cancer</td>
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<td></td>
<td>• Care meets the best evidence-based standards (clinical protocols followed)</td>
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<td></td>
<td>• Reduction in emergency readmissions within 30 days of discharge from hospital</td>
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<td></td>
<td>• Sustainable provision of health and care</td>
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<td>Delivering the right care, at right place, at the right time along the whole cycle of care</td>
<td>Increased proportion of care delivered in the community</td>
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<tr>
<td></td>
<td>• Reduced length of stay</td>
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<td></td>
<td>• Reduced A&amp;E attendances and emergency admissions</td>
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<tr>
<td>Quality of Care</td>
<td>Commitment to people having a positive experience of care</td>
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<tr>
<td></td>
<td>• Patient experience of primary care (GP services, GP OOH services, NHS dental services)</td>
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<td></td>
<td>• Patient experience of hospital care</td>
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<td></td>
<td>• Staff experience / satisfaction</td>
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<td></td>
<td>• Friends and family test</td>
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<td></td>
<td>• Overall satisfaction of people who use services with their care and support</td>
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<tr>
<td></td>
<td>• Overall satisfaction of carers with social services</td>
</tr>
<tr>
<td></td>
<td>• Patient Experience Headline score for Focus on Dignity and Respect</td>
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<tr>
<td></td>
<td>Customer Service:</td>
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<tr>
<td></td>
<td>• Waiting time</td>
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<td></td>
<td>• Convenience</td>
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<td></td>
<td>• Accessibility (carers)</td>
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<tr>
<td></td>
<td>• Respect (care givers/experience)</td>
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<tr>
<td></td>
<td>• Safe (measure)</td>
</tr>
<tr>
<td></td>
<td>• There is appropriate care planning</td>
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</table>
Caring for people in a safe environment and protecting them from avoidable harm

- Reduced variation of care
- Reduced avoided harm
- Reduced late complications
- Patient safety incidents reported
- Safety incidents involving severe harm or death
- Reduced hospital deaths attributable to problems in care

The indicators for the proposed outcomes are still being developed, with particular reference to the NHS outcomes framework, the public health outcomes framework and the social care outcomes framework, to ensure that they are sufficiently comprehensive and are consistent with outcomes already agreed through local partnerships.

8. Public Health Workstream

One of the critical success factors for Our Healthier South East London is to ensure it builds upon and supports the development of strong and confident communities. These communities will exhibit measurable improvements in public health, with reduced health inequalities, and will be served by a health system that has a focus on prevention. This requirement sits at the centre of the strategy, alongside the aims stated in the first section of this paper, to ensure health services are fit for purpose and deliver improved outcomes for the whole population.

Improving public health is also tied into the strategy outcomes which focus on:
- Population Health
- Quality of Life
- Quality of Care
- Effectiveness of Care

Alongside the work of Clinical Leadership Groups, we have set up a specific Public Health project group. This is led and delivered through the six boroughs’ Directors of Public Health and their teams. This group is overseen within the strategy governance structure by the Clinical Executive Group.

The group is currently undertaking a review of public health outcome measures and the current baseline of public health in south east London. Building on this review it has been decided that the group will focus on the public health challenges which have the biggest impact on the health of our population. It is in the process of creating a consolidated list of the most effective public health interventions that deliver the best value proposition (value = biggest health impact for the financial resource required) for those biggest areas of challenge.
The group is focusing on the following domains in order to agree the appropriate risk factors/biggest health challenges for which we need to focus our interventions;

- Health inequalities
- Preventable mortality
- Amenable mortality
- Mental health
- Sexual health

It is anticipated that the main risk factors (those which have the biggest impact on health) are likely to be:

- Tobacco
- Alcohol
- Mental health
- Obesity

The outcomes of this work will feed into the work of the Clinical Leadership Groups to identify how the best value public health interventions need to be embedded within the new models of care. Each Clinical Leadership Group and its planning group already include public health leads to support the work they are undertaking to develop models of care and the outcomes to be achieved by introducing these models of care. These public health leads will continue this support to ensure the integration of the proposed public health interventions as the models of care are further developed.

In order to understand how the work of the strategy can deliver as effectively as possible to meet the aim of improved public health we have also been engaged with public health experts across a wide range of fields. Experts include those working within Kings Health Partners, the Health Innovation Network, South London CLAHRC, Local Authority partners supporting the development of resilient communities, Public Health England and NICE.

In early 2015, we will be bringing these experts together within a workshop to help us to shape the way in which we deliver our public health outcomes within the strategy and its implementation. A key element of the workshop will be to agree an approach to coordinating public health expertise within south east London to enable delivery of these outcomes. We have a significant opportunity, by pulling expertise together, to implement public health interventions and services in the most effective way, and to gather practical evidence for investment in public health within the wider context of London and other cities.

9. Public engagement

The co-commissioners are taking a strong engagement approach to the strategy development, aiming to involve partner organisations, patients and local people in the process of developing the strategy. Initial thinking is being developed and amended through the engagement process. Engagement is being undertaken through a number of complementary activities, including the following.
• Using existing borough-level channels and planned activities, supplemented by engagement on a wider basis where this is helpful. Initial engagement included developing the emerging and draft case for change, testing emerging strategic opportunities across south east London and the scope and vision and the ambition of the programme. The focus of engagement is moving onto priorities and proposed models of care as the programme develops
• Our Plain English version of the case for change has been updated and is available on our website
• Regular updates on the strategy development have been provided at local public meetings of CCGs’ Governing Bodies and Health and Well-Being Boards
• CCGs’ GP memberships are being provided with briefings on the clinical developments and progress with the strategy

Patient and public participation within the programme is also key. Healthwatch representatives and local patient and public voices have been recruited and are working in each of the six Clinical Leadership Groups with clinicians and social care leads from organisations across south east London. Healthwatch representatives and local patient and public voices are members of the Partnership Group, Clinical Executive Group and the Clinical Commissioning Board and therefore involved in shaping the overall strategy.

Patient and public voices also meet monthly as a single body – the Public and Patient Advisory Group – advising the programme on all aspects of public engagement and involvement. The Patient and Public Advisory Group has recently set up a Reading Panel, which supports the programme by ensuring that all published materials are understandable, jargon free and in Plain English. To complement existing local engagement work, wider engagement events across south east London with voluntary and stakeholder organisations, patients and local people has taken place. Two deliberative events for voluntary organisations and other stakeholders took place on 3 June and 18 June 2014. The feedback from these events (and other feedback from local people) contributed to the first ‘You Said We Did’ report, summarising and responding to feedback on the strategy, which was published in November. A further ‘You Said We Did’ report will be published early in 2015. This will take account of further public engagement events run recently by the Innovation Unit. These took place for Lambeth and Southwark on 3 December and Bromley on 9 December. A further event for Bexley, Greenwich and Lewisham will take place shortly.

The strategy team is participating in local or wider events organised by south east London-based voluntary organisations and other stakeholders where the aim or content is relevant to the further development of the strategy.

Market research: An independent survey was commissioned with a representative sample of local populations to gain deeper insight into local people’s attitudes towards health and care services. The learning from this exercise is being shared
across the programme and the CCGs. Further market research will be carried out during 2015.

Since September 2014, the programme has had a dedicated website – www.ourhealthiersel.nhs.uk – ensuring that stakeholders and members of the public can access all relevant information in one place.

All communications and engagement activity is planned by a Communications and Engagement Steering Group, made up of the programme communications team and Senior Responsible Officer, plus the communications and engagement leads from each CCG. Communications and engagement activity is discussed monthly at the Public and Patient Advisory Group and fortnightly at the Implementation Executive Group.

In Southwark, the SEL programme team and the CCG Chief Officer have presented a draft of the SEL Plan to the Health and Wellbeing Board. The HWB has continued to receive monthly written updates on the programme via the CCG’s membership engagement team.

Members of Southwark’s Engagement and Patient Experience Committee (EPEC) are involved in the programme through the strategy programme’s clinical leadership groups and the Patient and Public Advisory Group (PPAG). A Southwark EPEC member chairs the SEL programme’s PPAG and provides regular updates to EPEC members and Southwark local patient involvement network.

10. Alignment with CCG Plans

Throughout the development of the strategy to date, the work has been tested against existing CCG plans for alignment and it has, in turn, contributed to shaping these plans. Specifically, CCG Operating Plans and borough-based Better Care Fund Plans have been reviewed and contributed to the strategy. The Community Based Care programme has held two workshops this year to enable CCGs to share best practice and innovative approaches in integrated care and in primary care/local care networks. On 2 December, Chief Officers and colleagues came together to review the elements of the strategy and assess their current position on implementation and this work will inform the next stages of planning.

11. Risks and Mitigations

The strategy programme has a full risk register, which is reviewed regularly at the Implementation Executive Group, the Clinical Executive Group and the Clinical Commissioning Board. The risks currently assessed as having a score of 16 or more, following mitigation, are set out below and will continue to be actively managed through the forward plan.
<table>
<thead>
<tr>
<th>Risk Title</th>
<th>Risk Title</th>
<th>Description</th>
<th>Impact</th>
<th>Mitigation Controls in place</th>
<th>Residual Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Strategies</td>
<td>Information Systems</td>
<td>Lack of integrated or interoperable information systems undermines ability to integrate services across the health system in South East London</td>
<td>Possible duplication of system, process or information, resulting in poorer patient experience, poor quality of services across integrated pathways and additional cost</td>
<td>IM&amp;T supporting strategy workstream established. Content to be developed in line with strategy.</td>
<td></td>
</tr>
<tr>
<td>Supporting Strategies</td>
<td>Workforce capability</td>
<td>Existing workforce lack skills or capability to deliver new models of care</td>
<td>New models of care may not be implemented. Services may not be delivered safely.</td>
<td>Workforce supporting strategy workstream established. Content to be developed in line with strategy, with input from HESL to identify workforce impacts of proposed changes and develop plans for resolution</td>
<td></td>
</tr>
<tr>
<td>Core Programme</td>
<td>Financial sustainability of health system</td>
<td>New service models in primary care and community services do not deliver reduced demand for hospital care or hospital capacity does not reduce in line with demand</td>
<td>Potential increased system costs through duplication of services and low productivity leading to poor patient and staff experience. Quality remains variable. System may be unsustainable.</td>
<td>Clinical Executive Group and Partnership Group review integrated system model and all draft service models as a whole to ensure that any proposed changes to the health system are effectively balanced. Impact of areas of early implementation (primary and community care, integrated care) reviewed in models as they develop</td>
<td></td>
</tr>
<tr>
<td>Communications and Engagement</td>
<td>Patient/Public Resistance to Change</td>
<td>If partners and stakeholders are not sufficiently engaged throughout the development of the five year strategy – or if the case for change is not sufficiently convincing -</td>
<td>Further engagement required. Possible legal challenge. Delays to implementation of changes leading to increased cost and delay. Need to amend strategy in</td>
<td>Engagement activities will be undertaken with a broad range of partners and stakeholders throughout the development and implementation of the strategy. Dedicated communications</td>
<td></td>
</tr>
<tr>
<td>Risk Title</td>
<td>Risk Title</td>
<td>Description</td>
<td>Impact</td>
<td>Mitigation Controls in place</td>
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<tr>
<td></td>
<td></td>
<td>any proposed service change could be subject to significant local opposition</td>
<td>response to concerns</td>
<td>and engagement enabling workstream to coordinate these activities. Patient and Public voices in all key groups to help shape strategy.</td>
<td></td>
</tr>
</tbody>
</table>

12. Forward Plan

The next three months will encompass considerable activity with specific focus upon the refinement of the whole system model and the models of care; modelling expected impacts for providers and commissioners; and further development of the supporting strategies. As CCGs will be refreshing their operating plans, these will be tested against the strategy, which in turn will be modified as appropriate, to ensure that there is consistency between the short and longer term plans. The developing strategy will be presented to Health and Wellbeing Boards and other key meetings for review and input and will be the subject of wide engagement to help shape and develop it further.

Subsequent months running into mid 2016 will focus upon activities such as developing options, developing criteria to assess options for implementation, modeling to support option appraisal, the development of business cases and any consultation if required. Implementation of elements not requiring consultation, such as the development of the local care networks, community based care and improved clinical pathways, will continue.

The summary Forward Plan is attached at Appendix B.

13. What would happen if we did not develop a south east London strategy?

We know that if we do not proceed with strategic change in south east London, our health outcomes will continue to be highly variable, health inequalities will persist and in some cases worsen and the current healthcare system will become unsustainable. All Strategic Planning Groups are required by NHS England to deliver five-year strategies to address the challenges set out in the national ‘Call to Action’ last year.

14. Finance Considerations

The strategy reflects the financial plan and savings required to deliver a financially balanced position over the five year period, as described in the CCG’s operating plan.
15. Staffing Considerations

The strategy will be accompanied by a number of supporting strategies, including a workforce strategy, which is under development.

16. Corporate and Strategic Objectives

The strategy is aligned to Southwark CCG’s corporate objectives as described in the Business Plan 2014/15. The specific objectives are listed below:

- Improve health, outcomes, address inequalities and secure a parity of esteem
- Improve the quality and safety of local health services
- Secure delivery of the NHS Constitutional rights and pledges for all Southwark residents
- Ensure good governance, financial stability of the local health economy, VFM and delivery of statutory responsibilities
- Commission proactive care focused upon the prevention and the early detection of illness.
- Improve outcomes for Southwark patients and achieve better value, integrated care through transformation programmes delivered in partnership with stakeholders and our residents.”
- Ensure the CCG’s commissioning resource and organisational capability are effectively aligned to deliver its objectives
- Ensure patients and the public play a central role in the commissioning of the services they receive
- Ensure effective involvement of member practices and other partners in commissioning decisions

17. Previous discussion of this paper

The development of the strategy is overseen by the Implementation Executive Group, Clinical Executive Group and Clinical Commissioning Board. This paper was discussed by the Implementation Executive Group on 19 December 2014.

18. Health Inequality Duty

A key driver of the strategy is to address variation in health outcomes and to tackle health inequalities across south east London. The programme is also setting up an Equality Group, made up of equality leads from the CCGs, to ensure that equality considerations are central to development of the strategy.

19. Public Sector Equality Duty

An early Equality Impact Assessment was carried out in 2014 to ensure that the final strategy reflects the diverse needs of local people and that we meet our obligations
under the Equalities Act 2010 to identify and address any adverse impacts on groups with ‘protected characteristics’. An action plan was developed following the Equality Impact Assessment and is now being implemented. A further Equality Impact Assessment will be carried out between March and May 2015. We are committed to ensuring that our strategy is proactively informed by equality considerations and the need to ensure that the needs of all groups and any potential adverse impacts on groups with protected characteristics are fully taken into account.

20. Conclusion and Next Steps

The south east London commissioning strategy, Our Healthier South East London, has continued to develop since last reviewed by the CCG Governing Body in June last year. The focus has been on:

- further development and testing of the clinical models,
- the development of the whole system model to frame the individual elements
- work to define the intended outcomes of the strategy
- modeling the impact
- testing alignment with the plans of individual CCGs and taking stock of progress towards implementation
- work with public health colleagues to begin to identity how the greatest impact on public health can be achieved

This work will continue through the first part of 2015, with extensive engagement with partners, stakeholders, patients and local people to test and develop the strategy further. Progress reports will be brought to the Governing Body on a regular basis.
Whole System Model

Appendix A
Local Care Networks are the foundation of the whole system model providing person centred services to populations.

**Self care**
- Health coaching
- Self management tool kits
- Social prescribing
- Optimising neighbourhood assets

**Managed care**
- Anticipatory care planning
- Active case management
- Disease management
- Public health programmes

**Population needs and budget**

**Strong confident communities**

**Proactive, Accessible, Coordinated, Continuous Care**

**Specialist input shared between LCNs:**
- Pulled into care delivery from outside the network: Virtual clinics | Specialist nurses | Consultants | Geriatricians | End of Life expertise | Specialist rehab

**Wider community infrastructure:**
- Police | fire service | schools | Housing

**Affordable high quality outcomes**

**Urgent and emergency**
- Local Care Networks will operate beyond usual GP hours in order to reduce referrals to emergency care
This is Our Healthier South East London health and care whole system model

- This is our integrated system model.
- Local Care Networks are the foundation of the whole system model providing person centred services to populations.
- The petals are the pathways providing services to cohorts of people and drawing on specialised services.
- The orange circles represent key features of the model.

- Mums-to-be will receive a personalised service, continuity of care and a range of birthing options.
- Children and young people will be able to access more specialised services through children's integrated community teams.
- A rapid response team will make sure patients who need urgent and emergency care will receive the treatment they need in the right place at the right time and will support patients to return home and move back to local health and care services.
- Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer.
- Strong confident communities are a critical part of the foundation of the model. Initiatives will seek to build community resilience so that they support local people to be physically and mentally healthy and take care of peoples social needs.
- Patients who need planned care across SEL will receive consistent quality and outcomes regardless of the setting.

This is our integrated system model.

Local Care Networks are the foundation of the whole system model providing person centred services to populations.

The petals are the pathways providing services to cohorts of people and drawing on specialised services.

The orange circles represent key features of the model.

- Maternity
  - Condition focused midwife cohorts for high risk mothers
  - Geographic midwife teams for low risk mothers

- Children & young people
  - Children's Integrated Community Teams
  - Rapid response “home ward”

- Urgent & emergency care
  - Specialist Response Clinic

- Planned care
  - Elective care centres

- Tertiary care
  - DAU and 24/7 triage

- Secondary care
  - Shared across LCN’s Specialist teams

- Acute oncology
  - Early detection

- Self care
  - Managed care
  - Personalised care

- Care coordination

- Physical

- Mental wellbeing

- Social

- Home
### Key Activities

#### Phase 1
- Further refinement of the Whole System Model and the models of care, including testing with providers, partners and wider stakeholders
- Modelling expected impacts for providers and commissioners
- Further development of the supporting strategies
- Clinical model implementation
- Workshops – CO discussion on commissioner models, Provider and CLG
- Detailed implementation plan
- Presentation to NHSE
- Provider outline of steps required to operationalise the Whole System Model
- Development of the supporting strategy by providers
- Equality Impact

#### Phase 2
- Identification of potential for significant service change.
- Developing criteria to assess options for implementation
- Developing options
- Option appraisal
- Decisions on reference cases/preferred options
- Modelling to support option appraisal and decision making
- Further support to implementation: CBC and LCN
- Continued work with partners to ensure
- Modelling Impact Assessment
- Publish Equalities Impact Assessment and action plan
- Refinement of implementation plan
- Recommendation options

#### Phase 3
- Development of business cases. There will need to be agreement as to the business cases required and who will lead them (commissioners or providers).
- Modelling to support development/review of business cases
- Decisions making processes for business cases
- Continued wide engagement
- Refinement of detailed implementation plan
- Gateway review
- Business Case sign off

#### Phase 4
- Any consultation, if required. Note: In the event that consultation is not required, and for any elements of implementation where consultation is not required, the timetable will be shortened, but for planning purposes this paper assumes that there will be some formal consultation, although the subject of such consultation has yet to be established.
- Launch consultation
- Interim consultation report
- Deliver consultation plan if required

#### Phase 5
- Conclusion of any consultation
- Further modelling if required
- Decision making
- Preparation for implementation
- Refresh of Equalities Impact Assessment
- Deliver consultation plan if required
- Production of consultation report

#### Phase 6
- Continuation of strategy execution implementation. Note: as per CCG level implementation level roadmaps
- For mobilisation of the strategy

### Live implementation and continuous quality improvement

- Continuous input throughout the process with regular meetings
- Continued aligned plan to ensure the programme continues with a high level of engagement
- Modelling to establish the baseline position, required investment and quantify benefits to be realised
- Continue the commissioning framework, LCN, workforce, IM&T systems and estates configuration needed to realise the change

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**Appendix B**

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**A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England**
ENCLOSURE F

Report of the Director of Public Health

CCG DIRECTOR RESPONSIBLE: Dr Ruth Wallis / Andrew Bland
CLINICAL LEAD RESPONSIBLE: Dr Ruth Wallis / Andrew Bland

AUTHOR: Dr Ruth Wallis, Director of Public Health (Lambeth & Southwark)

INvolvement required from the CCG governing body:

Southwark CCG Governing Board is asked to receive the Report of the Director of Public Health for Lambeth and Southwark.

SUMMARY:

This is a quarterly report of the Director of Public Health to the Lambeth & Southwark Clinical Commissioning Groups and the Lambeth & Southwark Health and Wellbeing Boards.

This report covers the following health intelligence work streams:

- Update on the annual public health reports for Lambeth and Southwark
- Public Health Outcomes Framework – update on Health Care Public Health domain
- Update on Marmot indicators
- Joint Strategic Needs Assessment (JSNA)
  - Web site development
  - New factsheets on suicides
  - Development of primary care profiles
  - Shisha survey in South East London
- Alcohol Licensing
KEY ISSUES: As above

INVolVEMENT: N/A

RECOMMENDATIONS:
The CCG Governing Body is asked to:-

Note the Report of the Director of Public Health for October - December 2014

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E-mail: andrewbland@nhs.net

AUTHOR CONTACT:
Name: Dr Ruth Wallis
E-Mail: ruth.wallis@southwark.gov.uk
Public Health in
Lambeth and Southwark

Director of Public Health Report
October - December 2014
Introduction

This is the quarterly report of the Director of Public Health for Lambeth and Southwark for the third quarter of 2014-15. The report is for the London boroughs of Lambeth and Southwark and Lambeth and Southwark Clinical Commissioning Groups as well as for all Health and Wellbeing Boards partners.

The aim of the quarterly reports is to update partners on the activities of the Lambeth and Southwark specialist public health team and work being done in partnership; and to provide information about current public health issues relevant to Lambeth and Southwark, including alerting people to areas of concern or risk.

This quarter summaries are from the health intelligence work streams, including an update on the annual public health reports for Lambeth and Southwark, Public Health Outcomes Framework – update on Health Care Public Health domain, update on Marmot indicators, Joint Strategic Needs Assessment – including web site development, new factsheet on suicides; summary of data section of; development of primary care profiles; key findings from the Shisha survey in South East London and alcohol licensing.

Comments and ideas for future topics are welcome. Please contact PHadmin@southwark.gov.uk

2. Annual Public Health Reports (APHR) – data section

The APHR data section is a supplemental indicator profile supporting the APHR. Indicators cover geography, population, life expectancy, infant mortality, teenage conceptions, mortality, long term condition prevalence and vital statistics.

Lambeth

Lambeth is a densely populated, young ethnically diverse population with over 150 languages spoken. The resident population, 314,242, is estimated to increase by 9% over the next 10 years. Lambeth will remain a young borough in 2024 with 21% of the population aged under 20 and 50% of the population aged 20-44.

Lambeth records comparatively high levels of internal migration, migrant national insurance number registrations, estimates of non-UK born residents and migrant GP registrations. Lambeth has an ethnically diverse population with the Black, Asian and Minority Ethnic (BAME) community accounting for around 43% of the total population. Approximately 30% of people are classified as Black with almost equal proportions of Black African (12%) and Black Caribbean (9%). Projections estimate the
The Black Caribbean population is likely to decrease by 6% in the next 10 years, compared to increase in the Black African population by 9%. The Chinese & Pakistani population will experience a population increase by 19% and 5% respectively. The projections suggest BAME overall will increase by 14%.

The 2010 Index of Multiple Deprivation (IMD) places Lambeth as the 9th most deprived borough in London and 29th most deprived in England. Variation of deprivation can be seen across the borough, 37% of Lower Super Output Areas (LSOAs) are in the 20% most deprived areas in England and 89% of LSOAs are in the 40% most deprived areas in England. Fig 1 shows the proportion of Lambeth LSOAs assigned to each deprivation range.

The 2012 under-18 conception rate for Lambeth is 33.2 per 1,000 girls aged 15-17, representing an overall decline of 61.1% since 1998, the baseline, and a 65.4% reduction since 2003, when under 18

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1 Index of Multiple Deprivation 2010 (IMD)
conceptions rate was highest. That is a reduction from 415 in 2003 conceptions to 142 conceptions in 2012.

Infant mortality (deaths of infants aged under 1 year) has dropped from 8.8 per 1,000 live births in 1995-97 to 6.0 per 1,000 live births in 2010/12, which is a reduction of over 33%; however, there is still a gap when compared to the London and England rate.

At national level, Fig 2 shows life expectancy (LE) gap between Lambeth and England. For males and females, circulatory and respiratory conditions are key contributors to the LE gap. For males, cancer related deaths are also key, 2/3 of which were due to lung cancer. Chronic obstructive pulmonary disease explained 100% of male and 60% of female respiratory disease gap.

Fig 2

2 Public Health England, Segment Tool, Life Expectancy Gap
At local level, Fig 3 shows LE gap between Lambeth’s least and most deprived areas. For males and females, circulatory and respiratory conditions are key contributors to the LE gap. Heart disease explains 1/3 of male and 2/3 of female circulatory disease. Chronic obstructive pulmonary disease explained 100% of male and 50% of female respiratory disease gap.

Fig 3

Life expectancy gap between Lambeth least and most deprived areas, by cause of death, 2009-2011

Source: Public Health England, Segment Tool, Life Expectancy Gap

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³ Public Health England, Segment Tool, Life Expectancy Gap
The pie charts in Fig 4 show the proportion each cause of death contributes to total deaths. In 2013 there were 1,410 deaths to Lambeth residents. Cancer is the largest cause of death (31%) followed by circulatory disease (24%).

**Southwark**

Southwark is a densely populated, young ethnically diverse population with over 300 languages spoken. The resident population of 299,304 is estimated to increase by 16% over the next 10 years. Southwark will remain a young borough in 2024 with 23% of the population aged under 20 and 48% of the population aged 20-44.

Southwark records comparatively high levels of internal migration, migrant national insurance number registrations, estimates of non-UK born residents and migrant GP registrations. Southwark has an ethnically diverse population with the Black, Asian and Minority Ethnic (BAME) community accounting

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4 ONS Public Health Mortality Files
for around 47% of the total population. Approximately 30% of people are classified as Black with a larger proportion of Black African (16%) and Black Caribbean (6%). Projections estimate the Black Caribbean population is likely to decrease by 1% in the next 10 years, compared to increase in the Black African population by 15%. The Asian (Chinese 30%, Pakistani 22% and Indian 20%) population will experience a population increase. The projections suggest BAME overall will increase by 23%.

The 2010 Index of Multiple Deprivation (IMD) places Southwark as the 12th most deprived borough in London and 41st most deprived in England. Variation of deprivation can be seen across the borough, 35% of LSOAs are in the 20% most deprived areas in England and 79% of LSOAs are in the 40% most deprived areas in England. Fig 5 shows the proportion of Southwark LSOAs assigned to each deprivation range.

**Fig 5**

![Index of Multiple Deprivation 2010 (IMD)](image)

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5 Index of Multiple Deprivation 2010 (IMD)
The 2012 under-18 conception rate for Southwark is 31.8 per 1,000 girls aged 15-17, representing an overall decline of 63.5% since 1998, the baseline, and a 25.5% reduction since 2011. This accounts for a reduction of 46 conceptions between 2011 and 2012.

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

At national level the following Fig 6 shows life expectancy (LE) gap between Southwark and England. For males and females, respiratory disease and cancer were key contributors to the LE Gap. Chronic obstructive pulmonary disease accounts for 90% of all respiratory diseases for males, and 100% for females. 2/3 cancer deaths contributing to the gap were due to lung cancer.

**Fig 6**

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6 Public Health England, Segment Tool, Life Expectancy Gap
At local level, Fig 7 shows the life expectancy gap between Southwark’s least and most deprived areas. For males and females, circulatory diseases were a key contributor to the LE gap, as were respiratory diseases and cancer. For females, mental and behavioural disorders contributed to the LE gap. Heart disease explained 40% of male and 65% of the female gap. Other conditions not specified for females contributed to 22% of the gap. COPD accounted for most of the gap for respiratory disease.

Fig 7

Source: Public Health England, Segment Tool, Life Expectancy Gap
The pie charts in Fig 8 show the proportion each cause of death contributes to total deaths. In 2013 there were 1,321 deaths to Southwark residents. Cancer is the largest cause of death (30%) followed by circulatory disease (27%).

ONS Public Health Mortality Files

The PHOF “Healthy lives, healthy people: Improving outcomes and supporting transparency” sets out a vision for public health, desired outcomes and the indicators that help us to understand how well public health is being improved and protected.

The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four ‘domains’ that cover the full spectrum of public health as illustrated in the figure on the left. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life. Data are published as part of a quarterly update cycle in August, November, February and May.

More details on the overarching outcomes and life expectancy can be found in the JSNA web pages (www.southwark.gov.uk/jsna and www.lambeth.gov.uk/jsna). In this report, we are updating local boards on the fourth domain (Health Care Public Health and Preventing Premature Mortality), with a focus on premature/preventable mortality.

The figures on the next page summarise the changes in the four main causes of preventable mortality in Southwark and Lambeth. These are heart disease/strokes, cancers, respiratory disease and liver disease. There has been a significant reduction in preventable deaths from heart disease and strokes – this is as a result of reduced smoking levels, better dietary measures and blood pressure controls as well as the availability of effective treatments. However, as the population ages, more people are developing cancers and this is reflected in the shift in the proportion of people dying from preventable cardiovascular diseases to cancers over time. There has been significant change in the preventable respiratory disease mortality in Southwark, with a slight worsening in Lambeth. Lambeth has seen a slight improvement in preventable liver mortality, with Southwark seeing a slight worsening. The
relative percentage of preventable mortality from these two areas has also increased over time. Continuing effort needs to be put into prevention of risk factors related to these four conditions – smoking, blood pressure control, alcohol, obesity (diet and physical activity), and lipid control. These require both the implementation of healthy policy as well as targeted individual behaviour.

Fig 9

Source: Public Health Outcomes Framework (PHOF)\(^{11}\)

Fig 10

Source: Public Health Outcomes Framework (PHOF)\(^ {12} \)

\(^{11}\) Public Health Outcomes Framework (PHOF)
4. Marmot indicators update

The Marmot Indicators are a specific set of indicators that form part of the Public Health Outcomes Framework (PHOF). The Marmot indicators specifically address wider determinants of health, health outcomes and health inequality. The data presented here shows an update of these indicators, and progress since last year. In addition, some new indicators were introduced that seek to reflect educational attainment, wellbeing and income. Unless otherwise stated, indicators cover the period from 2010-12 and compare to the period of 2009-2011.

Overall, the indicators show that the situation has not changed much compared to the previous reporting period. In summary:

- In **Southwark**, healthy life expectancy for women has improved from 60.2 to 62.5 years, but with no change for men, and is significantly worse than the England average. Healthy life expectancy in **Lambeth** has improved from 61.1 to 63.1 years for men and with no change in women 62.3 to 62.2 years, both of which do not differ significantly from the England average.
- Life expectancy at birth in **Southwark** has slightly improved for men (78 years) and women (83.1), but male life expectancy is still significantly lower than for the whole of England. Life expectancy at birth in Lambeth is similar men (78.2 years) and women (83 years), again with male life expectancy significantly lower than for the whole of England.
- **Southwark**’s inequality in life expectancy at birth within the borough is 7.1 years for men and 7.3 for women, meaning that people in the poorer parts of Southwark die seven years earlier than those in the wealthier parts. In **Lambeth**, this gap is lower with 5 years for men and 2.8 years for women.
- 7.8 per cent of **Lambeth** residents report a low life satisfaction, which is not significantly different to England’s value of 5.8%.  

On development and educational attainment, key predictors for later income and health and wellbeing, Lambeth and Southwark achieve different outcomes:

- In **Lambeth** in 2012/13, 46 per cent of children at the age of five have a good level of development, which is significantly worse than England’s average of 51.7 per cent. Children at age 5 with free school meals perform close to the English average: 36.5 per cent have a good level of development, compared to England’s average of 36.2 per cent. In **Southwark**, more children

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12 Public Health Outcomes Framework (PHOF)
13 This indicator is not available at Southwark level
achieve these outcomes: 59.6 per cent of children at the age of five have a good level of development, and 51.6 per cent on free school meals.

- In both boroughs, the percentage of young people who have obtained 5 A*-C GCSEs including English and Maths is higher than the English average (60.8%) for all pupils (Lambeth: 65.9%, Southwark 65.2%), and also for those on free school meals (Lambeth: 59.9%, Southwark: 60.1%, England: 38.1%)

- The percentage of 19-24 year olds not in education, employment or training isn’t broken down to borough level, but for London, the value is 13.7.

Employment, long-term employment and income in Southwark and Lambeth also reveal some differences to the England average:

- Employment levels in Southwark (10.4%) are worse than the England average of 7.4%, but similar in Lambeth (8.3%). In Southwark, 15.4 per 1000 population are long-term unemployed, and in Lambeth 16.8 per 100,000 (England: 9.9%). In 2012, 7.5% of Lambeth and 6.4% of Southwark households were in fuel poverty, both significantly fewer than the 10.4% average in England.

- In 2011/12, 2920 per 100,000 Londoners had a work-related illness, and income levels in for 29.4% of Londoners in 2011/12 did not reach minimum income standards. 14

What are we doing locally?

The Public Health Directorate is working with both councils and the CCGs to improve on these indicators, and to reduce inner-borough inequalities, for example in life expectancy for men and women. Current work includes an analysis of existing PHOF indicators to determine inner-borough inequalities and to include an inequality dimension in an assessment of the impact of certain indicators on the boroughs’ populations, such as number of people affected, the severity of the impact, and the financial impact on the person, the council and the NHS. We provide CCGs and the council with expert input and data analysis on departmental strategies (e.g. housing, air quality) and work towards building capacity in recognising the wider determinants of health and ways that organisations can mitigate against them in all their work.

The public health team has worked with the councils on integrating public health outcomes framework with the council plans. For example, we have completed with Southwark CCG an in-depth analysis of inequalities in the borough and are planning to do the same for Lambeth CCG. Public Health is represented on the housing and air quality steering groups to highlight the impact of poor

14 Both of these indicators are not available on borough levels
housing and air quality on public health, and to inform what can be done to prevent ill health. Further projects are in development.

5. JSNA

Background
As part of the JSNA, the Public Health Team produces a series of factsheets to bring together local data for Lambeth and Southwark to provide a snapshot profile of current or local issues to a broad audience using standard statistics. Factsheets on Wellbeing, Life Expectancy and Demography have been completed and uploaded to the respective Southwark (www.southwark.gov.uk/jsna) and Lambeth (www.lambeth.gov.uk/jsna) JSNA websites.

5.1 Suicide Factsheet

The Suicide factsheet is the first to cover both Lambeth and Southwark as a single report. It provides a summary of the national context and how Lambeth and Southwark fare compared to national indicators, in addition to a comprehensive list of ‘What works’ in terms of suicide prevention strategies.

Suicide rates in England are historically low and lower than in most other European countries. Rates have remained stable over time. The highest suicide rates overall are in the 45-49 year age group. Men are three times more likely to take their own life. Suicides have substantially decreased since a national target of 20% reduction was set in 1995-97 (see fig 8). Number of deaths from suicide in Lambeth and Southwark remain low in men and very low in women. Suicide rates in Lambeth and Southwark are similar to the England average.

Admissions to hospital after an episode of self-harm or self-poisoning tend to suggest severe harm or a ‘near miss’. This group of people are at higher risk of taking their own lives in the future and are an important group to review alongside deaths due to suicide as they represent a level of severe distress. There has been an increase in admissions in men and women in the last 5 years. Admissions for women remains higher than that for men and rates are highest in young women aged 15-19 (338 per 100,000). Admission rates for intentional self-harm and injury of undetermined intent are lower in Lambeth and Southwark compared to England.
5.2 Primary Care Locality Profiles

The Health Intelligence team has been working with both Southwark and Lambeth CCGs to develop the Primary Care Locality profiles. The final drafts have been presented to the CCGs and further work is on-going to present to localities within the CCGs. The profiles includes a map of the localities with practice locations, key health priorities, demographic information on populations relevant to both primary care and community services, vital statistics, deprivation, variation in Quality and Outcomes related prevalence of specific conditions, and variation in hospital admissions for selected causes. The profiles will be available on the JSNA web pages in January 2015.

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Fig 11

Deaths from suicide in men shows a downward trend

Source: IC Indicators (HSCIC) Health and Social Care Information Centre

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IC Indicators (HSCIC) Health and Social Care Information Centre
5.3 Shisha: An Emerging Public Health Issue in South East London

The rapidly rising popularity of shisha tobacco is a new and unwelcome development in public health. A shisha smoker inhales large volumes of tar, carcinogens and carbon monoxide deep into their lungs which exposes them to all of the diseases associated with smoking cigarettes. Smoking shisha products that do not contain tobacco is not necessarily less damaging in terms of the effect of the smoke inhaled, as it will still expose users to carcinogens and carbon monoxide.

In response to this emerging problem the South East London Illegal Tobacco Network (SELITN) commissioned an adult and young people survey during 2013-14 and drew together available information on shisha use in South East London.

Shisha use in South East London is endemic. The survey of adults revealed that 31% of those adults surveyed had smoked shisha at least once and that 16% had smoked it in the year prior to the interview. This compares to an adult smoking rate for cigarettes of 17.3% for London. Approximately 70% of the adults interviewed indicated that they were aware of shisha before the interview, and 96% of those aware of it had seen it being smoked in the UK. The majority of people who smoked shisha last year were from ethnic groups identifying as ‘white’, and Arabic or Asian users now represent less than 25% of users in South East London.

Shisha use is particularly prevalent among younger people. Amongst the 18-34 age group in South East London, 45% have tried shisha and 25% have smoked it at least once in the last year. By the age of sixteen more than 40% of young people in South East London will have tried shisha. The most common place for young people to report first trying shisha is either at a shisha café or a friend’s house.

The dangers of shisha smoking are poorly understood by the public. Although the use of shishas is widespread, understanding of what shisha is and its potential impact on health remains poor.

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16 In smoking shisha using a water pipe the user draws air over a charcoal briquette to create the hot gas that vaporises the shisha molasses, this means that significant quantities of carbon monoxide are inhaled. In addition as the smoke has been cooled more is inhaled and it is inhaled deeper into the lungs.

17 SELITN is a collaborative network of Trading Standards and Public health teams in the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

Action Being Taken in South East London

While an over-arching strategy for dealing with shisha has yet to be agreed these boroughs are taking the following actions to limit its impact on their communities.

- Trading Standards and Environmental Health teams are working to ensure that shisha café type businesses operate in accordance with the laws on under age sales of tobacco products and smoke free legislation (smoking indoors).
- Trading Standards teams are working jointly and individually with HM Revenue and Customs to prevent illegal shisha being sold in in South East London.
- Public Health teams are looking at ways of ensuring that residents of their boroughs can make informed choices regarding shisha use and that parents better understand the risks that shisha poses to their children.
- The SELITN is also working with Public Health England, Action on Smoking and Health (Public Health charity) and the London Trading Standards Association to help develop more effective shisha policies for London as a whole.

6. Alcohol licensing

Public Health is increasing its role in local licensing decisions. Lambeth and Southwark both have large numbers of people who are drinking at unsafe levels. It is estimated that over 100,000 people (in both boroughs combined) are drinking at increasing or higher risk levels. This means drinking more than 3-4 units a day for a man or 2-3 units for a woman; one pint of lager or one large glass of wine can be over three units.

The licensing process is one way Public Health Teams can contribute to reducing alcohol-related harm. Under the Police Reform and Social Responsibility Act (2011), the Government amended licensing legislation to give health authorities a statutory role in the licensing process. This means the Director of Public Health can submit evidence to inform local licensing decisions.

The Lambeth Alcohol Prevention Group (APG) commissioned Safe Sociable London Partnership (SSLP) to develop a Lambeth Public Health Licensing Process Tool and pilot it for five months (Jan – May 2014). The Lambeth & Southwark Public Health Directorate has also funded SSLP to develop a similar Licensing Tool for Southwark, which is now available.
Within the 5-month pilot in Lambeth, 53 applications were received. After putting each application through the Lambeth Public Health Licensing Process Tool, it was decided that for just over a quarter of applications (14 in total), health representations should be made to the licensing sub-committee. Of the 12 representation which have been heard by the sub-committee, 9 (75%) resulted in the license being revoked/refused, withdrawn or granted based on conditions that reduce alcohol-related harm. Verbal feedback indicates that the Lambeth licensing sub-committee and the other responsible authorities welcomed the collaboration with, and representations from Public Health.

The process developed for the Lambeth pilot is being used by Public Health England as an example of best practice for national guidance.

A business case, based on the results of the Lambeth pilot, was put forward to Lambeth and Southwark Councils to jointly fund a 2-day per week post to lead on the delivery of public health input into local licensing decisions. The Lambeth Joint Commissioning Group has recently allocated money to fund half of this post for one year. The post was successfully recruited to in December and work will be evaluated.
ENCLOSURE G

Arrangements for CCG Commissioning of Primary Care

CCG DIRECTOR RESPONSIBLE: Andrew Bland, Chief Officer

COMMITTEE CHAIR: Dr Jonty Heaversedge, CCG Chair

AUTHOR: Kieran Swann, Head of Planning and CCG Assurance

IN INVOLVEMENT REQUIRED FROM THE CCG GOVERNING BODY:

The Governing Body is asked to:

1. Endorse an expression of interest to be submitted to NHS England for the CCG to permit it to enter into joint arrangements for the commissioning of primary care services in Southwark.

SUMMARY:

1. The purpose of this paper is to seek the support of the Governing Body to submit an expression of interest to NHS England on 30 January 2015 to enter into the following arrangements, along with the five other CCGs in south east London, for the co-commissioning of primary care services in Southwark:

   The joint commissioning of primary care services with NHS England from the 1 April 2015, with a commitment to a programme of work to explore and potentially apply for full delegation of these commissioning responsibilities from 1 April 2016.

2. If Governing Body support is provided the CCG would then be required to complete an expression of interest with the NHS England Area Team by the end of January.

3. The paper provides further background for, and summarises the key issues associated with this decision - identifying the key milestones and final recommendation.
IN VolVEMENT

Membership and Patients and the public

CCG Locality Group Meetings
CCG Council of Members

Between October 2014 and January 2015 the CCG has engaged with local residents, key partners and its member practices (since June 2014) to explore the potential for co-commissioning in the borough and to determine the form that co-commissioning might take.

Stakeholders

The CCG will work collaboratively with south east London CCGs and NHS England.

RECOMMENDATIONS:

The Governing Body are asked to:

1. Endorse an expression of interest to be submitted to NHS England for the CCG to permit it to enter into joint arrangements for the commissioning of primary care services in Southwark.

2. Note the engagement that has been completed with member practices and the Council of Members on co-commissioning.

3. Note that the submission of an expression of interest is for the co-commissioning of services for Southwark but would be made alongside the expressions of interest of the other five CCGs in south east London who are seeking to collaborate in the implementation of these future.

CCG DIRECTOR’S CONTACT:

Name: Andrew Bland
E-Mail: andrewbland@nhs.net
Arrangements for CCG Commissioning of Primary Care

1. Purpose

1.1. The purpose of this paper is to seek the support of the Governing Body to submit an expression of interest to NHS England on 30 January 2015 to enter into the following arrangements, along with the five other CCGs in south east London, for the co-commissioning of primary care services in Southwark:

The joint commissioning of primary care services with NHS England from the 1 April 2015, with a commitment to a programme of work to explore and potentially apply for full delegation of these commissioning responsibilities from 1 April 2016.

1.2. If Governing Body support is provided the CCG would then be required to complete an expression of interest with the NHS England Area Team including the following key documentation and content by the end of January:

- Statement of objectives
- Declaration of agreement of Governing Body and members
- Governance documentation (Committee in common Terms of Reference incorporating scheme of delegation)
- Copy of CCG IT toolkit
- Constitution or proposed constitution amendments submitted

1.3. The remainder of this paper provides further background for, and summarises the key issues associated with this decision - identifying the key milestones and final recommendation.

1.4. The Governing Body is asked to note that the proposal for this future form of co-commissioning in the borough has been discussed and supported by the Council of Members of the CCG - who will receive and take a decision upon the changes to the constitution required by any such change to the responsibilities of the CCG in March 2015.

1.5. The Governing Body is further asked to note that the submission of an expression of interest is for the co-commissioning of services for Southwark but would be made alongside the expressions of interest of the other five CCGs in south east London who are seeking to collaborate in the implementation of these future arrangements.

2. Background

2.1. In October 2014 the NHS Leadership in England published a Five Year Forward View that makes clear that co-commissioning of primary care services will exist in some form across England by 1 April 2015.
2.2. This followed an initial invitation from NHS England to all CCGs in May 2014 to consider the potential benefits to the health and wellbeing of their residents of taking greater control or having greater involvement in the commissioning of primary care services delivered to their population.

2.3. Between October 2014 and January 2015 the CCG has engaged with local residents, key partners and its member practices (since June 2014) to explore the potential for co-commissioning in the borough and to determine the form that co-commissioning might take. The CCG has also worked with the other CCGs in south east London to determine the level of collaboration that could usefully be established between CCGs in making this expression of interest.


3. Primary Care Co-commissioning

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

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

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

3.3. Importantly the development of co-commissioning arrangements on a borough basis will allow for a population focus for the commissioning of these services rather than the single operating model for commissioning that currently exists and is exercised once for England irrespective of local circumstance.

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

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

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

4.3. In the context of financial constraint right across the public sector - the bringing together of these budgets, in what might be termed a ‘Place based budget’ also provides the opportunity to build upon local work in areas such as the Better Care Fund and create pooled or aligned budgets that reward improved population outcomes for those providers who can collaborate or integrate across health and social care to deliver them.

5. CCG involvement in co-commissioning

5.1. In any future arrangement the statutory responsibility for primary care commissioning remains with NHS England and co-commissioning arrangements describe the way in which different parts of the commissioning system will work together to provide greater local focus to drive high quality, best value and locally responsive care.

5.2. The form that co-commissioning takes is for local CCG determination, working with their partners and residents to determine this. National arrangements do, however, stipulate three potential levels of involvement in co-commissioning:

- Greater involvement in NHS England Decision making (Greater Involvement)
- Joint decision making by NHS England and CCGs (Joint Commissioning)
- CCGs taking on delegated responsibilities from NHS England (Delegated Commissioning)

5.3. Whilst CCGs are asked to determine their level of involvement by 1 April 2015 there is then an annual opportunity to enhance that involvement by moving to the next level (e.g. from Joint to Delegated Commissioning).

Options

5.4. Three co-commissioning options have been identified for CCGs to consider:

5.5. Greater Involvement: ‘An invitation to CCGs to collaborate more closely with their area teams to ensure that decisions taken about healthcare services are
strategically aligned'. This would not require a new governance arrangement to be established.

5.6. **Joint Commissioning:** Commissioning functions would be undertaken with NHS England and *could* include:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" AND "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality of Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving Mergers, and;
- Making decisions on ‘discretionary’ payments (e.g. returner/retainer schemes).

5.7. This would require a change in the CCG Constitution and revised governance arrangements with:

- A Joint committee or ‘committee in common’ with area teams/other CCGs (where appropriate)
- A Model terms of reference adapted for local circumstance
- Individual CCGs and NHS England always remain accountable for meeting their own statutory duties
- Retained and clear clinical leadership
- Potential for Pooled funds

5.8. **Delegated Commissioning Arrangements:** The full delegation of responsibilities to be enacted by the CCG providing functions that *will* include:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" AND "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payments (e.g. returner/retainer schemes).

5.9. This would again require a change in the CCG Constitution and revised governance arrangements with a Primary Care Commissioning Committee and specific membership to reflect national guidance on decision making and the management of conflict of interest.

6. **Local consideration of these options to inform a Governing Body decision**

**Engagement**
6.1. Over the last eight months the CCG has engaged its members, partners and local residents in an exploration of the strengths, weaknesses, opportunities and threats (SWOT) offered by the options outlined above. The SWOT analysis is available along with the outcomes of those discussions and this has informed the recommendation to the Governing Body - a two stage proposal that seeks to establish joint commissioning arrangements in the first instance with a further process to determine whether to move toward full delegation in 2015/16.

6.2. In addition to engagement with partners, members of the Health and wellbeing Board, the Engagement and Patient Experience Committee and the Local Medical Committee - the CCG has also undertaken an extensive programme of member practice engagement to inform the decision making of the Governing Body. This has included:

- The establishment of an online ‘Question and Answers’ forum from July 2014 with regular responses from the Chair and Chief Officer, published for all members to access
- The development of an engagement document issued to all member practices in October 2014 including the SWOT analysis undertaken by the Governing Body and regular updates on co-commissioning as they have emerged
- Locality and individual practice visit discussions
- Two Southwark wide practice events (November and December 2014) to review the options and inform a recommendation

6.3. Importantly the CCG has also discussed the future proposals with the Council of Members and tested the recommended decision for the Governing Body at the last meeting on 14 January 2015. As well as establishing the support of the Council of Members for this proposal the CCG also made that body aware of its future role in considering the necessary changes to the CCG Constitution that would be required in March 2015.

Rationale

6.4. In summary the proposal being considered by the Governing Body at its January 2015 meeting is to pursue the two stage proposal, outlined above. This was based upon the following considerations:

- That co-commissioning of primary care services offers significant opportunity to improve local outcomes for patients and reduce inequalities by adopting a more integrated and locally responsive approach to commissioning.
- That the ‘Greater Involvement’ option did not maximise the potential of this important opportunity and represented an ‘as is’ option for the borough based on current working relationships with NHS England Commissioners
- That both forms of greater responsibility held significant opportunities but that Joint Commissioning, rather than full delegation, should be adopted in the first instance taking in to the account the following:

  - A recognised need for due diligence over the available local budget and any pre-commitments or unforeseen future financial commitments and of future
governance requirements for full delegation. The proposal would allow for that process over the next year

- That joint commissioning in the first year of this new arrangement would secure sufficient influence over local decision making whilst allowing the CCG to learn more about the implications and resource requirements of fully delegated responsibilities

- The clear opportunity to adopt full delegation in future years

7. Further issues of consideration

7.1. In addition to the concept and forms of co-commissioning that might be adopted the CCG has also given, and continues to give full consideration to the following areas. Each of these issues would need to be adequately addressed in the period following the expression of interest and before formal agreement of the Governing Body to establish joint commissioning arrangements in March 2015, then taking effect on 1 April 2015:

Financial allocation/ Budgets

7.2. Preliminary information has been provided to CCGs regarding their share of the area team 2014/15 allocation and high level information regarding actual expenditure against allocation. The CCG would wish to continue working with NHS England to determine the exact position for joint commissioning and to undertake a further due diligence exercise ahead of proposing any enhanced arrangement in 2016/17.

7.3. It is clear however, that co-commissioning does not in and of itself provide any additional resource for primary care, but does provide an opportunity to better influence the utilisation of those resources in a context where the Five Year Forward View is describing enhanced investment in primary care.

Running Costs

7.4. There is no additional resource to support running costs in 2015/16. NHS England (London Region) however, has re-organised its existing team and made available senior commissioning staff to support commissioning across London. Their contracting staff will also be retained to provide pan London services.

7.5. It is probable that some project support costs will need to be incurred to enable co-commissioning to be developed during 2015/16.

Conflict of Interest

7.6. It is clear that greater involvement in the commissioning of primary care services will heighten the potential for conflict of interests and the CCG will need to take the requisite steps to ensure its arrangements remain robust. On the 18 December 2014, NHS England published ‘Managing Conflicts of Interest: Statutory Guide for CCGs’ (http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf). By way of preparation for joint commissioning, CCGs will need to review their Conflicts of Interest policy in line with their guidance to:
Enable CCGs and clinicians in commissioning roles to demonstrate they are actively, fairly and transparently and in the best interest of their partners and local population.

Ensure that CCGs operate within the legal framework, but without being bound by over prescriptive rules that risk stifling innovation.

Safeguard clinically led commissioning whilst ensuring objective investment decisions.

Provide the public, providers, parliament and regulator with confidence in the probity, integrity and fairness of commissioning decisions; and

Uphold the confidence and trust between patients and GPs

7.7. Formally, the Audit Committee Chair and Accountable Officer will be required to provide direct formal attestation to NHS England that the CCG has complied with this guidance. Further details regarding the form of this attestation is to follow.

South east London working

7.8. Each CCG in South East London has been engaging with their own membership and local stakeholders and have also been exploring how best to work together. A cross CCG Task and Finish Group have overseen this process and two cross CCG workshops have taken place with representation from each CCG. From those discussions it has become clear that there is a large degree of commonality of approach across south east London and benefits of working together.

7.9. A key part of the governance arrangements moving forward is a proposed ‘committee in common’ with NHS England and the five other CCGs in south east London. In addition, each individual CCG expression of interest will contain commonality and consistency of approach in terms of the key documents and statements submitted. During January, individual Governing Bodies will be making their own decisions in consultation with their members but are all recommending a joint commissioning approach across the full scope of the offer.

8. Next steps

8.1. To finalise the documentation for submission to NHS England by the 30 January 2015, to include the necessary supporting documentation.

8.2. Due to the pan south east London and NHS England input into the supporting documentation and governance arrangements, this documentation is not available in time for sign off at each CCG governing body meeting in January. The proposed final draft Expression of Interest and associated documentation will be subject to a final review by the Chief Officer, CCG Chair, Audit Committee Chair and Council of Members Chair and formally signed off through Chairs action.

9. Recommendations

To support an expression of interest for the Joint commissioning of primary care services with NHS England from the 1 April 2015, with a commitment to a programme of work to explore and potentially apply for full delegation of these commissioning responsibilities from 1 April 2016.
To note the process to finalise the submission and associated documentation
To agree that final sign off of submission and supporting documentation be taken through Chairs action
CCG Governing Body

DATE OF MEETING:

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**CCG DIRECTOR RESPONSIBLE:** Gwen Kennedy, Director of Quality and Safety

**CLINICAL LEAD RESPONSIBLE:** Dr Sian Howell, CCG Clinical Lead

**AUTHOR:** Kate Moriarty-Baker, Head of Continuing Care & Safeguarding

**IN INVOLVEMENT REQUIRED FROM THE CCG GOVERNING BODY:**

1. To note the work undertaken during 2013-14 to ensure that the CCG is meeting its statutory responsibilities with regards Children Safeguarding

**SUMMARY:**

The Children Safeguarding Annual Report demonstrates NHS Southwark Clinical Commissioning Group's (CCG) strong commitment to safeguarding and promoting the welfare of children at risk who are living within the local communities. It provides information about how the CCG carries out its statutory responsibilities in this regard.

The report also provides assurance that provider services within Southwark are working collaboratively to meet the commitment of ensuring that children and adults live free from abuse and neglect and that those people in vulnerable circumstances are not only safe but also receive the highest possible standard of care.

**RECOMMENDATIONS:**

The CCG Governing Body is asked to:

1. Note and approve the Children Safeguarding Annual Report
CCG DIRECTOR’S CONTACT:
Name: Gwen Kennedy
E-Mail: gwen.kennedy@nhs.net

AUTHOR CONTACT:
Name: Kate Moriarty-Baker
E-Mail: kate.moriarty-baker@nhs.net
Safeguarding Children Annual Report

September 2013 – August 2014

Clinical Lead: Dr Sian Howell
Accountable Officer: Andrew Bland
Director Lead: Gwen Kennedy
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Appendix 1 – Southwark Child Safeguarding Activity
1. SUMMARY AND BACKGROUND INFORMATION

This report demonstrates NHS Southwark Clinical Commissioning Group’s (CCG) strong commitment to safeguarding and promoting the welfare of children at risk who are living within the local communities. It provides information about how the CCG carries out its statutory responsibilities in this regard.

This report also provides assurance that provider services within Southwark are working collaboratively to meet the commitment of ensuring that children and adults live free from abuse and neglect and that those people in vulnerable circumstances are not only safe but also receive the highest possible standard of care.

The requirements upon health are enshrined in statute within children’s services. The Children Act 1989 and 2004 provides the legislative framework for safeguarding children and is supported by statutory and supplementary guidance in Working Together (HM Government 2013). This guidance sets out the roles and responsibilities of all agencies including CCG’s in ensuring their functions are discharged with regard to the need to safeguard and promote the welfare of children.

The mandate from the Government to the NHS England published in November 2012 says:

'We expect to see the NHS, working together with schools and children’s social services, supporting and safeguarding vulnerable looked after and adopted children, through a more joined-up approach to addressing their needs.'

2. EXECUTIVE SUMMARY

Clinical Commissioning Groups, as with all other NHS bodies, have a statutory duty to ensure that they make arrangements to safeguard and promote the welfare of children and young people and to protect vulnerable adults from abuse or the risk of abuse.

As a commissioning organisation, Southwark CCG is required to ensure that all health providers from whom it commissions services (both public and independent sector) have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect vulnerable adults from abuse or the risk of abuse.

Safeguarding children is part of Southwark CCG’s Business Plan and Operating Plan Objectives and key areas of delivery to improve the quality and safety of local services. More widely Southwark CCG participates in the South London Quality Surveillance Group which looks more broadly at quality issues across the regional CCG and provider landscape and includes relevant safeguarding issues.

Leadership and responsibility for safeguarding at the Governing Body level is achieved through the CCG Accountable Officer. The CCG also has a
Clinical Lead and a Director responsible for safeguarding children who provide clinical expertise in partnership with the Designated Doctor, Named GP and Designated Nurse. In addition there are commissioned Designated Professionals in respect of Looked After Children and Designated Paediatrician.

3. PURPOSE OF THE REPORT – SAFEGUARDING ASSURANCE

Under Section 11 of the Children Act 2004 Southwark CCG has a mandatory requirement to ensure that robust arrangements are in place to safeguard and promote the welfare of all children and young people.

The annual report to the Board provides assurance that, as commissioners:

- The CCG has robust child protection / safeguarding arrangements in place for 2013/14
- Assures the Governing Body / Board that systems are in place to ensure organisational learning from serious case reviews and internal management reviews that are supported by robust action plans that address both our statutory responsibilities and respond to local need
- Confirms joint working with partner agencies, including working with the Southwark Safeguarding Children Board on the key themes, for 2014-15 this includes Child Sexual Exploitation, Neglect and Female Genital Mutilation (FGM)

4. COMPLIANCE

NHS Southwark CCG is fully compliant with the current statutory guidance ‘Working Together to Safeguard Children 2013’ and ‘Children Act 1989 & 2004’.

Our compliance is supported by the following involvement and actions:

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

- Designated Doctor and Designated nurse roles are in place. These roles support the acute providers by providing advice and supervision for the Named Safeguarding Leads. The designated roles attend the safeguarding children board meetings within local acute Trusts. For Southwark the Trusts supported are Kings College Hospital NHS Foundation Trust, Guy’s & St Thomas’ NHS Foundation Trust and the South London & Maudsley NHS Foundation Trust

- The CCG has a bi-monthly Safeguarding Children and Adult Executive Committee. Members include Clinical Leads, Accountable Officer, CCG Director, Local Authority and Health Providers. This group reports into the CCG Integrated Governance and Performance Committee for decisions and endorsement of relevant actions plans. The CCG Safeguarding Executive is well attended by all organisations and considers key
documents from both the Southwark Safeguarding Children Board (SSCB) and the Adults Partnership Board

- The CCG host a bi-monthly Health Sub-group of the SSCB which has membership from all relevant health partners including health providers, Looked After Children Designates, Public Health and the Local Authority. The purpose of the sub-group is to build and maintain an accurate picture of the quality and effectiveness of safeguarding arrangements, areas of strength and good practice and areas of risk and vulnerability across the health sector in Southwark. The sub-group takes the lead in instigating developments designed to improve safeguarding arrangements and improved outcomes for Looked After Children (LAC) which have cross sector or inter-agency relevance

- Local Safeguarding Children Boards are the key mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and adults in that locality, and for ensuring the effectiveness of what they do. The CCG supports the SSCB through attendance at Board meetings and actively supporting the sub groups. The Designated Nurse co-chairs the Practice Development and Training Sub Group. This high profile involvement of Southwark CCG with SSCB enables a robust dialogue between Health and multiagency Southwark.

- The Designated Professionals supervise all the Named Professionals within the key Southwark NHS Providers and provide advice and mentoring of these roles. A designated nurse supervision policy is in place to enable robust supervision across boroughs and to avoid conflict and confusion.

- The Designated Professionals assist in providing Southwark Safeguarding Children Board (SSCB) multiagency safeguarding training including disseminating key messages from National and Internal Serious Case and Management Reviews. The Clinical Lead for Safeguarding and Designates were directly involved in planning the SSCB Annual Safeguarding Conference held in January 2014. The focus of the conference was child neglect and attendance and feedback from this event was extremely positive

- The Designated Nurse is a member of Lambeth and Southwark’s Child Death Overview Panel (CDOP) and provides professional opinion on issues and feeds back key messages across primary care and the wider health system.

- The Designated Nurse has established strong links with the Multi Agency Risk Assessment Conference (MARAC) who consults the Designated Nurse if there are questions or feedback required for GPs. The key element of MARAC is the risk assessment, which is carried out by Police Officers attending incidents of domestic abuse. Systems are also in place through the Designated Nurse to ensure linkage with the Multi Agency Public Protection Agency (MAPPA) in the event that actions for Health are required from Southwark CCG or its providers. MAPPA is the name given
to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.

- Southwark CCG appointed a Named GP for Safeguarding in July 2013 to support all activities necessary for GP practices to meet their safeguarding and child protection responsibilities. The Named GP works alongside other designated and named professionals and contributes to both the strategic planning of services to safeguard children and ensures appropriate methods of engaging the wider Southwark GP community in matters of child protection and safeguarding.

- The Clinical Lead for Child Protection provides clinical leadership for Southwark CCG and liaises closely with other clinical leads, key directors, stakeholders and the designated professionals for child protection to enhance understanding of safeguarding issues, and ensure synergy in respect of policy, practice and safeguarding training. Joint work continues with the Local Authority and all health providers (Acute Hospitals, Independent Contractors and Mental Health Trusts) and partner agencies to promote and safeguard children’s welfare by ensuring robust governance and organisational systems are in place to support quality safeguarding practices.

- Southwark CCG continues to lead the work around reviewing existing commissioning standards across the local safeguarding partnership to ensure they reflect the most recent government guidelines and to improve reach and ownership across the key stakeholders.

- The CCG undertakes Serious Case Reviews (SCR), single agency management reviews and multi-agency reviews of cases as required. This includes the dissemination of learning across health organisations and implementing recommendations as required. SSCB is currently undertaking a SCR on a teenage LAC where there was an alleged sexual assault that took place. SCCG and its Health providers are contributing to this SCR by way of chronologies and IMRs. The Multi-Agency SCR Sub-Group of the SSCB advises on relevant cases and oversees progress around relevant SCRs and management reviews. There is also a concise review being undertaken on a child where there was a chronic case of neglect. This has been commissioned by SSCB and again SCCG and its Health providers are contributing to the review by way of chronologies and IMRs.

- The CCG is responsible for provider safeguarding quality assurance through contractual arrangements. Regular monitoring of progress against targets is carried out through CCG led assurance meetings with individual providers.

5. TRAINING AND SUPERVISION

Safeguarding training is critical to protecting children and young people from harm. All NHS staff must know how to identify abuse and neglect and how to act
on their concerns. Safeguarding training is mandatory for all NHS staff in relation to Children.

Each staff member within the CCG has had the level and frequency of safeguarding training they require identified. Level 1 and Level 2 is achieved through e-learning packages. All training once undertaken has been recorded at a central point within the CCG. Health single agency training has been quality assessed by the SSCB.

Southwark CCG has excellent staff training percentages for safeguarding children:

- Level 1 100%
- Level 2 Currently no staff member requires this training level in the organisation
- Level 3 100%

Key safeguarding documents and information is sent to GP Practices via the CCG Communications Department to ensure GP’s have access to up-to-date safeguarding information available to support them in their role. The CCG also has a CCG GP Safeguarding Webpage to promote access to safeguarding information and related resources.

**SCCB Annual Conference**

The SSCB Annual Conference was held on 23 January 2014 and the subject was ‘Neglect’. The Southwark CCG widely advertised this conference to Primary Care and therefore there was a stronger uptake of places by GPs and affiliated staff than in previous years. Members of the Southwark CCG also attended, including the director of Client Group Commissioning. The Designated Nurse and Doctor were instrumental in putting on workshops that covered certain aspects of neglect in children, including obesity and dental decay.

The GP Protected Learning Time in April 2014 on safeguarding children reflected the content of the SSCB Annual Conference to ensure the message on appropriate response to childhood neglect was spread further in Primary Care in Southwark.

**GP Protected Learning Time (PLT)**

The annual GP Protected learning time event took place on 17 April 2014 with 200 attendees predominately GPs and their Practice Nurses and some affiliated staff such as counsellors. This Level 3 training reflected on child neglect, Female Genital Mutilation (FGM), Southwark services – MASH, Children’s Social Care, Early Help, Solace (domestic violence organisation) and Common Assessment Frameworks (CAFs). The PLT was led by the Clinical Lead and Named GP and included table top discussions on scenarios relating to domestic abuse and a Bubble Theatre Company presentation on neglect. The event was extremely well evaluated and received.
Supervision

Working in the field of child protection entails making difficult and risky professional judgements. The work is increasingly demanding and can be distressing and stressful, not least because of the public interest created by national headline stories. All those staff involved in safeguarding situations have access to immediate advice and support from the CCG safeguarding team.

All health practitioners involved in day to day work with children and families require effective safeguarding supervision. Supervision and support standards are included in the Safeguarding Children Policy for provider organisations. Designated Professionals provide continuing support and supervision to Named Professionals within the local NHS economy. They also provide supervision, support and advice when required and on an individual case basis. This includes support for GP practices.

Designated professionals for safeguarding children obtain supervision through the Designated Professionals Network and NHS England South London Medical Director.

6. AUDITS

NHS Southwark CCG has the responsibility of assuring that its commissioned health providers discharge their safeguarding children responsibilities in a robust and effective manner.

During 2013/14 Southwark CCG has implemented a safeguarding children’s audit in primary care to assure safe practice in respect of safeguarding and to identify areas for further training and development. This audit was based on The Royal College of GPs (RCGP) Safeguarding Children and Young Peoples toolkit for 2011. 82% of GP Practices responded.

Following analysis of the results a number of actions have been identified to support best practice in safeguarding. These actions are detailed below and will be taken forward by the Named GP assisted by the Designated Nurse for Safeguarding. These actions will form part of the CCG Safeguarding Action Plan and future primary care audit development:

Action 1: To follow up non-returning practices reasons for this and to support Primary Care in understanding their safeguarding audits and in completing future audits.

Action 2: To support all GP practices to have high quality safeguarding policies and procedures in place and in understanding their responsibility for this.

Action 3: For GP practices to be aware of how they and their fellow practices are performing in certain aspects of safeguarding so that best practice may be shared between them. This will be done by ensuring that the information obtained by the audit is transparently shared with GP practices in Southwark and all of the information will be RAG rated in a format that is easy to understand.
Action 4: The audit showed that support around ensuring an appropriate response to domestic violence was an area for development. The CCG will provide protected learning time for practices specifically to share best practice.

Action 5: Support for GP practices to understand the different levels of training that staff will need to access as per the inter collegiate guidance.

7. SUPPORTING SAFEGUARDING WITHIN PRIMARY MEDICAL CARE AND OTHER PRIMARY CARE SERVICES

CCGs are not directly responsible for commissioning primary medical or other primary care services but they have a duty to support improvements and address quality issues.

General Practitioners have been identified as key professionals in protecting adults at risk and children from harm, and promoting the welfare of children through early intervention. The designated professionals and named doctors for safeguarding will continue to work closely with practitioners to ensure that the quality of safeguarding practice within primary care is high.

In order to ensure that Care Quality Commission (CQC) safeguarding standards are met, Southwark CCG has worked with Primary Care to ensure that:

- All practices have a lead GP for safeguarding. All updated safeguarding information is sent through this lead
- All GPs are aware of their increased training requirements as set out in the intercollegiate document. Level 3 training sessions are delivered through the Safeguarding Children Protected Learning Time, the Safeguarding Children Annual Conference and the SSCB Safeguarding Children Training Programme
- GPs are aware of their practice’s responsibility to record safeguarding training
- GP practice staff are able to seek advice from the CCG designated professionals when they have safeguarding concerns

8. LOOKED AFTER CHILDREN (LAC)

The SSCB Health Sub Group, chaired by Southwark CCG is required to quality assure the services delivered to LAC are of a good quality and robust to raise the profile of LAC and develop and ensure implementation of procedures to enhance the health component of each looked after child’s care plan. Within this is a strong commitment to safeguarding these particularly vulnerable children.

Work has been undertaken to improve the quality of LAC review health assessments and ensure that when children move these health reviews follow in a timely way so that services follow children up and deliver the care they require. Work is progressing on how best to support looked after children who are housed far from their home borough of Southwark which includes timely sharing of health
information, mentoring for those children and professional panel decisions on where children should be placed. As of 11/8/14 there were 511 children looked after children and 110 of these children placed more than 20 miles from Southwark. Recent national reviews and research has highlighted how this group of vulnerable children are more susceptible to Child Sexual Exploitation and Southwark CCG are working with the SSCB to raise the identification and understanding of this particular form of abuse.

There is a current Southwark SCR being undertaken on a teenage LAC. The recommendations from this SCR will be used to further advance the work outlined above and, for the multi-agency, action plans will be monitored by SSCB and additionally for Health providers by the Southwark CCG via the SSCB Health Sub Group.

9. KEY ACHIEVEMENTS 2013/14

- Safeguarding Children standards have been updated and are included in contracts with main providers
- A Named GP for Safeguarding has been leading in the development of safeguarding in primary care
- Awareness raising of neglect in primary care has been achieved through the SSCB Annual Conference and Protected Learning Time Event
- 82% of GP Practices have completed the Safeguarding Children Audit. Learning from this audit will be shared with Primary Care Safeguarding Leads and is being used to inform the NHS Southwark CCG Action Plan for Children and Young People 2014/15
- Progress has been made in ensuring the views of children and young people are heard and considered in the planning and development of safeguarding services. A process is now in place to include the views of young people and carers, through interviews and discussions, as part of multi-agency case audits
- Additional LAC resource has been identified and work initiated to assess and meet the health needs of this group of vulnerable children
- CCG commissioning advice has been provided to ensure the range of services commissioned by CCG takes account of the need to safeguard and promote the welfare of vulnerable children

10. KEY OBJECTIVES FOR 2014/15

To support the CCG to fulfil their statutory responsibilities for safeguarding children and young people including:

**Partnership Working**
- To further develop safeguarding children links with accountability frameworks for safeguarding with NHS England in order to ensure that safeguarding remains joined up within the NHS and within our local area
- To work with NHS England to promote best quality safeguarding practice within General Practice, including training, information sharing and promoting early help for families
• To continue to promote a multi-agency integration of safeguarding services utilising MASH and MARAC channels
• Continue to work collaboratively with provider organisations inclusive of schools, Local Authorities, Trusts and private providers to ensure a more joined up approach is achieved in caring for our vulnerable groups within the community
• To continue to support the work of the Child Death Overview Panel and enhance the multi-agency rapid response process for all sudden unexpected deaths of children
• To continue to work with the SSCB priorities in the coming year, particularly the need to engage on the early intervention / help agenda. As reflected in ‘Working Together to Safeguard Children’ 2013

Service Development
• To positively contribute to early intervention / early help work through commissioning in order for children, young people and families to be able to access help and have their health needs met at the earliest possible stage
• To strengthen the safeguarding of young people through transition into adult services by developing a safeguarding vulnerable people approach to working with families
• To ensure health service planning and developments consider the views made by children and young people

Training and Development
• Raise awareness of domestic abuse, by ensuring the implementation of Identification and Referral to Improve Safety (IRIS) training in Primary Care
• Promote awareness around Child Sexual Exploitation and Female Genital Mutilation in Primary Care.
• To ensure the children’s neglect agenda remains a high priority within Primary Care
• To develop a robust training programme for Primary Care around the particular vulnerabilities of Looked After Children, linking to Child Sexual Exploitation

8. CONCLUSION

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

The CCG takes its duty seriously to ensure functions are effectively discharged with regard to the need to safeguard and promote the welfare of children and vulnerable adults. This Annual Report demonstrates how we are fulfilling our duty to safeguard children and young people and identifies planned improvements for 2014/15. These planned improvements take account of the Government’s mandate to NHS England, published in November 2012, which sets a specific objective of continuing to improve safeguarding practice in the NHS and also reflects the commitment to prevent and reduce the risk of abuse and neglect to adults.
Appendix 1 - Southwark Safeguarding Children Activity

The Borough of Southwark has a resident population of approximately 62,900 children and young people aged 0 – 18 (estimate taken from GLA population tool). As of end August 2014 Southwark had 511 Looked After Children (LAC) of which 110 were placed more than 20 miles outside Southwark and 347 children on Child Protection Plans.

Overall the number of LAC has risen over the last 3 years. The breakdown of ages are 175 (0-9) of which 24 are under one year, 157 aged 16-17, 94 children aged 5-9.

Very young children that do become looked after are more likely to leave the care system through adoption or other permanence routes. Children over the age of 5 who become ‘looked after’ on a Care Order are likely to remain in the care system longer term. Children who become looked after when they are older are most likely to have had a number of unsuccessful preventative interventions and are unlikely to return home quickly. They are likely to present with complex and significant difficulties that require long term expensive specialist services.

Southwark Children Subject to a Child Protection Plan – Table 1

<table>
<thead>
<tr>
<th>Year to:</th>
<th>Total Number of Children Subject to a plan in Southwark</th>
<th>Rate of Children Subject to a plan in Southwark per 10,000 of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2012</td>
<td>273</td>
<td>46.2</td>
</tr>
<tr>
<td>March 2013</td>
<td>272</td>
<td>46.1</td>
</tr>
<tr>
<td>August 2014</td>
<td>345</td>
<td>54.8</td>
</tr>
</tbody>
</table>

Children on Child Protection Plan as at Sept 2014 category – Table 2

<table>
<thead>
<tr>
<th>Category of abuse</th>
<th>No. of Children</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Abuse</td>
<td>98</td>
<td>29</td>
</tr>
<tr>
<td>Neglect</td>
<td>141</td>
<td>42</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>29</td>
<td>9</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Neglect &amp; Emotional Abuse</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Neglect &amp; Physical Abuse</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Neglect &amp; Sexual Abuse</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Emotional Abuse &amp; Physical Abuse</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>Emotional Abuse &amp; Sexual Abuse</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Emotional Abuse, Physical Abuse &amp; Sexual Abuse</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total (as at Sept 2014)</strong></td>
<td><strong>336</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Of those children with a child protection plan, the largest numbers have been placed on a plan under the categories of Neglect or Emotional Abuse. Southwark Safeguarding Children Board has identified the prevention of neglect, child sexual
exploitation, female genital mutilation (FGM) and early help as their top strategic priorities for the coming year.
ENCLOSURE I

Chief Officer’s Report – 22 January 2015

CCG DIRECTOR RESPONSIBLE: Andrew Bland, Chief Officer

GP CLINICAL LEAD RESPONSIBLE: N/A

AUTHOR: Andrew Bland, Chief Officer

IN Volvement Required from the Clinical Commissioning Committee:

The Committee is asked to:

Note the contents of the report.

SUMMARY:

The Chief Officer report provides the Governing Body with an update on major developments in local health system and within the CCG’s commissioning portfolio. This report gives focus to:

- The Five Year Forward View and Operating Planning guidance, 2015/16
- London Health Commission
- Operational Resilience
- Dulwich Programme Board update
- London Health Commission
- Primary and Community Care Strategy
- Secretary of State Message to the NHS on Candour
**KEY ISSUES:**

As described in the report.

**INVolvement**

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

**RECOMMENDATIONS:**

The Governing Body is asked to:

Note the contents of the report

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Chief Officer Report

22 January 2015

Five Year Forward View and progressing transformation across London

The Five Year Forward View and Operating Planning guidance, 2015/16

The NHS Five Year Forward View (5YFV) was published on 23 October 2014. It set out a vision for the future of the NHS in England that has been developed by NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, the quality of care and the funding of services.

National Operating Plan guidance for 2015/16 – The Forward View into Action, describing how the NHS will take forward this vision in 2015/16, was issued before the Christmas break. The operating guidance relays requirements and announcements from the NHS England Mandate; Five Year Forward View (5YFV); the Chancellor’s autumn statement; CCG and direct commissioners’ financial allocations for 2015/16. The guidance confirms the roadmap for year one of 5YFV.

As the CCG’s current plans were written last year to cover the period until the end of 2015/16, the guidance requires CCGs only to review and refresh their plans for 2015/16. The national requirements set out in the guidance are very similar to those issued last year. The exception is additional performance standards, which establish maximum waiting times for psychosis and IAPT services. The CCG is currently working with our providers to identify performance and activity trajectories in these areas.

The operating planning guidance emphasises the requirement for CCG’s to maintain an intense focus on ensuring performance and NHS Constitution standards are consistently delivered for their populations.

The additional £1.83bn allocated to the NHS through the NHS Mandate is described as well as a further investment of £480m to be used to support transformation in primary care, mental health and local health economies. The guidance confirms winter pressures funds will be made available to trusts (via commissioners) upfront rather than in-year as had been the case previously.

The guidance outlines a permissive approach to local health economies developing and implementing new models of care transformation. The document describes an opportunity for “vanguard” areas to move at pace on the implementation of the models of
change outlined in the 5YFV. The full document is available at: http://www.england.nhs.uk/ourwork/forward-view/

London Health Commission


It has been recognised that transformation will be need to be delivered at a local level, working with borough partners across London. For some aspects of this challenge working at a larger scale will also bring benefits in terms of shared capability and to ensure coherence across borough systems. London is a significant entity within this and CCGs have recognized, for the past two years, the benefits of working together across a range of ‘once-for-London’ issues. London’s 32 CCGs, together with NHS England, have been designing a programme across the 32 boroughs in line with the recommendations in Better Health for London. Specific proposals are being developed by the London Commissioning System Design Group, drawn from CCG and NHS England teams. Recommendations will be brought to the 22 January 2015 meeting of London CCG Chief Officers and of CCG Clinical Chairs, before consideration by all 32 CCG Governing Bodies. The aim is to have a coordinated programme in place for 1 April 2015. NHS England has offered funding for programme support and CCGs are considering up to 0.2% investment within Operating Plans in order to build upon existing London-wide initiatives. These will include standards for urgent and emergency care, cancer, child and mental health and homelessness and a range of supporting enabling programmes, including for primary care and specialist services.

Operational Resilience

Urgent care performance, in particular at hospital emergency departments, remains one of concern across the NHS and has featured heavily in the national press.

The local urgent care system has been under considerable pressure during December and throughout the festive period and demand across all sites has increased. To help support provider colleagues, a South East London CCG surge hub commenced in December 2014. The hub has led the daily conference calls with health and social care providers to provide coordinated support and gain assurance of the actions being taken to manage periods of high demand.

St Thomas’s Emergency department has continued to perform well as one of the best performing Trusts in London, achieving the A&E 4 hour standard for the Quarter Three
period. Kings Denmark Hill site has faced additional pressure. Whilst the standard was achieved in October and November 2014, additional pressures in December will mean the overall Quarter Three performance at the site will be below the 95% standard at 94.04%.

As part of the additional resources made available nationally to support winter pressures a total of 80 schemes were approved across Lambeth, Southwark and Bromley across two tranches of funding. The schemes are being monitored and performance managed across the three CCGs with oversight through the Lambeth, Southwark and Bromley System Resilience Group. 39 of the schemes are specific to Lambeth and Southwark. Of these schemes, 22 have already started with the others due to commence in January 2015.

The London Ambulance Service (LAS) has experienced extremely high demand over the last two months. During periods of particularly high pressure, LAS implemented a number of actions to try and alleviate some of the pressure including incentivising staff to cover weekends and implementing clinical review of low priority green calls. Hospital Trusts were also asked to support the LAS, including ensuring Rapid Assessment Triage and Treatment processes and by ensuring effective handover of patients from ambulance crews.

A tripartite review is on-going around A&E performance issues at Kings College Hospital NHS Foundation Trust with a clear focus on performance at the PRUH site in Bromley following non-delivery of the agreed recovery plan.

In response to issues with repatriations in particular from Kings and St. Georges, a repatriation project has commenced across south east and south west London. In a short period of time the project has delivered significant improvements; the numbers of patients awaiting repatriation to local hospitals from Kings, for example, was regularly reported in excess of 30 and this has now reduced to below 10 on a consistent basis.

**Dulwich Programme Board update**

The Dulwich Programme Board met on the 27 November 2014 and the following items were discussed and progressed. This report also updates Governing Body members on the decisions relating to the programme which are being made by external bodies.

**Formal Site Options Appraisal**

The CCG is pleased to confirm that the formal Site Options Appraisal has now been approved by the NHS England Project Assurance Unit. It has agreed the recommendation that the future Dulwich Health Centre should be a new build on the south-east corner of the Dulwich Hospital site. This agreement was formally noted at the NHS England Finance, Investment, Procurement and Assurance Committee. It has also been supported by both Community Health Partnerships and NHS Property Services.
This followed a detailed appraisal of all the options - including both new build and refurbishment, looking at the non-financial as well as financial benefits of each. That work, led by the CCG, has concluded that a new build represents best value for public money.

**Procurement strategy**

Community Health Partnerships and NHS Property Services (NHS PS) have been undertaking a further piece of work which compares the future costs of the facility given a number of funding scenarios. These include investment using Department of Health capital and funding through a LIFT development. The output of this work was considered by the NHS PS Asset and Investment Committee in December 2014 and they have asked for some additional work to be undertaken. This is now scheduled to be considered at the same committee at their meeting at the end of January 2015. Once those decisions are made the design process can begin.

**Issues relating to the wider site**

In the meantime NHS Property Services are seeking to reduce running costs of the site by consolidating the existing services onto a smaller footprint. They have confirmed that no services will move off site until the new centre is ready to be occupied.

There are on-going discussions between NHS PS and the Education Funding Agency (EFA) about education facilities being located on the surplus part of the site. NHS PS has confirmed that it needs to ensure sufficient space for a new centre and to safeguard existing services as well as seeking to accommodate the needs of the EFA.

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

**Primary and Community Care Strategy**

As part of our Primary and Community Care Strategy, NHS Southwark CCG is continuing to work with the neighbourhood GP provider organisations in the North (Quay Health Solutions) and South (Improving Health) of the borough to improve the quality of services and outcomes for their combined registered populations. These GP provider organisations are collaborations of the 20 practices in the South, and 23 practices in the North.

**Challenge Fund and 8am-8pm 7 Day Primary Care Access**

Following a review of Urgent Care Services in 2014, the CCG agreed to commission an Extended Primary Care Access Service from neighbourhood groups of practices in the North and South of the borough. The CCG has agreed to invest £2.1 million to fund recurrent service costs and was successful in securing additional funding from the Prime
Minister’s Challenge Fund (£975k) to support general practice engagement, and set-up costs.

The key elements of the new service model are:

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

The first of these clinics went live in the South of the borough at the Lister Primary Care Centre on Tuesday 11 November 2014, and replaced the Lister Walk-in Centre (a transitional arrangement is in place to support walk-in centre patients with the shift to a pre-booked service). A second clinic will go live in North Southwark in February 2015, with the site to be confirmed shortly.

Prior to the launch of the South Southwark service, the CCG issued patient leaflets and stakeholder communications around the changes to the service at the Lister Primary Care Centre to GP practices, pharmacies and other local health providers. A broader communications campaign is expected to commence in March 2015 once both sites are up and running.

In the first nine weeks of operation for the service in the South of the borough:

- Over 2,800 patients have been seen in the Extended Primary Care Access clinic, over half of which were booked via their general practice.
- All 20 practices in South Southwark have now used the service, although utilisation varies
- The number of walk-in patients remains low relative to activity levels at the Walk-in Centre previously based at the Lister Health Centre
- Patient feedback captured by PALS and through patient experience surveys has been positive.

The CCG is continuing to work with the neighbourhood groups of practices in the South of the borough to monitor activity, the impact on the urgent care system more widely, and to identify opportunities for service improvement.

**Neighbourhood Development Plan Scheme**

This Scheme has been in place since August 2014 and has enabled neighbourhood practices to work collaboratively to improve the consistency of access to primary care,
as well as on service improvements to improve patient outcomes in the following areas - dementia, flu and childhood immunisations, and NHS Vascular Health Check follow-ups.

Delivery of Extended Services

The two neighbourhood GP provider organisations are continuing to work towards mobilisation of extended service contracts to be delivered on a neighbourhood basis; including Population Health Management (i.e. NHS Vascular Health Checks; Smoking Cessation advice, prescribing and support; Ambulatory Blood Pressure Monitoring; Holistic Health Assessments for over 65s; and early identification and management of Long Term Conditions). The start date of these contracts has been agreed as April 2015.

Community Pharmacy

The CCG is supporting leadership development within Community Pharmacy to build the capacity and capability for neighbourhood working in primary care more broadly. This will complement the existing general practice development programme funded by Guy’s and St Thomas’ Charity, and encourage closer working between general practice and community pharmacy on a neighbourhood basis.

Secretary of State Message to the NHS on Candour

The Secretary of State for Health published a personal message to all NHS staff in November 2014 following the Government’s final response to the Francis report, urging staff to speak up when encountering poor care. For the first time, there will be an explicit Professional Duty of Candour in both General Medical Council and Nursing and Midwifery Council regulations which makes it clear that if there is any avoidable, unintended or unexpected harm, doctors and nurses have a professional duty to tell the patient and their organisation. The full message has been shared with all Member Practices and with staff and can be found on the Department of Health website.


We submitted our 2013/14 annual report on engagement “Involving People” to NHS England at the end of September 2014 and just before Christmas we received very positive feedback. The Report was assessed by the Patient and Public Voice Team against the progress we have made in developing engagement capacity and for delivery against the two statutory duties of engaging communities and putting patients in control.

I am delighted to report that NHS Southwark CCG has been rated as GREEN, having demonstrated we have a solid infrastructure, with processes and mechanisms in place to ensure that both our individual and collective duties are met. We were one of a small number of London CCGs to receive a GREEN rating. My thanks are extended to all our staff and our Members for their work to support this achievement.
ENCLOSURE J

Strategic Commissioning Framework for Primary Care Transformation in London

<table>
<thead>
<tr>
<th>CCG DIRECTOR RESPONSIBLE:</th>
<th>Andrew Bland Chief officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP CLINICAL LEADS RESPONSIBLE:</td>
<td>Dr Jonty Heaversedge</td>
</tr>
</tbody>
</table>

**AUTHOR:** Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)

**INVolVEMENT REQUIRED FROM THE CCG GOVERNING BODY:**

Members of the Governing Body are asked to discuss and note this item.

**SUMMARY:**

Strong primary care is important for a wide range of health and care ambitions across the capital and it is widely recognised that, despite some great examples, there is a significant transformation challenge to be faced. Responsibilities for shaping and delivering change in primary care sit primarily with providers and commissioners, but a wide range of other partners have close interests and/or potentially positive roles to play.

The Strategic Commissioning Framework for Primary Care Transformation provides a new vision for general practice, and an overview of the considerations required to achieve it.

From December 2014 to April 2015, a period of engagement will be undertaken locally to fully understand the implications of the Framework, and how it fits into the context of wider plans.

**KEY ISSUES**

The CCG Governing Body is asked to consider the following:

- Does the Framework cover the correct areas?
- Are there other areas that should be considered in the Framework that currently are not?
- How could the Framework be strengthened?

**INVolVEMENT**

Described in the presentation.
**RECOMMENDATIONS:**
The CCG Governing Body Group is asked to:-

Note the minutes included in Enclosures M-Q

**CCG DIRECTOR’S CONTACT**
Name: Andrew Bland
E-Mail: andrew.bland@nhs.net
There is significant focus on the need for change in Primary Care

Both the Five Year Forward View and the London Health Commission report set out several objectives for Primary Care:

- Stabilise core funding for general practice and review how resources are fairly made available
- Give CCGs more influence over the NHS budget – investment: acute to primary & community
- Provide new funding through schemes such as the Challenge fund – innovation, access
- Expand as fast as possible the number of GPs, community nurses and other staff.
- Design new incentives to tackle health inequalities.
- Expand funding to upgrade primary care infrastructure and scope of services
- Help the public deal with minor ailments without GP or A&E
- **Potential new care models** such as Multispecialty Community Providers (MCPs) and Primary & Acute Care Systems (PACS)

- Increase the proportion of NHS spending on primary and community services
- Invest £1billion in developing GP premises
- Set ambitious service and quality standards for general practice
- Promote and support general practices to work in networks
- Allow patients to access services from other practices in the same network
- Allow existing or new providers to set up services in areas of persistent poor provision
London has also been working on how some of the challenges faced by general practice could be mitigated.

The *Call to Action* outlined some of the challenges of General Practice in London.

In April a draft publication was released, which outlined a new patient offer. Since then there has been considerable engagement to further strengthen this offer, and understand the necessary considerations for delivering it.
The Strategic Commissioning Framework

The result is a draft *Strategic Commissioning Framework*, aiming to support transforming primary care in the capital.

- A new vision for General Practice
- A new Patient offer described in a general practice specification
- A description of considerations for making it happen
A new vision for General Practice in London

Patients and clinicians alike have told us about the importance of three areas of care. This forms the basis of the new patient offer (also called the specification)

Accessible Care
Better access primary care professionals, at a time and through a method that’s convenient and with a professional of choice.

Coordinated Care
Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

Proactive Care
More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.
Which has been widely tested

Following an initial development stage, the specification has been tested with a widening range of patients, clinicians and other stakeholders. Around **1,500** people have now been involved in testing this.

Here are the groups involved in testing:

<table>
<thead>
<tr>
<th>Group</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Leadership Group</td>
<td>30 people</td>
</tr>
<tr>
<td>3 Expert Panels</td>
<td>20-50 members inc patient reps</td>
</tr>
<tr>
<td>Patient review panel</td>
<td>10 people</td>
</tr>
<tr>
<td>3 virtual groups</td>
<td>60-80 people</td>
</tr>
<tr>
<td>Clinical Board</td>
<td>35-50 people</td>
</tr>
<tr>
<td>Transform-ation Board &amp; Delivery Group</td>
<td>~60 people</td>
</tr>
<tr>
<td>Borough based Health &amp; Social Care</td>
<td>100 people</td>
</tr>
<tr>
<td>- CCGs &amp; LAs</td>
<td></td>
</tr>
<tr>
<td>Senate / SCNs</td>
<td>800+ people</td>
</tr>
<tr>
<td>Patient/Public focus groups</td>
<td>180 people</td>
</tr>
<tr>
<td>Over 50 Charities</td>
<td></td>
</tr>
<tr>
<td>Clinical Challenge Panel</td>
<td>~20 people</td>
</tr>
</tbody>
</table>

The *Strategic Commissioning Framework* which has been released for engagement reflects the feedback gathered from the above discussions.
The Framework includes several areas of focus to support delivery of the specification

<table>
<thead>
<tr>
<th>Area</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Models of Care</td>
<td>This area proposes collaborating across groups of practices, and with other partners</td>
</tr>
<tr>
<td>Commissioning</td>
<td>This area outlines the importance of supporting commissioners to work together and support to CCGs taking on co-commissioning</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>This includes the estimated cost shift towards Primary Care required to deliver the new specifications, and the year on year funding shift to achieve this (see next slide)</td>
</tr>
<tr>
<td>Contracting</td>
<td>This area looks at contractual considerations of delivering the specifications e.g. contracting at a population level</td>
</tr>
<tr>
<td>Workforce Implications</td>
<td>This area looks at the need for the right roles and skills in a practice and as part of a wider team</td>
</tr>
<tr>
<td>Technology Implications</td>
<td>This area looks at the ways technology could be used to deliver the specifications and maximising its use to support empowerment and innovation</td>
</tr>
<tr>
<td>Estates Implications</td>
<td>This area references the findings of the London Health Commission in terms of the variability of Primary Care estate and recommendation for investment</td>
</tr>
<tr>
<td>Provider Development</td>
<td>This area outlines the importance of supporting providers to deliver the specifications and some of the potential areas for development</td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>This area outlines ways in which tools (largely already existing) can be used to support faster adoption of best practice, as well as for commissioner assurance</td>
</tr>
</tbody>
</table>
The specification will require investment...

A high level estimation of the cost of delivering the new service has been made. This will be further developed in parallel to the engagement phase, but indicates what a gradual shift in funding might look like, and an overall year on year cost increase.

**Years 1 – 5**
Example gradual shift in funding towards Primary Care

**Years 6 +**
Annual costs of providing the new service offer

Overall shift of **2 – 5.36% of total health spend today**

An annual cost of **£310 – 810m**
...and changes to the workforce..

The Framework also outlines that to deliver the specification, a larger and more diverse workforce is required.

**INCREASE EXISTING ROLES..**

*We will need more GPs and nurses to deliver the change*

**BROADEN THE TEAM..**

*There will need to be more new roles to support the clinicians*

**...AT A PRACTICE LEVEL**

**..OR ACROSS SEVERAL PRACTICES**
The next stage of engagement has begun, and is expected to continue until April 2015. This document will be refreshed and reissued at the end of that period.

- **Transforming primary care**: *General practice – A Call to Action* was published to start a debate.
- **A set of specifications for General Practice** was led by expert GPs, building on the national vision for primary care.
- The Specifications were tested over the summer with a wide range of patients, the public, charities and independent clinicians as the other aspects of the Strategic Commissioning Framework were developed.
- The developing Strategic Commissioning Framework, was shared at the end of November 2014.

There will be a period of **further planning and engagement** by CCGs and their partners, with NHS England, **from December 2014 to March 2015**.

**Implementation** is expected to start from **April 2015** and will take place over **the next 5 + years**.
Appendix
...The estates will need to be fit for purpose...

~13% of Primary Care Estates in London requires significant refurbishment or rebuild.

and ~34% does not meet basic DDA compliance levels and needs rebuilding
...And with supporting technology...

..For all areas of the specification..

Accessible care

Coordinated care

Proactive care

..for example through email appointments and telephone triage

..for example interoperable systems

..for example through online wellbeing assessments

And making better use of what’s in place..

77%

But...

..Of practices have the ability to enable patient access to records online...

28%

..Only 28% have enabled this...
GPs will need to work together and with other partners

This vision will be achieved by general practice working together at scale, and working with partners in the wider health system. With the Patient remaining at the centre of all care considerations
London CCGs have been asked about new models of care in their area in terms of the state of readiness and likely size of scale models. 97% of London CCGs responded, and findings from those responses are below:

- 85%* are in or planning to be in either a network or federation
- 68%* have all practices engaging in new scale models
- Over 95%* of practices across CCGs are collaborating

* Of the 97% of respondents
Patients have identified several benefits of the Framework

During the pre-engagement process, discussions with patients and the public to enhance the specification, also identified several benefits which patients looked forward to experiencing.

**Flexibility**

“The enhanced flexibility to schedule appointments at times that fit around other work/family commitments”

“A reduced need for ad-hoc appointments where a care plan is in place or because of being signposted to more appropriate support services.”

**Co-ordinated Care**

“A greater sense of control, influence and patient input in the development of patient centric care plans”

“Greater whole system working supported by clarity of roles and responsibilities”

“The empowerment that effective sign-posting of services and support would bring in enabling patients to take a greater ownership of their own health outcomes.”

**Relationships in Primary Care**

“The stronger GP/patient relationships that would materialise through the provision of a named GP.”

“An ability to be supported in holistic needs- whether as a patient or carer.”

“Support needs can be effectively met by other staff (apart from the GP and/or being referred on to them as a source of specialist support/care.”
And we believe this can help GPs deliver a better service for their patients

Once implemented, the specifications also have the potential to help GPs deliver a better service for their patients:

<table>
<thead>
<tr>
<th>Addressing current challenges</th>
<th>- Addresses key issues for General Practice, such as building the workforce and ensuring investment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting an attractive profession</td>
<td>- Allowing GPs to be ‘expert generalists’ that they came into the profession to be.</td>
</tr>
<tr>
<td></td>
<td>- Modernizes service.</td>
</tr>
<tr>
<td></td>
<td>- Will help attract more graduates to the profession.</td>
</tr>
<tr>
<td>More time for patients who need it</td>
<td>- Those that require more care from clinicians receive this.</td>
</tr>
<tr>
<td></td>
<td>- Patients assisted to stay well independently, freeing up GP time for patients who need it most.</td>
</tr>
<tr>
<td>Empowering better care provision</td>
<td>- By building a team around the GP, patients are able to see the right person at the right time.</td>
</tr>
<tr>
<td></td>
<td>- GP directs patients to the right person to deliver the care they need.</td>
</tr>
<tr>
<td></td>
<td>- Expertise is most appropriately used.</td>
</tr>
<tr>
<td>‘Headspace’ to innovate</td>
<td>- Reducing the burden on GPs to allow them time to consider service development and innovation</td>
</tr>
<tr>
<td>Supporting patients’ care journey</td>
<td>- Better connections to other health providers/ multi-disciplinary teams allows GPs to support</td>
</tr>
<tr>
<td></td>
<td>patients to transition throughout their health service.</td>
</tr>
<tr>
<td></td>
<td>- Improves GP satisfaction (they see the outcome of their work)</td>
</tr>
<tr>
<td></td>
<td>- Enhances patient/doctor relationships.</td>
</tr>
</tbody>
</table>
Strategic Commissioning Framework for Primary Care Transformation in London

Better Health for London: A New Deal for General Practice

Draft for engagement
This Strategic Commissioning Framework is presented by the Transformation Board and Primary Care Clinical Board, and has been developed by clinicians, commissioners, patients and other partners across London.

Due to the number of individuals involved, it is not possible to name everyone individually. However without these people, production of this Framework would not be possible.

In particular, we would like to extend our appreciation to the:

- Clinical Expert Panels
- Primary Care Transformation Board
- Primary Care Patient Board
- Primary Care Clinical Board
- Primary Care Delivery Group
- Primary Care Transformation Team
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Glossary 59
The NHS is unique because of its system of general practice – a medical home for the patient – underpinned by a life-long medical record. General practice is the first point of access for many people, where a high proportion of care is delivered close to people’s homes with the potential for a continuous relationship with the same clinical team from birth through to the end of life.

General practice has served patients, the public and the NHS well for over 60 years. It has delivered accessible, high quality, value for money care. However our patients are changing, both in the complexity of their conditions and in their expectations. This means that if the NHS is going to continue to provide the excellent standard of care to which we all aspire, we will have to be more innovative.

Tweaking at the edges is not an option. London needs solutions that will sustain primary care for the next 60 years. We must maintain the integrity and core purpose of general practice (to provide holistic, patient-centred continuous care to patients and their families). But at the same time we must address the need to improve coordination of care, access to services and take a more proactive approach to our patients’ health and wellbeing.

I believe that this Strategic Commissioning Framework for Primary Care Transformation in London represents a platform where clinicians, commissioners, and other stakeholders can build on the work done to date and find solutions to the challenges for general practice; supporting the healthcare community to make care better for all Londoners.

With the scale of support which has been seen for this developing work, and the opportunity of additional focus on primary care provided by the NHS Five Year Forward View and Better Health for London from the London Health Commission, now is the time to make these changes together.

Dr Clare Gerada, Chair of the Primary Care Clinical Board
We are pleased to present this developing Strategic Commissioning Framework for Primary Care Transformation (the Strategic Commissioning Framework or Framework) on behalf of the London Primary Care Clinical Board¹ and Transformation Board². This document provides both a new vision for general practice, and an overview of the considerations required to achieve it. From December 2014 to April 2015, London’s clinical commissioning groups (CCGs) together with NHS England (London) and working with other partners (such as the Care Quality Commission (CQC), Health Education England (HEE), Academic Health Science Networks (AHSN)) will engage locally to fully understand the implications of this Framework, and how it fits into the context of wider local plans. During this period, further work will also be undertaken to understand the implications of implementation, and this document will be updated to reflect this.

Transforming primary care is a concept that is rapidly gaining momentum as a key priority area in the NHS – both nationally and across London. Two important pieces of work have recently been published which set the platform for building on this energy and achieving the ambitions that are developing.

1. **NHS Five Year Forward View³**

In October 2014, Simon Stevens published the *NHS Five Year Forward View*, developed by NHS England, Public Health England (PHE), Monitor, HEE, CQC and the NHS Trust Development Authority (TDA). This sets out ‘a new deal for general practice’ recognising the central importance of the registered list and everyone having access to a family doctor. It also confirms the need for greater investment.


In October 2014, the London Health Commission published *Better Health for London*. The Framework closely aligns to, and is supportive of this report, which contained a number of recommendations specific to general practice.

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¹ See Appendix 1: Governance board membership
² See Appendix 1: Governance board membership
³ http://www.england.nhs.uk/ourwork/futurenhs/
⁴ http://www.londonhealthcommission.org.uk/better-health-for-london/
This developing Framework provides a response from commissioners across London to these important pieces of work.

Since April 2014, around 1,500 key stakeholders have been engaged as part of a ‘pre-engagement’ phase. These activities have strengthened our ambitions for describing a new patient offer for all of London.

Throughout the co-development of this Framework it has been excellent to see the level of clinical leadership, public and patient contribution and significant commitment from commissioners across London, together with their partners. We have received support from all 32 CCGs across London to enter into the next stages of engagement, which will take place at a local level with GPs, the public and other key stakeholders. There has also been positive support from the London-wide Local Medical Committee, the Clinical Challenge Panel (which was set up for independent clinicians to review the specification (also known as the patient offer) on behalf of the London Clinical Senate) and the CQC, for the aspirations we wish to achieve.

The NHS Five Year Forward View and Better Health for London provide a new impetus to seize the moment and bring about sustainable transformation of the bedrock of healthcare in London. There are no easy solutions to the challenges we all face in the transformation of primary care but there is a strong belief that by working together and building on the focus and commitment to date, success can be achieved and we can develop services that Londoners deserve.

Dr Marc Rowland
Co-Chair of the Primary Care Transformation Board

Dr Anne Rainsberry
Co-Chair of the Primary Care Transformation Board

Dr Clare Gerada
Chair of the Primary Care Clinical Board
This document, developed by commissioners across London, is both a new vision, and in effect a response to the *Five Year Forward View* and London Health Commission publications. It details a specification for Londoners in the future, and begins to articulate how these changes fit within the wider out-of-hospital context. The document also includes considerations for how this specification might be delivered, as well as sections on current estimations of cost, changes required to primary care workforce, contracts, and other key enablers.

**Background: responding to A Call to Action**

In November 2013, NHS England (London) published *Transforming Primary Care in London: General Practice A Call to Action*[^5], which examines the challenges facing general practice in London today. It has been used by NHS England (London) and London organisations to obtain a consensus view on the need for changes to the way general practice is provided.

*A Call to Action* showed that London contains world-class examples of general practice but that urgent action is needed to tackle significant variations in quality. The report identified challenges including an increasing workload; an expanding population; people living longer and with increased care needs; all of which have occurred whilst investment in general practice has fallen significantly as a proportion of total health spend. The pending workforce crisis was also highlighted, as a large swathe of GPs in the capital are near retirement and practice nurses are becoming increasingly difficult to recruit. The report was a call for bold action to develop solutions that will better meet the future needs of Londoners and provide a sustainable model of general practice for the next 50 years.

During 2014 clinicians, patients and commissioners from across the capital have been developing an ambitious strategy for service improvement in three key areas – proactive care, accessible care, and coordinated care.

In March 2014, NHS England (London) released a pre-engagement draft document entitled *The London GP Development Standards: A Framework for Service Improvement*[^3]. The document was developed by a clinical board and three expert panels working in partnership with CCG leads and patients.

Over the summer London CCGs and NHS England (London) worked in partnership with others to ensure that the service changes described in the initial draft would meet the needs of Londoners, address current and future challenges and develop a strong mandate for the overall direction of general practice development across the capital. In addition, there has been further development on answering ‘how’ this specification could be delivered. It is clear that changes are needed to support primary care in delivering a new vision.

The initial view on the enabling work required is included in this document. This includes, for example, the fact that changes to the numbers, skills and roles in the workforce are needed. There is also reference to the importance of suitable estates, and the fact that this change will need to be underpinned by investment.

Over the summer, two new important pieces of work have been published – from the NHS England Chief Executive, and the result of a piece of work commissioned by the Mayor of London.

These publications provide added impetus for the ideas developed in the *Framework* and will provide a platform for building on these proposals, ensuring that London gets the investment required in order to drive these commitments forward.

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The *NHS Five Year Forward View*

In October 2014 Simon Stevens, the Chief Executive of NHS England, published the *NHS Five Year Forward View* developed in collaboration with PHE, Monitor, HEE, CQC and TDA. This also referred to funding in general practice – mentioning both “Stabilis[ation]” and “new funding”. The commitments included are listed below.

In addition to emerging GP federations, networks and super partnerships across London the *NHS Five Year Forward View* identifies two further models which may be applied.

These have been described as Multispecialty Community Providers (MCPs) or Primary and Acute Care Systems (PACs).

---

**A new deal for general practice**

Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.

Give GP-led clinical commissioning groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.

Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.

Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.

Expand funding to upgrade primary care infrastructure and scope of services.

Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.

Build the public’s understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.
The London Health Commission

Also in October 2014, the London Health Commission launched its report *Better Health for London*. This report makes several recommendations for general practice, and the *Framework* aligns very well with these recommendations:

- increase the proportion of NHS spending on primary and community services.
- invest £1 billion in developing GP premises.
- set ambitious service and quality standards for general practice.
- promote and support general practices to work in networks.
- allow patients to access services from other practices in the same network.
- allow existing or new providers to set up services in areas of persistent poor provision.

Additionally, the vision of this *Framework* supports several of the broader recommendations, such as:

- engage with Londoners on their health and care. Share as much information as possible and involve people in the future of services.
- commission holistic services with clearly defined outcomes developed by listening to people who use services.

A Strategic Commissioning Framework for Primary Care Transformation in London

This document builds on work already undertaken and aims to support further development of local plans and other responses that London is making to the challenges currently faced in general practice as well as the two key publications referenced above. The *Framework* aims to complement and enhance other service requirements and standards, such as those published by the Care Quality Commission (CQC) in the *Provider Handbook for Primary Medical Services* (October 2014). Going forward, London’s primary care transformation programme and the CQC will collaborate closely to ensure that there is true alignment between the vision set out in this *Framework* and standards articulated by the CQC. This also aligns with the National Institute for Health and Care Excellence (NICE) in their regularly updated guidelines. In summary, the specification outlines a new service design, but this must also be delivered to, for example, the level of safety and quality described by these other standards.
The **Strategic Commissioning Framework** is a developing document which aims to support primary care transformation across the capital. A high-level overview of the content of the Framework is included below, however more detail may be found in the full sections of the document.

**Future of general practice**

General practices in London are under strain and are bearing the brunt of pressures to meet increasing and changing health needs.

This developing Framework sets out an ambitious and attractive vision of general practice that operates without borders, and in partnership with the wider health and care system. A patient and their GP should be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care in general practices which are recognised as centres in each neighbourhood, developing community resilience and supporting Londoners to stay as well and as healthy as they can.

The Framework focuses on ‘function’ not ‘form’ and sets out a new patient offer for all Londoners that can only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations. These organisations will be aligned to a shared geography in support of a population health model with other health, social, mental health, community and voluntary organisations. How this looks will differ from area to area and will be designed and owned locally. It will require an environment which supports innovation; shares best practices and new technologies; and is an attractive place to work for a variety of healthcare professionals.

**The service specification (patient offer)**

At the core of the Framework is a specification for general practice that sets out the new patient offer. This specification is arranged around the three aspects of care that matter most to patients:

- **Proactive care** – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy
- **Accessible care** – providing a personalised, responsive, timely and accessible service
- **Coordinated care** – providing patient-centred, coordinated care and GP-patient continuity

Some elements of the specification have already been achieved and implemented in some parts of London. General practice will be transformed when all patients in London are able to access the care described in this document and when that care is of a sufficiently consistent high quality.
Local planning

This Framework is not intended to be a static document but will form the basis of wider engagement over the coming months in each local area, on the changes that are needed. London CCGs with NHS England (London), will lead this engagement as part of developing local plans. It is anticipated that different areas will deliver this patient offer in different ways, at different paces. In order for local populations to be able to take part in discussions to decide what is best for their local community, it is essential that plans are locally designed based on different starting points.

Co-commissioning

NHS England (London), CCGs and local authorities recognise that the vision in this Framework will require significant collaboration across all parts of the commissioning system; co-commissioning will be a key enabler. The NHS Five Year Forward View sets out the aim to provide CCGs more control over NHS budgets, with the objective of supporting more investment in primary care, and CCGs across London have expressed an interest in becoming more involved in the commissioning of primary care services.

Co-commissioning will allow for a varying level of increased involvement. The options and considerations are described in detail in Next Steps Towards Primary Care Co-commissioning, published in November 2014. Currently the possible arrangements include:

- allow CCGs greater involvement in commissioning decisions, including actively participating in discussions about all areas of primary care
- joint commissioning model that enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or “committees in common”
- delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning some aspects of general practice services. The exact models for delegated commissioning will need to be worked up in local areas.

Financial implications

The new patient offer and the changes to, for example, the workforce and estates required to deliver it, cannot be made without significant investment.

Further work is required to understand all of the financial implications of this Framework, but high level financial analysis has been completed to estimate the cost of providing the new patient offer.

The required additional investment is currently estimated to be in the region of £310-810 million per year, which represents a 2% – 5.36% shift in the overall health care budget. This will need to be phased, and can be achieved, for example, over five years with an average shift of 0.4 – 1.07% per year.
Contracting approach

The specification described here can only be delivered in full by general practice working together at scale and with other parts of the health and care system. The Framework proposes new funding, not at an individual practice level but delivered through a wider population-based contract. The exact nature of these arrangements will vary by nature of the provider landscape but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which investment will be made. Local approaches will be determined through co-commissioning arrangements and in discussions within each CCG area.

It is likely that the contracting vehicle will need to ‘wrap around’ existing national contracts (unless constituent practices are opting for a full merger/super partnerships and therefore may voluntarily relinquish their current contract). It may also need to be flexible to wider collaborations and partnerships with other types of providers, for example where the strategic intent locally is for accountable care organisations that can hold capitated budgets and shared risk for whole populations. Although current legislation does not allow it, co-commissioners may also want to consider a future in which the accountability for constituent General Medical Services, Personal Medical Services and Alternative Provider Medical Services might sit with the lead provider/at-scale primary care organisation.

The full contracting approach section outlines example contractual forms and potential initial changes. Many areas already have a strong ambition towards bringing general practice and community services together over the next two years. It is however anticipated that most areas will be looking to contract networks/ federations of general practice as a starting point.

Workforce

A workforce of appropriate number, skills and roles is imperative for transforming care. Bolstering the primary care workforce has been identified as a core objective of Health Education England (HEE) and its Local Education and Training Boards (LETBs).

This document describes a future of more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations. Although the way that roles and teams fit together will evolve in local areas, it is anticipated that the roles required will be as shown in the table below.

<table>
<thead>
<tr>
<th>Within each practice</th>
<th>Aligned to each practice but working across a wider geography / at-scale primary care organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates</td>
<td>Prescribing advisors, GPs with a special interest (GPSIs), care coordinators, wellbeing teams, and ‘super practice managers/directors’ with sufficient skills to lead the development and operational management of at scale primary care organisations. As part of, for example, a wider Multispeciality Community Provider (MCP): Secondary care specialists, social care, mental health and community services teams, community pharmacy</td>
</tr>
</tbody>
</table>
The full workforce section outlines these in more detail, as well as some of the programmes being taken forward to support workforce development, however it also highlights that there is a great opportunity for partners associated with workforce development in London to collaborate. Ensuring the workforce is appropriate to deliver the specification will be crucial in improving outcomes across the capital.

**Technology**

This Framework does not aim to provide a technology blueprint for London, however it recognises that technology is a key enabler for delivering the specification. This is complemented by the recent publication by The National Information Board, *Personalised Health and Care 2020* which describes the need to better use technology to improve health, transform quality and reduce the cost of health and care services. Technology usage should support organisations working together – allowing less focus on co-location, and a smoother patient journey through the healthcare system. People should also be empowered with information about their care in order to participate in their care planning, set health goals, and better manage their health.

The technology section of this Framework identifies ways in which technology can support:

- **Proactive care**, for example through online wellbeing assessments, health improvement resources or support communities
- **Better access**, for example with online service portals, telephone triage and email appointment systems
- **Care coordination**, for example with interoperable systems for information exchange across a multidisciplinary team and with patients through integrated patient-held records
- **Modernising care**, for example, remote monitoring and diagnostic devices.

**Estates**

The recent London Health Commission (LHC) report, *Better Health for London* presented evidence that the quality of general practice estate in London is highly variable. This results in a poor patient experience and poor working conditions in some London practices and lost opportunities to improve health and healthcare. The specification in this Framework does not rely on estate changes, but there are a number of practices in London for which premises solutions are now urgently needed. The estates section of this document outlines some of the findings of the LHC report, and its recommendation for approximately £1 billion to be invested in general practice estates over the next five years.

**Provider development**

None of the changes set out in this Framework will be delivered unless there is significant investment in organisational development and capability building. The real change cannot be delivered by commissioning levers alone but will require providers to grab the development challenge and find successful ways to adapt it in their local area. The provider development section outlines some requirements for example, leadership for change, strategic planning, business development, legal guidance. It recommends a
forum for London’s emerging providers and system leaders to share innovation and learning. It identifies the need for a strategic and comprehensive approach to building system capacity and capability for delivering change; an approach that is mapped to a development journey for emerging organisations and which can respond to their evolving needs over time.

**Monitoring and evaluation**

The purpose of this *Framework* is to improve outcomes, patient experience and working lives. Monitoring and evaluation will be designed to support practice teams working together on quality improvement at a population level. This *Framework* outlines the principles that monitoring and evaluation should build on systems already in place, and also focus on supporting provider development (through best practice sharing and peer learning), as well as commissioner assurance.

**Next steps**

This developing *Strategic Commissioning Framework for Primary Care Transformation* is being shared more widely in each local area of London as part of continuing engagement on the changes needed and to ensure each area can develop robust delivery plans in advance of implementation from April 2015.

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**Equality impact assessment**

Commissioners (CCGs and NHS England) of general practice are required to give specific consideration to addressing health inequalities as stated in the Health and Social Care Act 2012 and requirements relating to people with protected characteristics as outlined in the Equality Act 2010. An equalities impact assessment has been completed to accompany this framework at its current stage, and is available as a separate supplement.

The equalities impact assessment concludes that the *Framework* provides a structure within which a consistent general practice patient offer can be delivered to all Londoners. The delivery and implementation of the specification outlined in the *Framework* has the potential to address health inequalities in London as commissioners work with general practices to secure services that are responsive to different needs and appropriate to all.

The *Framework* particularly notes the requirement for commissioners to give due regard to the reduction of health inequalities and to the statutory requirements of the Equality Act 2010 to consider the impact for people with protected characteristics. It is therefore recommended that local equality impact assessments are conducted to reflect local plans when these are sufficiently advanced. The proactive care specification also outlines the need to give consideration to additional vulnerable groups that have been identified such as travellers, sex workers, people recently released from custody, homeless people, vulnerable migrants or people with learning disabilities.
Patients tell us that they want better continuity of care ("my doctor, my nurse"). They also want better access to services when they need them, to contact a health professional when they need to; to have care closer to home, to stay healthier and more independent for longer, have fewer trips to hospital and more support to enable them to manage their own health more effectively. This latter point is particularly important. As demand for health services grow, patients will need a good understanding of the services and resources available to help them to stay well and look after themselves through minor illness. General practices will be recognised as centres within each neighbourhood that are supporting Londoners to stay as healthy and well as they can be. Local communities, voluntary groups, faith organisations, patients and volunteers are part of a network of support for wellbeing that can work both inside and outside general practice, supporting general practice to connect people to wider resources available in the community and extending its scope to deliver proactive health and wellbeing resources. Partnership working with these groups and with local authorities and health and wellbeing boards will be essential.

At the moment (and for a number of reasons) general practice is not able to deliver this level of care consistently across London. Probably the main reason for this is that funding for general practice has been declining in real terms over the last decade, now receiving just over 7% of the NHS England budget, compared with over 10% a decade ago. Yet primary care continues to deliver the majority of care to patients in the NHS. Increasing funding alone will not solve the problem, general practice still needs to change. Our patients’ needs are different now, and keep changing. The systems that are in place to care for them have to evolve to keep pace with this change.

If London is going to meet the challenges we all face there will need to be additional resource, but money is not the only answer. We will also need to achieve significant economies of scale and be more innovative in the way we deliver primary care. There is no ‘one size fits all’ solution. One of the great strengths of general practice is its variety – reflecting the great diversity of the population we serve in London. How we achieve excellence will be largely dependent on each local area, supported by their providers, their commissioners and their patients. But there are ten common building blocks that we need to address to reach the desired state, which are set out below.

1. The way we deliver care: inside and outside of the practice; how we best use skill-mix; how we work in and out of hours; how we work with others – not confined by our individual consulting rooms, practices and organisations; and how we work best with the primary, secondary, community and voluntary and charity sector services.

2. The way we organise ourselves. This applies to normal working hours and out of hours; how we deliver unscheduled care and how we organise our physical environment – the buildings we work from. Individual practices may want to form part of something bigger. Across London, practices are already starting to work together.

3. How we work together to deliver personalised care for certain groups of patients across a wider population for example:
   a. finding creative ways of connecting with the vulnerable, isolated and socially marginalized who are at highest risk of becoming ill and least likely to seek out support to stay well.
b. developing services across groups of practices where the complexity of care and range of professionals involved is such that it requires a central focus for higher intensity care coordination and frequent specialist input (e.g. complex frail elderly, people living with learning disabilities, people in care homes and prisons).

c. creating alternative access points for high volume, low complexity care services for minor ailments in order to free-up additional capacity in each GP surgery for the patients who need us most.

d. developing expert generalists and arrangements for working with secondary care practitioners such that they become a resource for groups of practices, enhancing the level of care and support offered and providing additional training and development activities for GPs locally.

4. How we meet the different access needs by allowing patients to choose from a range of service options (length of appointment, rapid access, booking ahead, GP of choice); choose the way they access general practice (in person, online, by phone, email or video conference); and how we meet any personal accessibility requirements (e.g. physical or sensory disability, language, chaperone/advocacy).

5. How we use data. Not simply to identify different patient needs but also to inform us; to provide intelligence that will improve the quality of clinical care; to provide early warning for system failure; to enable us to see patients on different sites; and to help us deliver care in different ways, for example through remote care (e-health and telecare).

6. How we improve ourselves and become a learning environment.

7. How we disseminate innovation.

8. How we develop a vibrant attractive workplace with career prospects for clinical and non-clinical staff (recruitment and retention).

9. How general practice can support patients, families and communities to stay well and cope with minor illness.

10. How we create an organisation that empowers health and wellbeing in our population.

What will Londoners notice?

People living in London will be able to have the right length of consultation for them provided by the most appropriate health professional, in better premises, using up-to-date technology. There will be more responsive care, which will be delivered in a range of ways, for example online, email and telephone rather than just face-to-face consultations. People will only need to make one call or click to book their appointment and won’t be told to call back the next day. There will be no need to take a day off work to see a GP as there will be the choice of early or late appointments or telephone consultations. Those who need to will be able to book appointments up to several weeks ahead at a time to suit them. Care will be centred around each person so they won’t need to have multiple appointments about different long term conditions; they will be arranged around them.

Patients will experience better management and care: of long-term diseases; when they are frail and elderly; and at the end of life. Their general
practices will be encouraged to organise themselves so that all patients have a named GP accountable for their care. The need for continuity of care should be defined by the patient and has the potential to be regarded as important irrespective of age. This care might be delegated to other GPs or healthcare professionals in the practice team as appropriate. Continuity of the personal care relationship is especially important for those patients with complex and chronic health care needs. The future practice will provide improved continuity of care for these patients and for those that require more coordinated care.

Multidisciplinary teams will work together to deliver care in- and out-of-hours, and in- and out-of-hospital.

There will be safer, less (unwarranted) variability and better quality care delivered closer to home by highly trained GPs, nurses and other professionals. Patients will not necessarily see “their” healthcare professional for all care at “their practice”. They may choose to access an extended range of services at convenient opening times either in their own practices or in those practices linked to it. There will be no gaps for patients who are unregistered to fall through.

**Models of care**

The health system needs to be primary care orientated so that it is focused on improving population health and wellbeing. In order to ensure that patients receive the maximum benefit from this, general practice needs to have a collaborative approach involving, for example: voluntary and community organisations; community health services; community pharmacies; mental health services; social care and other partners. Some elements of the specification can only be delivered by working with patients and other partners to deliver high quality care.

It is likely that general practice will need to work together to form larger primary care organisations if it is to improve sufficiently. This will give groups of practices the opportunity to focus on population health and provide extended opening hours whilst protecting the offer of local, personal continuity of care. What begins as a conversation about greater collaboration, will move towards formation of practice networks that increase joint working and will then go further towards shared teams and infrastructure requiring a single primary care organisation. The *Five Year Forward View* describes this as the development of a Multispecialty Community Provider (MCP) which could offer increased efficiencies through wider collaboration and integration. These organisations are likely to align to a single population catchment or locality with other health, social, community and voluntary organisations. The shared organisation will enable them to: provide a wider range of services including diagnostics; share infrastructure, expertise and specialists e.g. for mental health or children; create career paths; train and learn together.

Shared systems for peer review, developmental and supportive learning should improve patient safety, clinical quality and outcomes for all practices involved. The organisations will contain teams that support care coordination and will have arrangements in place for closer partnership with a wider range of practitioners and specialists beyond general practice.

How this all looks will vary from area to area – local communities and patients will need to be
involved in developing and agreeing these changes. In some boroughs there may be a review of the number and type of practices and other buildings. In areas of poor provision, existing and new providers may emerge and the opportunity described in the NHS Five Year Forward View, for acute, mental health and community services to also provide general practices services, may be taken.

The needs of an area will be met perhaps with fewer, smaller practices and some larger health and education hubs with diagnostics, day beds and leisure and exercise facilities for patients and the public. GPs will work together in a single system continuing to deliver first contact care but also providing continuity of care to those that wish to see the doctor of their choice. GPs will be linked together via a single electronic record with other practitioners such as elderly care doctors, paediatricians, palliative care and district nurses helping to deliver 24/7 care to those who most need it.

Patients will benefit through receiving care from a greater range of generalists, more specialist care and improved access to services in a better environment.

We need to work together to achieve this ambitious specification to ensure we can deliver the future requirements of our population.

**Dr Clare Gerada**  
Chair of the Primary Care Clinical Board
At the heart of this Strategic Commissioning Framework for Primary Care Transformation is a new service specification for general practice. This supports the need to define and commission a more consistent service for all Londoners, e.g. adults, children, young people, carers and families; reducing variations in access, patient experience and clinical outcomes. The specification provides a single definition of high quality care.

Three characteristics are needed for general practice to thrive and deliver the care that patients need and value.

1. **Proactive care** – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy

2. **Accessible care** – providing a personalised, responsive, timely and accessible service


The Framework covers these three aspects of care and contains a specification of the future patient offer covering 17 aspects of care. The document is informed by the London GP Innovation Challenge (2012) and Prime Minister’s Challenge Fund (2013). Some elements have already been achieved and implemented in parts of London. Whilst the Framework describes a common patient offer, it is sufficiently flexible and adaptable for groups of practices to design how the service specification might be delivered consistently for all patients. Delivering the specification described in this document will require local planning and customisation in order to ensure that these are provided in the best possible way for the whole population, for example particular differences needed to deliver this for children as well as adults. London’s general practice will be transformed when all patients are able to fully access the care described in this document and when it is of a sufficiently consistent high quality.

This Framework is about what is delivered and how it is delivered. From the moment a patient begins their interaction with general practice, they should feel they are treated with dignity and compassion. The Care Quality Commission assessment and inspection of general practices places great emphasis on whether patients are experiencing caring and empathetic services.

**Evidence supplement**

A supplement to this document is available on request (england.londonprimarycaretransformation@nhs.net) and provides a compendium of the supporting evidence. This includes:

- detailed insight obtained through the pre-engagement activities that have taken place over the summer months and a record of the changes made as a result

- research and evidence gathered from analysis and piloting activities.
Service specification development process

NHS England (London) has worked with London's clinical commissioning groups to lead an open, transparent and collaborative conversation with key stakeholders to identify the primary care services which patients value, what they need to remain healthy and the services that will positively impact on the wider health economy. The service specification has been defined by patient voices, clinical leaders, current best practice, innovation and best evidence.

Around 1,500 people have contributed to drafting, testing and challenging the future service requirements to ensure that they are as robust, ambitious and innovative as possible.

Number of people and groups engaged to develop the service specification
1. Proactive care specification

Primary care is at the heart of every community, putting it in a unique position to empower patients to keep safe and well, and to lead healthier lives. This is the essence of proactive care. This includes activities and interventions which contribute to improving health and wellbeing by: increasing self-reliance; building greater capacity for health and health resilience in patients, the people who support their care (for instance friends and families); and through partnership with local communities. By supporting people to live well we avoid unnecessary care interventions, improve quality of life and reduce the overall cost of the system for taxpayers.

Proactive care can reduce health inequalities by providing a targeted response to those who are highly reliant on additional support to stay well. People who are at higher risk of deteriorating health due to social isolation, or a lack of personal capacity e.g. homeless people, ‘looked after children’ and isolated elderly people require a differential level of support to achieve positive health outcomes. This care might be delivered across a group of practices by a team comprising roles such as care navigators, peer advocates, health coaches, wellbeing support workers and community volunteers. Reducing health inequalities is not just about focusing on illness, but providing a holistic response to social issues like debt, housing, employment and substance misuse to improve health and wellbeing.

Proactive care requires moving assets across multiple agencies and community organisations to re-balance the current focus on illness and a clinical agenda aimed at enabling people to live well.

General practice is well placed to improve population health because:

- it is the most accessed part of the health system
- it holds a registered list for a defined population in an immediate locality
- generalists deliver care to people with a full understanding of their social context.
Delivering the proactive care specification will require practices to co-design new approaches to improving health with individuals, families, other health agencies and local community partners. Londoners will recognise general practice as caring about their wellbeing and providing holistic support to enable them to stay well. But delivering proactive primary care will go beyond general practice and will draw on the whole family of primary care services and professionals including those within the voluntary and third sectors.

The nature of consultations will change, to better combine clinical expertise with patients' aspirations for wellbeing. Patients will notice that they are being asked more frequently about their wellbeing, capacity for improving their own health and their health improvement goals. They may be reminded of signs of early disease such as cancer, or be offered support to manage conditions themselves (e.g. health information, advice and equipment) or social prescribing (e.g. debt advice).

Patients will be offered additional services such as coaching, mentoring and buddying from professionals or peers offering support to help build patient knowledge, skills and confidence for self care.

These types of services are already offered by some London practices. Practices in Lewisham have been piloting a service to support patients reach their care plan targets including regular motivational callers (people who phone patients – helping and encouraging them to meet their health goals), self-management demonstrations and role play; and the Well Centre in Streatham has helped 650 young people with complex needs to manage their conditions better, reducing the need for further referrals.
P1: Co-design

Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population.

Involving individuals and communities in designing services will ensure that approaches are relevant locally; that they do not duplicate (and are integrated with) existing services in the community; and that they are more likely to be successful.

The process of co-design in itself will support improved understanding of health and wellbeing for those involved, support the identification of community advocates and volunteers and further build community resilience.

An example would be engaging young people, schools and youth workers locally in designing new ways of communicating with young people living with a long term condition.

P2: Developing assets and resources for improving health and wellbeing

Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy, and to feel connected to others and to support in their local community.

Practices will work with local voluntary and community organisations; health, third sector and other organisations; and local authorities to:

- provide additional capacity for improving health and wellbeing (e.g. Citizen’s Advice, community pharmacy services and the probation services)
- protect community resources for future generations (e.g. with the Environment Agency)
- test new ways to build and improve relationships with local communities
- build a map of local community assets that can be harnessed for health and wellbeing
- identify and develop local community health and wellbeing champions, advocates and volunteers.

Establishing and maintaining an up to date map of community assets will assist a range of organisations involved in an individual’s care. The map will support other ‘first contact’ providers such as NHS 111 and community pharmacies to offer patients a range of options.

P3: Personal conversations focused on an individual’s health goals

Where appropriate, people will be asked about their wellbeing, capacity for improving their own health and their health improvement goals.

Practices will co-ordinate plans of care, particularly for people who regularly visit the practice and whose health is at risk of deteriorating. If relevant, patients will be offered self-management support and/or social prescribing – directing them onto other information, resources and services available in their local communities e.g. debt advice.
P4: Health and wellbeing liaison and information

Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.

These services would offer a range of interventions from brief focused information to more extensive advice and support. Interventions could include group support, 1:1 coaching, signposting and improving health literacy. The service would also build partnerships to build on the contribution to health and wellbeing already made by leisure centres, gyms and voluntary groups.

P5: Patients not currently accessing primary care services

Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health

This specification focuses on two key areas:

1. People on the registered list (but not attending the practice)
   - Practices will design ways to reach vulnerable patients who may live in circumstances which make it harder for them to access general practice. This includes patients whose language and culture form barriers to receiving care, for instance gypsies, travellers, sex workers, homeless people, vulnerable migrants, people in care homes, and people with learning disabilities or severe mental illness.

   Practices will identify the patients on their registered list who have not been attending and are therefore at higher risk of ill health. These may be people who have declined invitations for services, are reaching crisis, suffering social isolation or stigma.

   These patients will require a more personalised service offer, care coordination and care planning. Using peer advocates who have direct personal experience and can empathise with patients has been shown to be an effective way of engaging with these groups of patients.

   - Primary care teams will also design approaches to follow up those patients who might be attending the practices from time to time but are not taking up invitations for services such as screening and vaccinations. Understanding the root causes for non-attendance will be crucial to ensuring maximum take-up of these services in the future; for example, understanding religious or cultural reasons for non-attendance.

2. The unregistered population
   - Working collaboratively across a population and across multiple agencies, primary care teams will also design, with the support of their CCG, ways to reach and care for the unregistered population, for example homeless patients and people released from custody or places of detention.
Good access to general practice is important to everyone. It’s important to patients who may be distressed or who may suffer if diagnosis and treatment is delayed; those who value a continuous relationship with their clinician in order to remain healthy and independent; and people who find it hard to see a GP within current opening times. It’s important to practices whose workloads can become inefficient if access is not managed systematically. It’s important to the NHS as good access to primary care has the potential to reduce unnecessary emergency admissions and reduce the number of patients attending A&E.

Although there are examples of excellent services at some practices, many London patients report that access to general practice does not always meet their needs. On average, patients in London are less satisfied than those in other parts of England with: contacting the practice; seeing a GP quickly; their ability to book ahead; opening hours; and seeing a GP of choice when they want to.

Patients who cannot access their practice because it is closed or they are unable to get an appointment are more likely to attend A&E with issues that their GP could have resolved. Less than half of patients wanting an appointment in London are seen by the next working day. Phone lines are busy first thing in the morning and same day appointments run out quickly. Many patients are asked to call back the following day. For many patients, access to weekend and evening appointments is limited and many practices still close on a Wednesday or Thursday afternoon.

More London patients report that it is hard to see a preferred GP in London than anywhere else in England. Consequently patients who need regular contact and a continuous relationship with a clinician may not receive the best support to manage their health effectively in the community.

Our proposals

Good access means different things to different people. In developing these specifications we have tried to consider the various needs of different patient groups – whether that is accessing continuity of care, rapid access, out of hours care or online services.
Often patients concerned about a new health problem want to be seen as quickly as possible but are less concerned about who they see. There is also evidence that some patients go to A&E with minor issues because they can’t get a same day appointment with a GP – especially at weekends when many practices are closed. So we’ve proposed that all patients should be able to access a consultation with a GP or senior nurse from their own practice on the same day in routine opening hours and on Saturday mornings. We’ve also suggested that patients should be able to access a primary care health professional seven days a week, 12 hours a day in their local area.

Commuters with occasional health needs want advice and care quickly, conveniently and in a variety of ways. Patients should be required to only make one call or click to make an appointment, and practices should promote online services including appointment booking, prescription ordering, viewing medical records and email. Many systems make telephone consultations the normal starting point for most patients – linking the two people who need to talk, in the shortest possible time.

Other patients, such as those with long term conditions, tend to need more frequent consultation and value continuity and familiarity – but are willing to wait a little longer to be able to do so. So this specification outlines that patients should be able to book at least four weeks ahead if they wish and see their GP of choice in an appointment with a flexible duration.

We know that patients will have different needs at different times. So we’ve suggested a specification that patients should be given a choice of access options to select the service that best meets their needs.

We also need patients to use the most appropriate service for their needs. For medical help or advice in a situation that is not life-threatening, patients can call 111 free from any phone. NHS advisers are on the line 24 hours a day, seven days a week and can give healthcare advice or signpost patients to local services.

Patients are often unaware of the range of services that their pharmacy can offer, so many people simply don’t consider visiting. But pharmacies can provide medical advice on a range of conditions and can even provide prescription drugs under minor ailment schemes, without an appointment.

The fact that different dimensions of access are valued differently by different people (and by the same people at different times and in different circumstances) presents a real task to the formulation of concrete measures of good-quality access. Our challenge is to design and deliver a truly personalised service that responds to all patients, irrespective of their particular circumstances. We hope that this specification outlines a service which does just that.

Dr Tom Coffey OBE
A1: Patient choice

Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.

Different patients, in different situations, have different access needs. Some patients value continuity of care over rapid access. Some people place more value on seeing a particular clinician. Others want a more convenient appointment time, or to book an appointment four or more weeks in advance.

General practice should make all these options available to the patient at the point of contact and allow the patient to select the service they want. Practices should also include reasonable adjustments to remove access barriers for patients, such as considerations for the homeless or non-English speakers, as well as adhering to the Equality Act (2010) for physical access needs (ramps, hearing loops etc).

A2: Contacting the practice

Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email consultations.

Currently appointments are often allocated based on who gets through to the practice rather than by clinical need. Many practices hold back appointments so that a patient getting through may be told that there are no appointments left but that they should call back later or the following day when more are released. This increases the number of calls coming into the practice as patients have to call several times before securing an appointment and patients who do call back join the back of the queue.

In future patients would have multiple options for making an appointment, and would only need to make contact once in order to have a discussion with a clinician.

A3: Routine opening hours

Patients will be able to access pre-bookable routine appointments with a primary health care professional (see ‘workforce implications’ for the proposed primary care team) at all practices 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays. An alternative equivalent patient offer may be provided where there is a clear, evidenced local need.

There is significant variation in opening hours across London. This specification will create an equitable offer to patients across London. During the specified hours, all practices will be open to allow patients to access all services, including attending an appointment, speaking to a receptionist, and collecting or ordering a prescription.

A4: Extended opening hours

Patients will be able to access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments.
This service will be delivered by networks of practices working together at scale. In most cases a larger practice in the local community will take the lead to provide this service on behalf of other practices. A suggested offer of 8am to 8pm is described here, however there could be a suitable alternative equivalent offer based on local population needs, for which the totality of the offer (seven days, 12 hours) is not reduced.

A5: Same day access

Patients who want to be seen the same day will be able to have a consultation with a GP or appropriately skilled nurse on the same day within routine surgery hours at the practice at which they are registered (see Specification A3: Routine opening hours).

Patients with new health conditions often want to see or speak to a GP as soon as possible. It’s important for patients who may be distressed or suffer if diagnosis and treatment is delayed. Consultations could be face-to-face or on the phone (or video phone) but will be provided by a GP or an appropriately skilled nurse on the same day.

Practices would be encouraged to use a demand-led telephone triage system. These approaches provide a phone conversation with an appropriate clinician throughout the day, often within 30 minutes of the patient contacting the practice. The patient can then discuss their needs with the clinician and between them they can then decide the most appropriate course of action (e.g. face-to-face consultation of appropriate length according to need; referral to community pharmacist, nurse, healthcare assistant or other service; booking for diagnostic tests; and self care).

A6: Urgent and emergency care

Patients with urgent or emergency needs will need to be clinically assessed rapidly. Practices should have systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.

In the event that a patient accesses general practice with emergency care needs, there should be sufficient processes and procedures in place to enable all members of the practice to respond to that patient’s needs appropriately.

A7: Continuity of care

All patients will be registered with a named GP who is responsible for providing an ongoing relationship for care coordination and care continuity. Practices will provide flexible appointment lengths as appropriate.

All patients should have a named GP for care continuity and coordination. Other GPs or healthcare professionals within the practice team may provide care as appropriate but the named GP will effectively still oversee delivery of the care plan.

General practice will routinely improve continuity of care through a range of mechanisms such as buddying; job sharing; forming ‘teams within teams’; developing organised handover systems; enhanced use of communication and record-keeping technology; and increased involvement of patients and carers in care planning. These measures are of particular importance where personal continuity is not possible.
3. Coordinated care specification

For people with complex health and social care needs, coordinated care is essential to support their health and wellbeing.

One in five Londoners are living with one or more complex conditions. Other people go through periods of severe, complicated, health problems which may last months or years before they are resolved. Changes to the GP contract focus on the over-75s, but in London it is often younger people who live with complex health problems which may be harder to manage because of drug or alcohol dependence, mental health problems or financial and social pressures. Many Londoners, young and old, will be receiving care from several different services, which can become confusing and frustrating if the services don’t work in close collaboration.

The National Voices report Integrated care: what do patients, service users and carers want? provides a powerful narrative which highlights clearly and effectively the kind of relationship people want with their health professionals. It stresses that coordination and care are the two ‘top lines’ in what people expect and need.

The statement “My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes” summarises the service which we want to outline in this specification. We know this type of service would result in significantly improved health outcomes and patient experience.

In the National Voices document, patients tell us they want a service: where their needs as a person are taken into account; where they are involved in discussions and decisions about their care; where they have regular reviews of their care, treatment and care plan; and where they have the information and support they need in order to remain as independent as possible. We also know patients want a first point of contact from someone who understands them and their condition and who they can go to ask questions at any time.

These are significant challenges for all health and care professionals, including GPs, which will require a fundamental change in the culture of general practice and communications between service users and professionals. New approaches to delivering care are needed, informing patients and their carers about their condition(s) and enabling them to participate effectively in decisions about their health and care.

Coordinated Care Expert Panel Chair: Dr Rebecca Rosen

Rebecca is a Senior Fellow in Health Policy at the Nuffield Trust, a GP in Greenwich and an accredited public health specialist. Her current policy interests include integrated care, primary care, new organisational models for general practice and NHS commissioning. Rebecca is a clinical commissioner with Greenwich CCG – where she leads on long-term conditions and quality. At her GP practice, Rebecca leads work to improve continuity and quality of care for people with chronic ill health. In the past, Rebecca has worked as a Medical Director of Humana Europe; as a Senior Fellow at the King’s Fund; and in NHS academic public health departments. Past research interests include the diffusion of new medical technologies, patient choice and primary care policy.
Our proposals

We want to move away from a reactive system which treats people when they become ill, to one which coordinates care and supports people to stay well.

Firstly we need to identify the patients who would benefit from this approach. Many will be elderly and suffer from multiple chronic conditions while others may suffer from mental health issues or have a set of social circumstances and lifestyle issues which are best addressed through coordinated care.

Secondly patients need a named clinician who will routinely provide the patient’s care or act as an advocate, guide and contact for the extended practice team and to the wider multidisciplinary team in line with their needs.

Thirdly we want all such patients to have a personalised care plan and to have played an active role in determining its aims and content – agreeing goals and the support they need to achieve them.

Fourthly we want to create an environment in which patients can maximise the potential of their self-care, lifestyle changes and knowledge to contribute to their own health and wellbeing.

Finally, patients who require coordinated care will need frequent reviews and input from a range of members of a wider team ranging from a micro-team of practice staff, pharmacy and community nursing to a macro-team of health and social care providers. Their provider network needs to be well-connected and their services seamless.

While these challenges sound daunting, a great deal of work has been done on how to deliver high quality services tailored to individual and population health needs and examples continue to be developed across London. The chronic care model introduced the idea of ‘informed, activated patients’ and a ‘prepared, proactive’ clinical team. The recently launched Delivering Better Services for People with Long Term Conditions – Building the House of Care adapts this model for the NHS, highlighting the four key components of coordinated care: informed, engaged individuals and carers; organisational and clinical processes; health and care professionals committed to partnership working; and effective commissioning.

The ambitions of National Voices’ patient-centred coordinated care and the organisational model of the House of Care feature heavily in the following specification. They create a framework around which practices can organise themselves to deliver high quality care with a relational continuity (seamless care), focused on the goals and preferences of individual patients and tailored to meet individual needs.

The specification is rightly ambitious and will not be achieved overnight. It requires a new culture for general practice in which the co-creation of health by patients, doctors, nurses and others becomes the norm. The specification addresses what individuals can do to keep themselves well; the ways in which professionals consult with patients; the ways in which practices are organised to support coordinated care; and the ways in which GPs work with other providers to deliver coordinated care. Practices may need additional resources to deliver the specification and these will have to be negotiated and put in place, but we believe achievement of the specification will result in better care for people with long term, complex health and care needs.

Dr Rebecca Rosen
C1: Case finding and review

Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis.

Patients with complex conditions who need care from more than one professional or team will be added to a coordinated care register and will be provided with an enhanced level of service.

These patients may have long term conditions but may also be patients with a range of other health conditions and social support needs such as children and families with complex problems; people with mental health conditions; people in nursing homes; people at the end of life; or vulnerable people who find it hard to access services (for example homeless patients; those with learning difficulties or members of the traveller community).

Patients will be identified using a combination of clinical alerts, risk profiling and clinical judgment. Every practice, or network of practices where appropriate, will run a regular risk profiling / risk stratification process in order to identify patients who should be on their care coordination register.

The intensity of care, frequency and duration of contact with patients should be scaled up or stepped down as a result of reviews and patient progress. This should enable practices to identify those who may be, or are at risk of, experiencing an exacerbation of their condition but who have not reached a crisis point to seek treatment.

C2: Named professional

Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity.

All patients identified as needing coordinated care should have a named professional from whom they routinely receive their care. The lead GP will provide continuity of care, either personally or in collaboration with a ‘micro team’ of clinicians and professionals in and around the practice, for example members of the wellbeing team or community pharmacists.

Patients may also be allocated an additional member of the practice team or an additional health or social care professional as a care coordinator to act as their first point of contact if they have questions, concerns or problems.

The person who coordinates their care should work with the patient to achieve their goals. For some patients, this will require extended consultations, for others it will mean regular contact with an extended primary care team. Patients with more complex needs would ideally be able to contact their care coordinator 24/7 for certain periods of very acute clinical risk or towards the end of their life.

The intensity of contact and amount of time spent with the named GP and extended team will fluctuate in accordance with need, as assessed by risk profiling and regular communication with patients and their family and carers.

The GP should act as an advocate and guide and should coordinate care with the extended practice team and a wider multidisciplinary team...
as appropriate. If patients go into hospital or transition to other services, general practice should continue to be proactively informed about the patient as they move between services, continuing to coordinate their care if appropriate.

C3: Care planning

Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.

Development of the care plan should follow the approach described in Delivering Better Services for People with Long Term Conditions – Building the House of Care. This represents a departure from the current focus on individual diseases towards a generic approach in which patients’ goals drive care delivery and greater attention is paid to the contribution that people make towards managing their own health.

Care planning should be based on a philosophy of co-created goals for maintaining and improving health. It should be an iterative process that continues for as long as an individual has complex needs.

Patients identified for coordinated care, and their carers, should be encouraged to play an active part in determining their own care and support needs as part of a collaborative care planning process. This should involve discussing care and support options, agreeing goals the patient can achieve themselves, and co-producing a single holistic care plan that includes the needs of family and carers.

C4: Patients supported to manage their health and well-being

Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing.

A culture of self-management support will underpin care coordination, recognising that the personal information that patients, their carers and families bring to the development of care plans can be as important as the clinical information in medical records.

Practices will develop an infrastructure to provide self-management support for patients with ongoing complex problems and support for their carers.

Following a new diagnosis of a long term condition (or identification of a need for coordinated care such as recovery from cancer), all patients will have at least one encounter dedicated to enhancing their ability to self-care, and then frequently according to need thereafter.

Support for patients could be provided by individual practices or across a number of practices and could for example include internet resources; advice from staff skilled in lifestyle training and/or motivational support; information packs; services provided by volunteers or voluntary organisations and access to patient groups in which patients support each other.
C5: Multidisciplinary working

Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.

Patients on the coordinated care register will have a review by a multidisciplinary team involving clinicians from within the practice and from linked services. GPs should be regular, active participants in multidisciplinary reviews of their registered patients who have been identified for coordinated care. The frequency of multidisciplinary reviews will vary according to changing needs.

Multidisciplinary reviews should ideally include professionals from both health and social care. This might include acute care specialists, social services, housing and finance advisors, community matrons, mental health specialists and district nurses depending on the needs of the patient.

General practice should fully participate in multidisciplinary work across the health and care system and use reflective learning to improve patient care and for system enhancement.
This Strategic Commissioning Framework for Primary Care Transformation represents a significant ambition for service improvement. Delivering this ambition will require strong collaboration from all parts of the NHS, the CQC, local education and training boards (LETBs), academic health science networks (AHSNs), local authorities, charities and voluntary organisations and health and wellbeing boards (HWBs) in London. This section of the Framework provides a strategic London-wide case of the underpinning enablers that will need to be utilised in order to meet the scale of that challenge.

Local plans to deliver the changes

CCGs across the capital will continue to develop (in partnership with NHS England (London)) local plans for delivering these changes. These plans will focus on how to improve general practice and the wider primary care system from April 2015 onwards. The changes required to the system will take a long time to achieve, however some changes and some practices may be quicker to implement than others. In order for local populations to be able to take part in discussions to decide what is best for their local community, it is essential that plans are locally designed based on different starting points.

The Framework is not intended to be a static document but will form the basis of wider engagement over the coming months in each local area. There is an expectation that different areas will work at different paces and NHS England (London) will work closely with those areas that are ready, and will share the learning across London. Commissioners across London aim to ensure that in the future, all Londoners will receive the primary care services described in this document.

Co-commissioning

The current commissioning landscape for primary care is complex, with up to three different commissioners (CCGs, NHS England and local authorities) and several different funding streams for some pathways of care. To achieve the transformation of out-of-hospital care and thus improve health outcomes and deliver more care closer to home, commissioners have recognised the need to make it easier for them to work together and to better integrate services. Co-commissioning is a first step on this journey to empower CCGs to have greater influence over the development of primary care services. This will help to ensure local primary care developments are better aligned with CCGs’ commissioning plans for hospital-based care and community services and better meet the needs of diverse local populations. Co-commissioning could potentially lead to a range of benefits for the public and patients including:

- improved access to primary care and out-of-hospital services, with more services available closer to home
- high quality out-of-hospital care
- improved health outcomes, equity of access, reduced inequalities
- a better patient experience through more joined up services
Options for models of co-commissioning

Proposals for co-commissioning arrangements across London, based on local requirements and plans, are being developed and their formulation is supported by national guidance. This national documentation, *Next Steps Towards Primary Care Co-Commissioning* describes several types of co-commissioning model. The exact nature of the arrangements will depend on local preferences but it is anticipated that co-commissioning arrangements with CCGs could be one of the following types:

- allow CCGs greater involvement in commissioning decisions, including actively participating in discussions about all areas of primary care, in order to make better decisions about how resources are allocated across primary care, community services and hospital services and with local authorities.
- joint commissioning model that enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or “committees in common”. This would allow CCGs and area teams to pool funding and give them an opportunity to more effectively plan and improve the provision of out-of-hospital services for the benefit of patients and local populations. Together, CCGs and area teams would be able to make better decisions about how primary care resources are deployed, for example by designing local solutions for workforce, premises and technology challenges.
- delegated commissioning model, offering an opportunity for CCGs to assume full responsibility for commissioning some aspects of general practice services. The exact models for delegated commissioning will need to be worked up in local areas.

Commissioners across London have set up a co-commissioning collaborative to develop thinking on some of the key elements required. Areas under consideration include finance, workforce, governance, benefits and contracting.

Financial implications

The changes described in this *Framework* cannot be delivered without significant investment. A high-level financial case has been completed at a London-wide level to estimate the cost of providing the new patient offer.

The financial modelling work has so far focused on the recurrent revenue investment required to provide the service specification for whole populations with differing degrees of care complexity. The modelling has focused on two main areas:

1. **Delivering a new service model.**
   Supporting clinicians to deliver more person-centred care by analysing the cost of new activities and the potential increase and diversification of the primary care team needed.

2. **Increasing patient access to primary care.** By creating additional appointment slots, allowing extended practice opening hours in each area including evening and weekend working.
Financial context

General practice undertakes 90% of first patient contacts, and in London this is done for 7.3% of the capital’s healthcare budget of £15.1bn – based on the combined CCG and NHS England commissioning budgets. Expenditure on general practice services has fallen in real terms between 2010/11 – 2011/12 in comparison to an increased spend in acute and community services.

The new service specification needs to be affordable within current NHS financial constraints, and NHS England and CCG budgets. There is a £2.4bn saving requirement for London by 2021/22, which means that finding ways to use existing resources more effectively is urgently needed.

Within this context there is a strong rationale for re-balancing the NHS investment profile towards primary care:

- Improving services for patients and creating a sustainable general practice service
- Supporting sustainability across the wider health system. For example there have been estimates that 10-30% of A&E attendances have the potential to be managed as part of a primary care offer
- Securing better value for money. Investing in general practice capacity and capability to deliver a higher proportion of activity closer to home would enable acute reconfigurations.

Estimate of the required investment

It is estimated that in order to reverse this trend, meet future population growth and deliver a modern, high quality service for all, £310 – £810 million (representing 2% – 5.36% of total health spend today) will need to be invested annually. This is expected to begin with a gradual shift in total health spend of 0.4% – 1.07% each year over five years. This shift in total health spend has the potential to deliver a significant increase in general practice capacity in the medium term. This will require changes at a local and regional level, both in terms of redirecting funding and supporting the process for doing this (e.g. with co-commissioning).

Caution: This estimate is a very high level calculation for the purpose of assessing the feasibility of the service changes, the methodology used is outlined below.

Financial modelling methodology

In developing the above hypothesis for the funding needed to deliver the envisaged primary care, a methodology was used to estimate the additional cost of delivery of the total specification as compared to current spend.

a) Calculating the additional cost of delivering the coordinated and proactive specification. The methodology is based on a differentiation of patients at different levels of need (i.e. some patients will require high frequency and longer appointments because they have more complex care needs, some may only require a quick consultation) and the requirements for involvement of
different members of the practice team. Clinicians then provided estimates based on clinical complexity categories and the complexity bandings associated with patients on different disease registers of the frequency, amount of time and member of the clinical team which would be required to treat each type. These figures were then adjusted to account for their relative proportion of the population (e.g. approximately 80.3% of the population are ‘mostly healthy’ and not on the disease registers).\(^6\) This allowed an overall cost to be estimated.

b) Calculating the additional cost of increasing patient access to general practice. There is a direct cost increase relating to additional opening hours. Extending the opening hours will result in additional workforce and non-pay costs. Two methods of estimating this additional cost are described below:

- Methodology A: calculating the cost of increased demand based on redirection of existing A&E minors
- Methodology B: The cost of increased access based on theoretical current estates capacity.

Summing these methodologies demonstrates that a range of between £310 – £810 million potential investment will be needed in primary care in London depending on the approach.

<table>
<thead>
<tr>
<th>Cost Type</th>
<th>Annual Cost (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of delivering a new patient offer (excluding access)</td>
<td>250 – 300</td>
</tr>
<tr>
<td>Cost of delivering better access. (Methodology A, low end of range)</td>
<td>60(^7)</td>
</tr>
<tr>
<td>Cost of delivering better access. (Methodology B, high end of range)</td>
<td>510</td>
</tr>
<tr>
<td><strong>Total Cost Estimate</strong></td>
<td><strong>310 – 810</strong></td>
</tr>
</tbody>
</table>

In addition to this, transitional funding will be required in the first few years to invest in the infrastructure and transition of organisations to these new ways of working.

### Current funding opportunities

Current funding opportunities for improving general practice that are already identified include the Better Care Fund (£3.2 billion nationally) and the Prime Minister’s Challenge Fund (£50 million 2014/15 expected to rise to £100 million in 2015/16). The *NHS Five Year Forward View* and London Health Commission have identified investment in general practice as a key priority for the health system with additional national transformation funds anticipated. In a survey of 24 CCGs in London, only two areas did not have resources already invested towards supporting

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\(^6\) As per the Quality and Outcomes Framework database

\(^7\) Includes a +20% optimism bias
general practice improvement, and one area had already confirmed a recurrent £4.9 million investment across a number of CCGs to support general practice improvements and wider out-of-hospital changes.

Next step financial modelling

The next phase of financial analysis would involve local scenario testing and detailed work up of CCG area-specific, operational-level financial models. This would include:

- adjusting the financial and activity model to take into account: local factors to underpin the additional access changes and other patient offer changes; the workforce change requirements – consulting with workforce experts; additional clinicians; and local analysis of need
- local (CCG area) estimation of the building, IT and other infrastructure costs, including any additional ‘pump prime’ or upfront investment in order to implement the specification
- local (CCG area) analysis of cost efficiencies, including what, when and how much effect these would have
- adjusting the modelling to local population demographics, in order to account for local variations in ‘healthy’ populations, and co-morbidity (multiple disease) duplications across the disease registers
- further analysis of the sources of capital and revenue funding required and potential to release these locally (by strategic planning group area)
- understanding the impact on non-primary care finances (for example adult social care, and the cost of prescribing).

Contracting approach

The service specification for general practice can only be delivered by general practices working together at scale and with other parts of the health and care system. With that in mind the proposal in this Framework is that the specification will not be funded at individual practice level but will be delivered through a new contract at a wider population level, offered to groupings of geographically aligned general practices or Multispecialty Community Providers (MCPs) (alternative options might be considered for individual practices that have a significant geographical footprint and alignment with other health and social care providers).

The exact contracting approach used in each place will be determined through co-commissioning arrangements in consultation with each CCG, taking into account local arrangements for delivering against the new service specification.

Potential contractual forms

Contracts will be developed that incorporate the service specification as a distinct, scheduled and incentivised service innovation and general practice collaboration.

Broadly speaking, the following contractual forms are likely to be reviewed and considered for use in commissioning the new service specification for general practice:
• Alternative Provider Medical Services (APMS)
• NHS standard contract
• hybrid of the APMS and NHS Standard Contract (note – this would represent a new form of contracting that would require legislative change).

Whatever contract form is used, it will typically include a phased transition for the primary care organisation/provider. For example, this could include a year on year increase to the contract value as well as greater degree of risk share and pooling of current incentives from constituent practices that might include:

i) complete or phased incentive sharing across constituent practices with regards to Quality and Outcomes Framework (QOF), Local Enhanced Service (LES) and other enhanced payments

ii) increasing the level of shared decision-making across constituent practices with regards to the specification for how current Personal Medical Services (PMS) investment contributes to delivery of the new service specification and specific local needs.

iii) increasing the level of pooled funding across constituent practices with regards to APMS, PMS and General Medical Services (GMS) for example £x per patient is pooled to represent the efficiencies that will be gained from working collaboratively or by delivering current services in different ways.

The contracting vehicle will need to ‘wrap around’ the existing national contracts unless constituent practices are opting for a full merger/super partnership in which case they may voluntarily relinquish their current contract. Whatever the approach, it will need to provide sufficient new financial incentive to increase the level of collaboration and joint ownership. The exact nature of these arrangements will vary by nature of the provider landscape but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which additional investment will be made.

Consideration will be given as to whether the accountability for delivering the constituent GMS, PMS and APMS can be attributed to a lead provider within a scale primary care organisation. That type of change would require new permissions and a shift in national policy. It could only be undertaken on the basis that systems for assuring quality and patient safety continue to have sufficient probity and it would require changes in the approach to regulation. There is however some evidence, from Tower Hamlets networks for example, that clinical governance systems that are owned and reviewed across a number of general practices by peers and local training leaders have greater potential to secure improved quality and patient safety.

The contractual form chosen will need to be flexible to allow for wider collaborations and partnerships with other types of providers, for example community services and the voluntary sector. This may be in the form of governance arrangements that reflect the wider partnership. In some local areas the strategic intent may be to take a single step towards a merged contract between general practices and the wider system to form an accountable care organisation that can hold capitated budgets and shared risk for a whole population.

Many areas already have a strong ambition towards bringing general practice and community services together over the next two
years. It is however anticipated that most areas will be looking to contract networks/federations of general practices as a starting point.

**Workforce implications**

Implementation of the service specification in this *Framework* is set in the context of growing demand for primary and community care, increasing expectation, and the changing patterns of needs of patients with more complex and long-term conditions. These demands, coupled with technological advances and the adoption of best practice across care settings, have important implications for how to develop and train primary and community clinicians and the wider workforce of the future.

General practices are typically small organisations, working in relative isolation from one another, with the exception of some networking for the purposes of out-of-hours cover and involvement in clinical commissioning. Increasingly however this is changing with the rapid formation of at-scale general practice organisations involving closer working and in some areas changes to legal structures to enable practices to come together. However the general practice workforce (including GPs and GP nurses) is under significant workload pressure and many are now considering early retirement. The number of mid-career doctors (under the age of 50 years) considering leaving the profession is also rapidly rising. Nationally the growth in GP numbers has not kept pace with that of hospital consultant numbers (per WTE) and boosting numbers entering GP training is proving difficult.

GPs in London are a lower proportion of the total workforce compared to national figures.

Ongoing planning of the future workforce requirements will be at the heart of transforming care. Bolstering the primary care workforce has been identified as a core objective in the Health Education England (HEE) mandate and is also recognised as a key priority for HEE and its Local Education and Training Boards (LETBs). Implementing the general practice specification and planning the future workforce requirements will require alignment of resources to:

- manage immediate and forecasted workforce supply shortages
- reshape existing roles through ongoing training, education and development
- modify core training programmes to align with new service needs
- develop and pilot new roles
- evaluate and research the effectiveness of new roles and workforce configurations
- manage expectations around the pace of workforce change
- develop new primary care learning environments that build on multidisciplinary approaches such as Community Education Provider Networks (CEPNs)

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8 BMA quarterly tracker survey: Current views from across the medical profession. Health Policy and Economic Research Unit, 2014
9 Securing the Future GP Workforce: Delivering the Mandate on GP Expansion. GP taskforce final report. March 2014
10 Centre for Workforce Intelligence; In-depth review of general practitioner workforce. June 2014
11 CEPNs: collectives or networks of primary and community organisations working collaboratively to enhance educational delivery in local geographical contexts
Implementation of the service specification in this Framework will require practices to offer an extended scope of services; more convenient opening times; personalised care; and an ongoing development of access options to match the needs of the population. Practices of all sizes will be faced with the challenge of how to:

- configure the workforce to ensure safe practice, on-going training and development whilst maintaining continuity of care; and harness the potential of temporary and locum staffing
- expand flexible working arrangements
- prevent professional isolation
- ensure staff are up to date on evidence-based practices, treatment developments, changes in medicines use, technological advances etc.
- efficiently manage workforce demands while ensuring the team has time for organisational development, service redesign and quality improvement.

The future health service will see more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations. The developments to commission the future workforce for general practice will be undertaken in the context of overall professional clinical training and increasing multidisciplinary working across organisational boundaries.

Governance arrangements will need to be developed to support the increasing numbers of staff that will be in training, on placement and working independently outside hospital, and in community settings. Delivering integrated primary care using multidisciplinary models of working in community settings will require new approaches to safeguarding, to support safe clinical practice whilst ensuring staff are supported to continually learn and develop.

How roles and teams fit together in delivering future care still needs to be determined and different roles and responsibilities are likely to evolve in each local area as the specification is implemented. Broadly it is anticipated that the roles detailed below will be required:

<table>
<thead>
<tr>
<th>Within each practice</th>
<th>Aligned to each practice but working across a wider geography / at scale primary care organisations</th>
</tr>
</thead>
</table>
| GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates | Prescribing advisors, GPs with a special interest (GPSTs), care coordinators, wellbeing teams, and ‘super practice managers/directors’ with sufficient skills to lead the development and operational management of at-scale primary care organisations.  
As part of, for example, a wider Multispeciality Community Provider (MCP): Secondary care specialists, social care, mental health and community services teams, community pharmacy. |
A number of new roles are appearing in the general practice setting enabling the delivery of high quality care, improved patient experience and improved clinical outcomes. These are additional to what is now considered a core team of GPs, practice nurses and GP nurse practitioners, managers and reception staff. A few examples are provided below to illustrate the functions these new roles are performing and how they are supporting new ways of working both within general practice and across a wider care team.

- **Healthcare assistants (HCA) / clinical assistants**: provide clinical support for GPs to enable them to allocate more time for patients with complex problems.

- **Health and wellbeing coordinators**: enable patients to maintain their health and wellbeing and improve self-management of their condition.

- **Physician associates**: work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, with the supervision of medical practitioners.

- **Care coordinators / navigators**: provide a central coordination role on behalf of the patient, working with their wider care team covering health, social care, voluntary and other local services.

For example, the National Association of Primary Care has joined forces with Health Education England to create a training programme for new Primary Care Navigators (PCN) to support patients with dementia, their carers and families. It is intended that this training will eventually be adapted and used for other long-term conditions.
The table below examines some of these roles and the functions they perform.

<table>
<thead>
<tr>
<th>Function</th>
<th>HCA/ clinical assistant</th>
<th>Health and wellbeing Coordinator</th>
<th>Physician associates</th>
<th>Care coordinator /navigator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic clinical checks and tests incl updating clinical records</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Input to diagnosis and treatment planning</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Refer to secondary care (incl A&amp;E)</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Focuses on acute conditions</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Supports patients with long term conditions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Broader assessment of patients’ own health goals</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Care plan facilitation</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Self-management support</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Health coaching</td>
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</tr>
<tr>
<td>Establishing referral pathways to preventative and wellbeing services and activities</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Multi-agency working</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directs patients to additional sources of support and care – health, social care, voluntary sector</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reports primarily to the named GP – largely practice employed</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reports to the named GP and a wider MDT – largely non practice-based / employed</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Planning the future workforce requirement is always challenging and many organisations, institutions and professional bodies are attempting to do this as they develop their long-term plans. Especially important are HEE and the LETBs who are working with patients, carers and other key stakeholders to explore the workforce challenges and find ways of meeting these challenges. Sharing and utilising existing learning will be pivotal as prototype delivery and education models are being developed and tested across the capital as part of:

- integration pioneer sites
- Prime Minister’s Challenge Fund sites
- LETB development programmes
- Academic Health Science Network (AHSN) primary care development work streams
- Community Education Provider Networks (CEPNs).

In addition, specific LETBs are taking forward programmes to support and enable the workforce.

**Health Education North West London (HENWL)**

Health Education North West London has invested funds to support all staff working in general practice to access continuous professional development courses which are block commissioned from Higher Education Institutes (HEI). £100,000 has been invested so far for 2014-15 and further funds will be added if demand exceeds this figure. The HENWL board has also funded £1.1 million workforce development activity for primary care for 2014-15, distributed via the CCGs to support the workforce transformation and development activity required to enable GP teams to cope with greater levels of demand and complexity as part of the wider system reconfiguration.

A further £1 million has been invested through the *Shaping A Healthier Future* programme to support the development of community learning networks which will be aligned to the whole systems programme in north west London (beginning with initiatives relating to the over 75s population).

As part of the planning work to inform the *Shaping a Healthier Future* service transformation programme, north west London’s (NWL) CCGs commissioned a piece of work called *From Good to Great, a workforce strategy to support out-of-hospital care in north west London* which was published in January 2013. The document explores the need for innovative new roles and has been used to shape some of the thinking about demand for new roles in the future NWL health system.

Following the 2014 workforce and education planning activity, it has been recognised that whilst overall demand for staff groups is reflective of the overall transformation programme, the detailed analysis of specific new roles and changes to skill mix are not clear. HENWL has initiated a series of task and finish

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12 Skills For Care. Principles for Workforce Integration. 2013
15 Greenaway D. Shape of Training: Securing the future of excellent patient care. An independent review of the way we educate and train our doctors. 2013
groups in 2014 to focus on the requirement for new and different roles to inform workforce development investment and future education commissioning decisions. Primary care will be a key focus of this activity.

Health Education South London (HESL)

Health Education South London’s approach to the on-going development of the primary care workforce is twofold, encompassing a short- and long-term view. In the short term, HESL has made a direct Continuing Personal and Professional Development (CPPD) allocation of £1.2 million available for staff working in primary care in both 2013/14 and 2014/15 (a total of £2.4 million over two years). This money has been distributed to CCGs based on weighted capitation. HESL’s Primary Care Forum (PCF) which acts as the advisory group to the HESL Board on matters relating to primary care, recommended that CCGs focus the CPPD money on bands 1-4, practice reception staff, HCAs working in primary care, practice managers and practice nurses. The PCF also noted that the funding could be used for clinical staff where no other allocation was available. In addition to the direct allocation made to CCGs, an indirect allocation of £400,000 was lodged with south London HEIs for practice staff to access. In 2014/15 this indirect allocation was overspent for the first time. In the future, the intention is for the CPPD budget for primary care staff to be allocated to the CEPNs rather than the CCGs and for the CEPNs to coordinate the on-going development needs of their local workforce. The above funding allocations were made in addition to funding for general practice nurse training and mentorship training for nurses working in primary care.

Health Education North Central and East London (HE NCEL)

A key priority for Health Education North Central and East London is to support the development of integrated care, especially across organisational boundaries. Local health economies have been invited to bid for up to £250,000 per borough to support education and training interventions that support integrated care based education. This has resulted in significant conversations and partnership arrangements that have previously not been possible. HE NCEL has engaged primary, community, secondary and social care providers in working together on workforce development opportunities. By the end of 2014, there will be a multi professional educator-led CEPN with cross-boundary engagement in every borough across HE NCEL. It is anticipated that as these CEPNs mature they will support local workforce planning, programme coordination, faculty development, support local workforce continuing professional development, and achievement of relevant HEE mandates. It is hoped they will be able to support both future and current workforce development.

The development of CEPNs is being supported through infrastructure funds and peer group support and is linked to a broader movement taking place across all three LETBs in London and Kent, Surrey and Sussex.

- Additional funding is likely to be provided to support apprenticeships in primary care (including both general practice and community pharmacy).
- A number of projects cross organisational boundaries and have a general practice element. For example, the mental health programme, which has included a successful

A number of initiatives are already in place to deliver prototype education and delivery models; for example CEPNs, which are being developed and tested as collectives or networks of primary and community organisations working collaboratively to enhance educational delivery in local geographical contexts. The LETBs believe that the CEPNs offer an unprecedented opportunity for the development of the primary care workforce including the development of new roles where appropriate. By understanding both the local population and the existing workforce within their geographic areas CEPNs will be able to ascertain the development needs of existing staff and be able to identify the future workforce required to deliver on CCG commissioning intentions. This may include new roles such as care navigators or the use of physician associates in general practice depending on local need.

CEPNs are being used as the mechanism to bring workstreams together within a defined geography. Their work currently includes:

- developing testing and evaluating new roles – with higher education provider involvement
- drawing together feedback from engagement with local stakeholders. Understanding future requirements in relation to preparation, supply and development of the primary care workforce
- exploring how to increase undergraduate and foundation placements for doctors to promote positive experiences of primary care and encourage choice of general practice as a career
- explore ways to provide inter-professional learning opportunities in community settings.

CEPN development must include the fostering of learning organisations in primary and community care. Currently LETBs accredit GP practices for training, and HEIs accredit practices and community providers for nurse and undergraduate medical teaching. Other AHPs are trained in a variety of community placements. However the transformation of primary care service delivery requires a transformation in primary care education and training facilities. In the same way that hospitals educate multidisciplinary teams, all primary care and community care providers could become education providers. CEPNs will be well placed to drive this necessary development as both education managers and education providers to their local professionals, commissioned by LETBs.

It is now important for partners associated with workforce development in London to collaborate to ensure a coordinated approach. This will include:

- working together to analyse future workforce requirements in London
- Leadership development programmes have been commissioned for the broad primary care workforce from the London Leadership Delivery Partnership as well as the Florence Nightingale Nursing Programme. The programmes have been offered to the network of general practice nurses and nurses sitting on governing bodies in north central London.

The enablers Draft

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- working to improve the recruitment and retention of clinical staff
- developing working practices to support the delivery of person-centred integrated care
- representing London’s priorities on national workforce initiatives.

**Technology implications**

Whilst this Framework does not aim to provide a technology blueprint for London, technology and digital health care provision will play an increasingly significant role in general practice service delivery. Technology will be a key enabler to delivering the service specification for proactive, accessible and coordinated care. There is already a considerable spectrum of useful technologies implemented or being implemented across the capital such as those outlined in the National Information Board publication *Personalised Health and Care 2020*. However, uptake of the available technology is varied and existing arrangements for information sharing are currently limited.

In order to best address the needs described in this document, there should be a focus on maximising the use of the technology available; empowering the patient, and ensuring that there is interoperability between systems and across providers.

Primary care teams in the future will need to rely less on co-location, but instead will be able to come together virtually around a patient to design services. This does not need to be using the same type of technology, but ensuring that communication can occur seamlessly across systems will improve teamwork and the patient experience.

People should be empowered with information about their care that: supports them to participate in care planning; helps set personal health goals; and enables them to better manage their own health independently.

New advances in digital healthcare will provide patients with more choice about how they access services and what they access. This will require active promotion of the new access approaches available.

**Technology to enable proactive care**

Proactive care services will be best enabled by the integration of general practice systems with other systems and applications sitting outside of general practice:

- Online wellbeing assessments that identify lifestyle risks and enable people to establish personal goals for staying healthy
- Online resources to support health improvement e.g. apps and information services
- Online communities that enable people to learn and care for each other based on similar experiences of living with, and managing physical, social and psychological challenges.

Existing systems can be used to identify people not making best use of healthcare resources and to reach out to those people not accessing care. Systems can also be enhanced to track patient reported symptoms and investigations, highlighting those at greater risk of, for example, cancer.
Technology to enable access

Providing improved access will require all practices in London to make use of the systems in place for online appointment booking, ordering of repeat prescriptions and giving people access to their care records. These will be provided through a single place for all Londoners via ‘Patients Online’. The evidence on the effectiveness of phone and email appointments is still relatively limited. However in this digital age, they are expected to become the norm and are already provided in many practices in London. Video conferencing may also become more commonplace. Other new systems already in operation in some parts of London, that are likely to become more widespread include:

- telephone triage and email appointment systems
- summary care records
- electronic prescribing service
- e-referral service.

Technology to enable care coordination

Coordinating care requires timely information exchange, across a multidisciplinary team, with patients and their carers. This will require general practice to have interoperable systems with other providers to enable shared management of patient information through an integrated patient-held care record.

Technology to modernise care

In addition to the technologies that will enable delivery of the service specification, there are many other examples of new technologies that are modernising care in general practice settings. Just a few examples include:

- online communities of practitioners, building relationships and sharing knowledge to deliver improved care
- remote monitoring and diagnostic devices, enabling patients to be cared for in the comfort of their own home; and new devices bringing hospital-based diagnostics into the general practitioner’s consulting room
- hand-held care record devices that allow practitioners to bring care away from the computer and alongside the patient and other practitioners.

Technology strategies

The technology available in each part of London varies and future development strategies for technology will need to be arranged in each local area. However there is a need to work together to:

- ensure wider strategic technology objectives relating to primary care are being met (such as those referenced in Personalised Health and Care 2020)
- identify where there may be advantages in implementing some technologies at a greater scale e.g. moving a range of different health, community, mental health and social care providers to a common interoperable system
• agree, across commissioners and providers, key design principles for future technology to enable patient-centred coordinated care and information exchange across organisational boundaries

• encourage the uptake of best practice. These groups will also encourage the uptake of best practice in the use of technologies and this is also reflected in the new approach of the CQC.

The technology changes required to deliver this specification are well supported by the ambitious plans of the National Information Board in their publication *Personalised Health and Care 2020*, which lays out a timeline of technology improvements from now to 2020.

### Estates

As evidenced in the recent London Health Commission report *Better Health for London*, the quality of the general practice estate is highly variable and there is a real challenge to improve it. This means poor patient experiences, poor working conditions for London GPs and lost opportunities to improve health and healthcare. In order to deliver the *Framework*, it is expected that modern, state of the art facilities will be required. It is likely that general practice will need to transition out of the existing estate gradually as investment is made in more modern buildings.

### Overview Timeline of NIB Framework Milestones

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>By March 2015</td>
<td>Proposals will have been set out to extend and enhance the MyNHS service on NHS Choices.</td>
</tr>
<tr>
<td>From March 2015</td>
<td>All citizens to have access to their GP records online.</td>
</tr>
<tr>
<td>From April 2015</td>
<td>Mandatory use of NHS number as primary identifier in clinical correspondence and for identifying all patient activity.</td>
</tr>
<tr>
<td>By June 2015</td>
<td>The HSCIC will develop proposals with industry for personal data usage reporting.</td>
</tr>
<tr>
<td>By September 2015</td>
<td>Proposals to be published for linking 111 with NHS Choices.</td>
</tr>
<tr>
<td>By October 2015</td>
<td>HSCIC, CQC, Monitor and NHS TDA to publish data quality standards for all NHS care providers.</td>
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<tr>
<td>By April 2016</td>
<td>HEE will introduce a new knowledge and skills framework for all levels of the health, care and social care workforce.</td>
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<tr>
<td>By 2018</td>
<td>Clinicians in primary care and other key transitions will be operating without the use of paper records.</td>
</tr>
<tr>
<td>By 2020</td>
<td>All care records will be digital real-time and interoperable.</td>
</tr>
<tr>
<td>From March 2018</td>
<td>All individuals will be able to record their own comments and preferences on their care record.</td>
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</table>
London’s GP practices are largely found in converted residential buildings – many are in poor condition. Many parts of the estate are not fit for the purpose and are underutilised. Better Health for London reported that 34% of premises need to be rebuilt and 44% are in need of repair. Often, even the most basic disabled access requirements are not in place. There are two main causes for this state of affairs: insufficient investment and fragmented decision-making on primary and out-of-hospital estate; and a lack of incentives for GPs to move from existing residential conversions to modern purpose-built facilities.

The NHS does not have any new funding to spend on fixing these problems and therefore must look to address the issues within the system. There are huge opportunities in the current (high value, even if it is in poor condition) estate. The estate could be used for health and care but also for public / social sector use, with the possibility of 550,000 new homes by 2021 and 118,000 new school places by 2016/17.

**Investment required**

Better Health for London set out that approximately £1 billion needs to be invested in the GP estate in London. The commission calculated that this investment, over five years, would secure modern general practice that is accessible to all Londoners.

This scale of investment would represent just 4% of the national NHS capital budget over the next five years, and 26% of London’s share of the national NHS capital budget (assuming it is equally distributed across the country based on population).

It is vital that these investments are led through a partnership of CCGs, NHS England, and local authorities. The opportunity to include wider public services – such as leisure facilities, citizen’s advice, libraries and education – should be explored.

Better Health for London also recommended that NHS England should reform the rent reimbursement system for GP premises, increasing incentives for GPs to move to more appropriate premises.

Commissioners across London have welcomed the Better Health for London recommendation on estates and are currently formulating their response.

**Provider development requirements**

GP provider development is fundamental to the success of primary care transformation in London and the implementation of the Framework. The strategic direction is ambitious, and the operational changes, working routines and learning needs are significant.

General practice teams and their health and care partners need to be supported in owning the new vision for primary care and be clear about the benefits it will deliver. This will require focused support and interventions so that general practice teams can co-develop solutions to the new operational requirements. There will be many attributes and behaviours to nurture in general practice, but the roles of effective leadership and collaboration are fundamental. Development and support programmes and activities should be flexible, tailored and provide practical support to a range of professionals across general practices. The intra- and inter-organisational development needs should not be underestimated, to ensure change happens.
The following diagram, provided by South West London Collaborative Commissioning partnership, identifies GP provider development requirements.

There is not a natural forum in London to bring together and support system change leaders to transform primary care. London would greatly benefit from an agreed forum for commissioners, providers and lead partners such as local authorities and the voluntary sector to share innovation and learning about transforming primary care.

London’s NHS should set out a strategic and comprehensive approach to building system capacity and capability for change in partnership with London and national partners. This should include a phased plan mapped to a development journey of emerging organisations which can respond to their evolving development needs over time.

Potential GP provider development requirements

**Individuals**
- Leadership for change
- Project management
- Peer support and buddying
- Supporting portfolio careers
- Secondments
- Mentoring and coaching
- Integrated working – care planning and case management
- Academia and research
- Undergraduate teaching and GP training

**System support**
- Workforce planning
- Modelling, forecasting and evidence-based decision making
- Overarching governance and accountability framework
- Building relationships with secondary care, mental health services, voluntary sector
- Health promotion and prevention service / role development
- Inter-organisational development across the full range of health and social care organisations

**Intra-organisational**
- Intra-organisational development
- IT training and informatics
- Fostering innovation
- Commercial awareness and development
- Collaborative working
- Decision support

**Inter-organisational**
- Workforce capacity development and management
- Strategic planning
- Legal support / contracting
- Quality improvement methodology
- Consultancy support
- Developing commissioning / procurement / commercial acumen
- Governance
- Inter-organisational development for networked leadership

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The enablers
Monitoring and evaluation

Providers and commissioners will be able to consider progress across the capital through a monitoring and evaluation framework. This will have a dual purpose:

A: Information to enable provider development

- To provide tools that support continuous improvement of general practice in both service delivery and health outcomes
- To enable peer learning and development across a wider geographical population

1. Practices complete an **individual** assessment (how am I doing?) then a **collective** assessment (how are we doing when we consider the network/group together). This can be used for best practice sharing and development discussions

2. This can be triangulated with other evaluations and outcome data (CQC, GP outcome standards, high level indicators, GPES, staff survey)

3. Additional process measures may be agreed and monitored locally as required for improvement

4. Practices across London will be encouraged to share innovative and successful approaches to improvement via learning networks

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**Self-Assessment** | **Impact** | **Monitoring** | **Learning**

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B: Information to provide commissioning assurance

- To demonstrate value for money from new investments
- To provide information on delivery, learning and impact; evidencing change and improvement

1. The collective assessment will require the support of local HealthWatch and H&WBB.

2. These will be triangulated with CQC evidence and inspection output, GP outcomes standards, high level indicators, and GPES to evaluate impact

3. A small number of ‘proxy markers’ will signal that things are improving. Sample visited or asked to share more detail on improvement work underway.

4. Practices across London will be encouraged to share approaches to leverage improvements at pace

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**Self-Assessment** | **Impact** | **Monitoring** | **Learning**

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The approach will encourage progression towards at-scale primary care organisations (in their various forms). The Framework will monitor improvements at both individual practice and at grouped practice/wider population levels. This approach to monitoring and evaluation work supports integrated care and practices working together on quality improvement at a population level. The direct impact that general practice developments have on population health and wider system activity are difficult to isolate from wider system changes. It is therefore important, in developing co-commissioning arrangements, to look towards monitoring the impact of whole systems on population health outcomes (this will be complemented by the work of the CQC in this area) as well as patient enablement and person-centred care and changes in overall activity.

Sources of information

General practices in London are already subject to considerable monitoring and assurance controls. The approach taken will use existing datasets and collection processes in order to minimise additional administrative burden on practices. Information will be drawn from CQC assessments, GP outcome standards, high level indicators, QOF and the national GP patient experience survey; forming a picture of progress to deliver the new service specification. In addition the following will be considered:

- An extension of the annual self – declaration used by practices to provide assurance of contractual delivery. This would include an appraisal of progress to deliver the new service specification (unless a suitable alternative approach is available through CQC).
- A small number of ‘proxy markers’ identified from existing data sets that provide additional assurance that improvements are having an impact. These act as a signal to undertake further enquiry and evaluation where measures are inconsistent with information provided through self-declarations.
- Refreshed national GP Patient Experience Survey to reflect changes in the patient offer (the national team is considering ways in which the survey can reflect different models of care across the country).
- A new survey of working lives to monitor the impact of these changes on staff.

The self-assessment tool

As described above, the annual self-declaration could be extended to include an online self-assessment tool. This would form the basis of a self-appraisal that can be undertaken by general practice teams, assured by people working with each practice and shared as a tool for enhanced development. The self-assessment tool will be designed in collaboration with various stakeholders in order to ensure this provides an appropriate reflection of progress and outcomes. The business intelligence team at NHS England (London) will establish a monitoring and evaluation reference group in order to ensure this work continues to align with, and not duplicate, the approach being undertaken by the CQC. An updated CQC assessment framework was published in October 2014. The design group will review this and may conclude that the
CQC evaluation is sufficiently comprehensive and that a new self-assessment tool is not required. The reference group will finalise an approach with the aim to have monitoring tools and processes in place as implementation begins.

Keeping Londoners informed of service changes

NHS Choices provides patients with a single online portal through which they can access information about services provided through general practice. Patients will be keen to know whether services are improving in their local area and what service changes are being planned, including any changes to access arrangements. NHS England (London) and CCGs working with local providers will need to ensure any service changes are well communicated and explained through both NHS Choices and other methods.
This Framework outlines a specification for general practice which aims to transform primary care. It also provides an analysis of the supporting work required to do this.

It is by definition a framework, as its purpose is to provide guidance for commissioners when making strategic plans and decisions on primary care, and outlines how the vision of a transformed service can be achieved. It represents a new consistent patient offer for all Londoners. However this document is not intended to provide the solution for how these changes are delivered throughout London as local plans are expected to be built on top of this foundation.

In November 2014 this document will be shared with CCGs in London prior to a period of local engagement (expected to be December 2014 – April 2015). This engagement will be conducted with health and wellbeing boards, local authorities and the CQC, as well as the public and member practices. This will help to develop deeper understanding of how the vision and specification can and should be delivered in local areas, including consideration of the fit with wider local plans. During the engagement period, consideration of how the specification will be delivered over a five year period will be discussed and agreed for each local area.

The ambitions outlined in this document will continue to be developed by CCGs and NHS England based on the findings of the engagement and continued consideration of key areas such as finance and workforce. An update outlining progress made on delivery plans in each local area is expected to be released in April 2015.

Investment and development of primary care transformation as described in this document is expected to start from April 2015. Although elements of the specification are already being delivered in some parts of London, in order to realise the vision of high quality general practice for everyone, it is expected to require a long term commitment from all commissioners of health and care in London.
Appendix 1: Governance board members

The below list indicates the membership of the transformation, clinical and delivery group boards as of November 2014. Please note – the patient board members are not included here to protect identities.

Our thanks go out to all board members, past and present.

Primary Care Transformation Board:

Co-Chairs:
- Dr Anne Rainsberry, Regional Director, NHS England (London Region)
- Dr Marc Rowland, Chair of the London Clinical Commissioning Council; Chair, Lewisham Clinical Commissioning Group

Members:
- Dr Sanjiv Ahluwalia, Primary Care Lead, Health Education North Central and East London
- Shahed Ahmed, Director of Public Health, London Borough of Enfield
- Ronke Akerele, Director of Programmes, Change & Performance Management, Imperial College Health Partners
- Caroline Alexander, Chief Nurse, Nursing Directorate, NHS England (London Region)
- Jane Barnacle, Director of Patients & Information, NHS England (London Region)
- Paul Bennett, Area Director for North Central and East London, NHS England (London Region)
- Alison Blair, Chief Officer, NHS Islington Clinical Commissioning Group
- Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group
- Eleanor Brown, Chief Officer, NHS Merton Clinical Commissioning Group
- Dr Charles Bruce, Managing Director, Health Education North West London
- Prof Adrian Bull, Managing Director, Academic Health Science Network, Imperial College Health Partners
- Helen Bullers, Director of HR & OD, NHS England (London Region)
- Conor Burke, Chief Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups
- Helen Cameron, Director of Transformation, NHS England (London Region)
- Karen Clinton, Head of Primary Care Commissioning (NW London), NHS England (London Region)
- Dr Nav Chana, Chair of the Proactive Care Expert Panel; Chairman NAPC; Joint Director of Education Quality for Health Education South London
- Sir Cyril Chantler, Board Member, London Health Board
- Dr Tom Coffey, Chair of the Accessible Care Expert Panel; Co-Clinical Lead for Urgent & Emergency Care, London Region
- Ged Curran, Chief Executive Merton Council; London Chief Executive Lead on Adult Services
- Dr Charlie Davie, Director of the Academic Health Science Network, UCL Partners
- Dr Michelle Drage, Chief Executive, Londonwide Local Medical Committee
- Dr Sam Everington, GP; Chair, NHS Tower Hamlets Clinical Commissioning Group
- Dr Clare Etherington, Head of Primary Care Education and Training, Health Education North West London
- Andrew Eyres, Chair of London Chief Officers Group; Chief Officer, NHS Lambeth Clinical Commissioning Group
- Prof Sir David Fish, Academic Health Science Network, UCL Partners
- Prof Chris Fowler, Managing Director, Health Education North Central and East London
- Professor Howard Freeman, previous Chair, London Clinical Commissioning Council
- Dr Clare Gerada, Clinical Chair, Primary Care Transformation, NHS England (London)
- Jemma Gilbert, Head of Primary Care Transformation, NHS England (London Region)
- Steve Gilvin, Chief Officer, NHS Newham Clinical Commissioning Group
- Claire Goodchild, Chief Officer, London Health Board
- Terry Huff, Chief Officer, NHS Waltham Forest Clinical Commissioning Group
- Aurea Jones, Director of Workforce, Health Education South London
- Zoe Lelliott, Director of Strategy and Performance, Health Innovation Network, South London
- Paula Lloyd-Knight, Head of Patient and Public Voice, NHS England (London Region)
- Dr Andy Mitchell, Medical Director, Medical Directorate, NHS England (London Region)
• Neil Roberts, Head of Primary Care Commissioning (North Central and East London) NHS England (London Region)
• Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)
• Dr Rebecca Rosen, Chair of the Co-ordinated Care Expert Panel; GP Board Member, NHS Greenwich Clinical Commissioning Group; Senior Fellow Nuffield Trust
• Thirza Sawtell, Director of Strategy and Transformation, NHS North West London Collaboration of Clinical Commissioning Groups
• Dr Kanesh Rajani, London GP; Governing Body Member, NHS Harrow Clinical Commissioning Group
• Stuart Saw, Head of Financial Strategy, NHS England (London Region)
• Grainne Siggins, Director, Adults Social Care, London Borough of Newham
• David Slegg, Director of Finance, NHS England (London Region)
• Dr Chris Streather, Managing Director, Academic Health Science Network, South London
• David Sturgeon, Head of Primary Care Commissioning (South London), NHS England (London Region)
• Dawn Wakeling, Director, Adults and Community, London Borough of Barnet
• Simon Weldon, Director of Operations and Delivery, NHS England (London Region)
• 3 x patient representatives

Primary Care Transformation Patient Board:
Co-Chairs:
• Jane Clegg, Director of Nursing, NHS England (London Region)
• 1 x patient representative

Members:
• 24 x patient representatives

Primary Care Transformation Clinical Board:
Chair:
• Dr Clare Gerada, Clinical Chair, Primary Care Transformation, NHS England (London)

Members:
• Sheila Adam, Chief Nurse and Director of Governance, Honorary Professor of Nursing Leadership, Homerton University Hospital NHS Foundation Trust
• Eileen Bryant, Nursing Advisor, NHS England (London Region)
• Tony Carson, Pharmacy Advisor, NHS England (London Region)
• Dr Nav Chana, Chair of the Proactive Care Expert Panel; Chairman NAPC; Joint Director of Education Quality for Health Education South London
• Jane Clegg, Director of Nursing, NHS England (London Region); Co-Chair, Primary Care Transformation Patient Board
• Dr Tom Coffey, Chair of the Accessible Care Expert Panel; Co-Clinical Lead for Urgent and Emergency Care, London Region
• Sarah Didymus, Independent Nurse Practitioner; Darzi Fellow in Community Nursing
• Dr Murray Ellender, Liberty Bridge Road Practice, Newham
• Dr Angelo Fernandes, Assistant Clinical Chair, NHS Croydon Clinical Commissioning Group
• David Finch, Medical Director (NW), NHS England (London Region)
• Dr Jane Fryer, Medical Director (South), NHS England (London Region)
• Jemma Gilbert, Head of Primary Care Transformation, NHS England (London Region)
• Dr Jonty Heaversedge, Clinical Chair, NHS Southwark Clinical Commissioning Group
• Dr Isobel Hodkinson, Principal Clinical Lead, NHS Tower Hamlets Clinical Commissioning Group; RCGP Clinical Champion for Person-centred Care and Support Planning
• Dr Sian Howell, PM Challenge Pilot representative; NHS Southwark Clinical Commissioning Group and Bermondsey and Landsdowne Medical Centre
• Dr Jagan John, PM Challenge Pilot representative; NHS Barking and Dagenham Clinical Commissioning Group  
• Dr Nicola Jones, Clinical Chair, NHS Wandsworth Clinical Commissioning Group  
• Dr Alex Lewis, Medical Director and Director of Quality (Mental Health), Central and North West London NHS Foundation Trust  
• Dr Steven Mowle, Board Member, RCGP South London, NHS Lambeth Clinical Commissioning Group  
• Maria O’Brien, Divisional Director, Central and North West London NHS Foundation Trust  
• Dr Tony O’Sullivan, Community Paediatrician, Lewisham and Greenwich NHS Trust  
• Terry Parkin, Director of Children’s Services, London Borough of Bromley  
• Dr Mohini Parmar, PM Challenge Pilot representative; Clinical Chair, NHS Ealing Clinical Commissioning Group  
• Virginia Patania, Practice Manager, Jubilee Street Practice, East London  
• Dr Niraj Patel, GP partner, Thamesmead Medical Associates; Visiting Fellow in Health Policy, The Nuffield Trust; Executive Member, NAPC  
• Dr Arup Paul, Locum GP, Medical Director at HCML  
• Dr Julian Redhead, Consultant in Emergency Medicine and Clinical Programme, Director for Medicine, Imperial College Healthcare NHS Trust  
• Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)  
• Dr Rebecca Rosen, Chair of the Co-ordinated Care Expert Panel; GP Board Member, NHS Greenwich Clinical Commissioning Group; Senior Fellow Nuffield Trust  
• Dr Tina Sajjanhar, Consultant Paediatrician, Lewisham and Greenwich NHS Trust  
• Dr John Sanfey, Appraisal & Revalidation Lead, North West London Area Team, NHS England (London Region); Freelance Chambers GP  
• Grainne Siggins, Director of Adult Services, London Borough of Newham  
• Ashi Soni, NHS Lambeth Clinical Commissioning Group; Royal Pharmaceutical Society Board Member  
• Dr Mark Spencer, Deputy Regional Medical Director, NHS England (London Region)  
• Karen Stubbs, Project Director, First4Health Federation  
• Fiona White, NHS Merton Clinical Commissioning Group  
• Dawn Wakeling, Adults and Communities Director, London Borough of Barnet  
• Jane Wells, Adult Community Services Director, Oxleas NHS Foundation Trust  
• 1 x patient representative

Primary Care Transformation Delivery Group:  
Chair:  
• Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)

Members (those not included in Transformation Board):  
• Carl Edmonds, Deputy Director of Delivery, NHS Waltham Forest Clinical Commissioning Groups  
• Olivia Farnesy, Communications Manager, NHS England (London Region)  
• Delvir Mehet, Deputy Head of Commissioning and System Development – OD, NHS England (London Region)  
• Ginny Morley, Assistant Director, South West London Collaborative Commissioning Group  
• Andrew Parker, Director of Primary Care Development, NHS Southwark Clinical Commissioning Group  
• Mike Part, Head of Strategic Systems and Technology, NHS England (London Region)  
• Paul Price-Whelan, Senior Financial Strategy Accountant, NHS England (London Region)  
• Katie Robinson, Head of Analytical Services, NHS England (London Region)  
• Sarah See, Programme Director, Primary Care Improvement, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups  
• Philip Spivey, Regional Head of HR, NHS England (London Region)  
• Matthew Walker, Programme OfficeLead, NHS North West London Collaboration of Clinical Commissioning Groups  
• Gary Williams, Senior Manager, Analytical Services, NHS England (London Region)
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<td>Integrated Personal Commissioning</td>
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<td>London-wide Local Medical Committee</td>
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<td>Monitor</td>
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<td>NAPC</td>
<td>National Association of Primary Care</td>
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<td>NHS IQ</td>
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</tr>
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<td>NHS TDA</td>
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<td>Primary Care Navigator</td>
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<td>Patient Participation Group</td>
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<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention Scheme</td>
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<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<td>RCGP</td>
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<td>SPG</td>
<td>Strategic Planning Group</td>
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<td>SWLCC</td>
<td>South West London Collaborative Commissioning partnership</td>
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<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
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Integrated Performance Report
M8 2014/15
22 January 2015
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1. Structure of the Document

The report is written to enable the CCG to review the key domains of finance, QIPP, performance, quality and safety in an assimilated format. The purpose of reporting in this way is to support the CCG’s committees in their consideration of the current status of the above domains as well as the interdependencies between them.

The report focuses on the current status of all key domains of quality & safety; finance & QIPP; and performance. It is structured to focus on the performance of the CCG but additionally provides a comprehensive overview of the range of indicators used to assess our main provider organisations: King’s College Hospital NHS Foundation Trust, Guy’s & St. Thomas’ NHS Foundation Trust (including community health services) and South London & Maudsley NHS Foundation Trust.

Performance dashboards are included in sections 2, 3 and 4 to provide a high-level overview of all performance domains, highlighting where performance is reported to have hit or exceeded target (green rated); where there is some variance from plan (amber rated) or where there is significant variance from plan (red rated). Dashboards are included for the CCG and for the four providers noted above.

Performance and quality and safety indicator trackers are included in section 5 to provide on-going monitoring of key indicators. Section 5 now also includes a quality and safety table which monitors King’s and Guy’s performance against indicators used in Sir Bruce Keogh’s review into hospital mortality outliers in 2013.

In Section 6, the report focuses in detail on those areas that are shown on the dashboards as having deviated from target. The tables included in Section 6 set out a description of these performance issues and include details of the forums the CCG uses to monitor and address these issues. Section 7 presents a finance summary.

A glossary of all the performance indicators referred to in this report can be found in Section 8. The indicator definitions and targets have been taken from the Department of Health’s Technical Guidance for the 2012/13 Operating Framework and the NHS Commissioning Boards Everyone Counts: Planning for Patients 2013/14 Technical Definitions document. Definitions for locally agreed targets have been taken from provider contract agreements.

The data and information included in the Integrated Performance Report is sourced from provider contract monitoring and finance reports, CCG QIPP and finance reports and provider quality, safety and performance reports. The reporting period included varies as some reports are quarterly and others monthly, although the data included in this report is as follows unless otherwise stated in the report:

**Table 1: Integrated Performance Report Data Sources and Period Covered**

<table>
<thead>
<tr>
<th>Data</th>
<th>Source</th>
<th>Period Covered</th>
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<td>Quality &amp; Safety</td>
<td>Trust Quality &amp; Safety reports</td>
<td>Q2 2014/15</td>
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<td>SLCSU Acute Int Performance Report</td>
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<tr>
<td></td>
<td>Community Contract Report</td>
<td>Q2</td>
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<td>SLaM Quality &amp; Safety Report</td>
<td>Q2</td>
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<td>Serious Incidents Reports</td>
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<td>CCG Finance Report</td>
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<td></td>
<td>SLaM Finance Report</td>
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<td>Performance Indicators &amp; Targets</td>
<td>SLCSU Acute Int Performance Report</td>
<td>M6</td>
</tr>
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<td>SLCSU Performance Report</td>
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2. Southwark CCG and Providers Performance Summary Dashboard

### NHS Southwark CCG

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<th>Amber-rated</th>
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<tbody>
<tr>
<td>National Standards</td>
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### King’s College Hospital Trust

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<td>Performance*</td>
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<tr>
<td>Quality and Safety (Q2)*</td>
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*Not including the PRUH site

### Guy’s & St Thomas’ Foundation Trust

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### Guy’s & St Thomas’ Community Health Services

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### South London & Maudsley Mental Health Trust

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*Note: not all indicators in the dashboards have been allocated target thresholds*
3. Southwark CCG Dashboard (M6)

Amber and red-rated issues are reviewed in further detail in Section 6.

### Finance

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<tr>
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<th>M1</th>
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<th>M3</th>
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<th>M6</th>
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<th>M8</th>
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<th>M10</th>
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<td>625</td>
<td>658</td>
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<td>1,493</td>
<td>1,991</td>
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<td>2,988</td>
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### Performance

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<th>M4 14/15</th>
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<th>M6 14/15</th>
<th>Target</th>
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<td>84.0%</td>
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<td>90%</td>
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<td>RTT non admitted</td>
<td>96.7%</td>
<td>96.4%</td>
<td>95.7%</td>
<td>95%</td>
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<td>RTT Incm. Path</td>
<td>92.5%</td>
<td>92.3%</td>
<td>92.6%</td>
<td>92%</td>
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<td>S2 weeks long waiters</td>
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<td>9</td>
<td>4</td>
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<td>A&amp;E Waits</td>
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<td>93.2%</td>
<td>92.6%</td>
<td>95%</td>
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<tr>
<td>Diag. wait &gt;6w</td>
<td>1.10%</td>
<td>2.16%</td>
<td>1.97%</td>
<td>1%</td>
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<td>MRSA</td>
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<td>0</td>
<td>0-14/15</td>
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<td>C Diff (ytd)</td>
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<td>30</td>
<td>42-14/15</td>
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<td>Cancer 2 yr</td>
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<td>98.8%</td>
<td>98.6%</td>
<td>93%</td>
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<td>Cancer 62 days</td>
<td>90.1%</td>
<td>96.4%</td>
<td>93.9%</td>
<td>85%</td>
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<td>Cancer 31 day</td>
<td>94.8%</td>
<td>96.4%</td>
<td>98.6%</td>
<td>96%</td>
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<td>MSA</td>
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<td>Amb. Resp 8 min</td>
<td>70.3%</td>
<td>68.7%</td>
<td>61.9%</td>
<td>75%</td>
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<tr>
<th>Quarterly Targets</th>
<th>Q4 13/14</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q2 target; 1.395</th>
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</thead>
<tbody>
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<td>IAPT - % receiving - Quarterly</td>
<td>9.5%</td>
<td>9.9%</td>
<td>7.9%</td>
<td>Annual: 15%</td>
</tr>
<tr>
<td>IAPT - % receiving - YTD (cumulative)</td>
<td>10.8%</td>
<td>10.9%</td>
<td>7.9%</td>
<td>Q2 target: 1.395</td>
</tr>
<tr>
<td>IAPT - number receiving</td>
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<td>1,645</td>
<td>1,672</td>
<td>50%</td>
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<tr>
<td>IAPT - % moving to recovery</td>
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<td>CPA 7 day follow up</td>
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<td>99.0%</td>
<td>97.1%</td>
<td>95%</td>
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<td>Dementia diag rate</td>
<td>57.6%</td>
<td>54.5%</td>
<td>57.6%</td>
<td>M6: 59.1%</td>
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<table>
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<th>Public Health Targets</th>
<th>Q2 13/14</th>
<th>Q3 13/14</th>
<th>Q4 13/14</th>
<th>Q1 14/15</th>
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<td>402</td>
<td>500</td>
<td>464</td>
</tr>
<tr>
<td>% offered Health Checks</td>
<td>5.9%</td>
<td>13.0%</td>
<td>8.4%</td>
<td>8.1%</td>
<td>Q1 - 5%</td>
</tr>
<tr>
<td>% offered received</td>
<td>52.2%</td>
<td>14.6%</td>
<td>43.4%</td>
<td>57.0%</td>
<td>50%</td>
</tr>
</tbody>
</table>
4. Provider Dashboards (M6 Performance Q2 Quality & Safety)

a. King’s College Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Quality &amp; Safety</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality - SMI</td>
<td>Q3 13/14</td>
</tr>
<tr>
<td>SIs - Notified Inc NeIs (All CCGs)</td>
<td>Q3 13/14</td>
</tr>
<tr>
<td>Complaints (Denmark Hill)</td>
<td>Q3 13/14</td>
</tr>
<tr>
<td>Child safeguarding training</td>
<td>Level 1</td>
</tr>
<tr>
<td>Pressure Ulcers - Denmark Hill</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Falls - Denmark Hill</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

**Notified Serious Incidents Q2 14/15**
1759/NEIs reported in Q2 14/15 (0 Southwark patients) compared to 22 in Q1 14/15 (8 Southwark patients).

1 serious fall, 6 hospital acquired and avoidable pressure ulcers grades 3 or 4.

<table>
<thead>
<tr>
<th>Performance</th>
<th>Month 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Targets</td>
<td>M4 14/15</td>
</tr>
<tr>
<td>RTT Admitted</td>
<td>78.7%</td>
</tr>
<tr>
<td>RTT Non-admitted</td>
<td>96.4%</td>
</tr>
<tr>
<td>RTT Incomp. Path</td>
<td>92.1%</td>
</tr>
<tr>
<td>S2 weeks long waiters</td>
<td>42</td>
</tr>
<tr>
<td>A&amp;E Waits Denmark Hill</td>
<td>32.6%</td>
</tr>
<tr>
<td>A&amp;E Waits Trust-wide</td>
<td>90.6%</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>C DIFF (YTD) - Denmark Hill</td>
<td>27</td>
</tr>
<tr>
<td>MSA</td>
<td>1</td>
</tr>
<tr>
<td>Cancer 2 wk</td>
<td>32.6%</td>
</tr>
<tr>
<td>Cancer 62 days</td>
<td>81.5%</td>
</tr>
<tr>
<td>Cancer 31 days</td>
<td>98.1%</td>
</tr>
<tr>
<td>Diag. Waits &gt;6w - Den. Hill</td>
<td>1.08%</td>
</tr>
<tr>
<td>Amb. Waits &gt;60 min - Den. Hill</td>
<td>17</td>
</tr>
<tr>
<td>Amb. Waits &gt;60 min - PRUH</td>
<td>34.7%</td>
</tr>
<tr>
<td>Amb. HAS Comp - Denmark H</td>
<td>95.3%</td>
</tr>
<tr>
<td>Amb. HAS Comp - PRUH</td>
<td>90.2%</td>
</tr>
<tr>
<td>Last minute cancelled ops</td>
<td>463</td>
</tr>
<tr>
<td>Cancellations 26 days</td>
<td>67</td>
</tr>
<tr>
<td>VTE Assessments</td>
<td>98.6%</td>
</tr>
<tr>
<td>Red shifts</td>
<td>102</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
</tr>
<tr>
<td>Complaints</td>
<td>2</td>
</tr>
<tr>
<td>Births/midwife</td>
<td></td>
</tr>
<tr>
<td>Total C-section</td>
<td>127.5%</td>
</tr>
<tr>
<td>Bookings[11] weeks (un-adjusted)</td>
<td>76.3%</td>
</tr>
<tr>
<td>Friends &amp; Family</td>
<td></td>
</tr>
<tr>
<td>Denmark Hill A&amp;E Resp rate</td>
<td>24.7%</td>
</tr>
<tr>
<td>Denmark Hill A&amp;E score</td>
<td>44</td>
</tr>
<tr>
<td>Denmark Hill Input Resp rate</td>
<td>50%</td>
</tr>
<tr>
<td>Denmark Hill Input score</td>
<td>66</td>
</tr>
<tr>
<td>Denmark Hill Antenatal score</td>
<td>100</td>
</tr>
<tr>
<td>Denmark Hill Birth score</td>
<td>86</td>
</tr>
<tr>
<td>Denmark Hill Birth Resp rate</td>
<td>12.5%</td>
</tr>
<tr>
<td>Denmark Hill Postnatal score</td>
<td>45</td>
</tr>
<tr>
<td>Trust wide Postnatal Comm</td>
<td>75</td>
</tr>
</tbody>
</table>

* The FTI score is no longer measured using the net promoter score and is now measured by the proportion of patients recommending and not recommending the service.
b. Guy’s & St. Thomas’ NHS Foundation Trust

<table>
<thead>
<tr>
<th>Quality &amp; Safety</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality - SHMI</td>
<td>Q3 13/14</td>
</tr>
<tr>
<td>0.78</td>
<td>0.61</td>
</tr>
<tr>
<td>Slips - notified Inc NEs (SWK only)</td>
<td>5</td>
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<tr>
<td>Complaints</td>
<td>204</td>
</tr>
<tr>
<td>Child safeguarding training</td>
<td>Level 1</td>
</tr>
<tr>
<td>Level 2</td>
<td>87%</td>
</tr>
<tr>
<td>Level 3</td>
<td>84%</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>Grade 2</td>
</tr>
<tr>
<td>Grade 3</td>
<td>21</td>
</tr>
<tr>
<td>Grade 4</td>
<td>4</td>
</tr>
<tr>
<td>Falls</td>
<td>Moderate</td>
</tr>
<tr>
<td>Major</td>
<td>10</td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
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</table>

Notified Serious Incidents Q2 14/15
There were 4 slips in Q2 2014/15 compared to 5 in Q1 2014/15.
1 was a pressure ulcer grade 3 and 3 were falls.

Performance

<table>
<thead>
<tr>
<th>National Targets</th>
<th>Month 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Admitted</td>
<td>M4 14/15</td>
</tr>
<tr>
<td>RTT Non-admitted</td>
<td>89.2%</td>
</tr>
<tr>
<td>RTT Incomp. Path</td>
<td>95.0%</td>
</tr>
<tr>
<td>S2 weeks long waiters</td>
<td>92.3%</td>
</tr>
<tr>
<td>A&amp;E Waits</td>
<td>96.1%</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>C Diff (YTD)</td>
<td>24</td>
</tr>
<tr>
<td>NSA</td>
<td>4</td>
</tr>
<tr>
<td>Cancer 2 wk</td>
<td>97.3%</td>
</tr>
<tr>
<td>Cancer 62 days</td>
<td>75.2%</td>
</tr>
<tr>
<td>Cancer 31 days</td>
<td>96.7%</td>
</tr>
<tr>
<td>Diag. Waits &gt;6w</td>
<td>1.8%</td>
</tr>
<tr>
<td>Amb. Waits &gt;60 min</td>
<td>0</td>
</tr>
<tr>
<td>Amb. HAD Comp</td>
<td>92.3%</td>
</tr>
<tr>
<td>Last minute cancelled ops</td>
<td>175</td>
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<tr>
<td>Cancell. ops 28 days</td>
<td>8</td>
</tr>
<tr>
<td>VTE Assessments</td>
<td>96.0%</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
</tr>
<tr>
<td>Complaints</td>
<td>6</td>
</tr>
<tr>
<td>Births/midwife (annualised)</td>
<td>31</td>
</tr>
<tr>
<td>Total C-section</td>
<td>32.0%</td>
</tr>
<tr>
<td>Bookings 13 weeks (adjusted)</td>
<td>109.3%</td>
</tr>
<tr>
<td>Friends &amp; Family</td>
<td></td>
</tr>
<tr>
<td>St Thomas’ A&amp;E Resp rate</td>
<td>12.7%</td>
</tr>
<tr>
<td>St Thomas’ A&amp;E score</td>
<td>41</td>
</tr>
<tr>
<td>St Thomas’ Inpatient Resp rate</td>
<td>35.1%</td>
</tr>
<tr>
<td>St Thomas’ Inpatient score</td>
<td>79</td>
</tr>
<tr>
<td>Guy’s Inpatient Resp rate</td>
<td>31.4%</td>
</tr>
<tr>
<td>Guy’s Inpatient score</td>
<td>76</td>
</tr>
<tr>
<td>St. Thomas’ Antenatal score</td>
<td>58</td>
</tr>
<tr>
<td>St. Thomas’ Birth score</td>
<td>57</td>
</tr>
<tr>
<td>St. Thomas’ Birth Resp rate</td>
<td>23.5%</td>
</tr>
<tr>
<td>St. Thomas’ Postnatal score</td>
<td>36</td>
</tr>
<tr>
<td>Trust wide Postnatal Comm</td>
<td>83</td>
</tr>
</tbody>
</table>

* The FIT score is no longer measured using the net promoter score and is now measured by the proportion of patients recommending and not recommending the service.
### Quality & Safety

<table>
<thead>
<tr>
<th>Quality &amp; Safety</th>
<th>Q1 13/14</th>
<th>Q2 13/14</th>
<th>Q3 13/14</th>
<th>Q4 13/14</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Incidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of Medicines</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult safeguarding training</td>
<td>90%</td>
<td>91%</td>
<td>90%</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>Safeguarding adults &amp; children</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Transition care plans</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Dressings</td>
<td></td>
<td></td>
<td>48%</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Pts with learning disabilities</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Public and Pt Engagement</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>End of life care</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
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</table>

### CQUINs

<table>
<thead>
<tr>
<th>CQUINs</th>
<th>Quarter 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Time Patient Experience Care Planning</td>
<td>Q1 14/15</td>
</tr>
</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>Performance</th>
<th>Month 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Children’s</td>
<td></td>
</tr>
<tr>
<td>% New Birth Visits Within 14 days</td>
<td>M1 14/15</td>
</tr>
<tr>
<td>% Contacts Outcomed</td>
<td>94.2%</td>
</tr>
<tr>
<td>% Staff Appraisals Undertaken</td>
<td>68.0%</td>
</tr>
<tr>
<td>Substantive Fill Rate - Clinical Posts</td>
<td>94.3%</td>
</tr>
</tbody>
</table>

### Community Children’s Quarterly Target

| % Infants Breast-Feeding at 6-8 Weeks | Q1 14/15 | ≥75% |

### Community Adults

| Community Adults                      | M1 14/15 | M2 14/15 |         |
| AA - Caseload Management new referrals In Mnth | 21       | 22       | 130     |
| AA&AD - @Home Average Caseload         | 32       | 21       | 40      |
| AA&AD - ERR Average Caseload           | 104      | 104      | TBC     |
| % DN Referral to Patient Contract Within 24 hrs | 37.30%   | 37.40%   | ≥95%    |
| % Contacts Outcomed                    | 93.5%    | 94.4%    | ≥95%    |
| % Staff Appraisals Undertaken          | 72.7%    | 66.2%    | ≥95%    |
| Substantive Fill Rate - Clinical Posts | 73.6%    | 72.9%    | ≥92%    |

### AA - Admission Avoidance

### AD - Advanced Discharge


### Performance

<table>
<thead>
<tr>
<th>National Targets</th>
<th>M4 14/15</th>
<th>M5 14/15</th>
<th>M6 14/15</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT - % receiving - Monthly</td>
<td>1.5%</td>
<td>1.03%</td>
<td>1.44%</td>
<td>1.1%</td>
</tr>
<tr>
<td>IAPT - % receiving - YTD</td>
<td>5.44%</td>
<td>6.47%</td>
<td>7.91%</td>
<td>M6: 465</td>
</tr>
<tr>
<td>IAPT - number receiving</td>
<td>677</td>
<td>432</td>
<td>635</td>
<td>M6: 59.1%</td>
</tr>
<tr>
<td>IAPT - % moving to recovery</td>
<td>99.1%</td>
<td>98.8%</td>
<td>95.1%</td>
<td>M6: 98.3%</td>
</tr>
<tr>
<td>Dementia diag rate</td>
<td>54.3%</td>
<td>55.8%</td>
<td>57.6%</td>
<td>TBC</td>
</tr>
<tr>
<td>Assertive Outreach</td>
<td>904</td>
<td>928</td>
<td>958</td>
<td>TBC</td>
</tr>
<tr>
<td>Home Treatment episodes (YTD)</td>
<td>774 Q4</td>
<td>140 Q1</td>
<td>288 Q2</td>
<td>TBC</td>
</tr>
<tr>
<td>Employment assessments - AMH</td>
<td>94% Q4</td>
<td>92% Q1</td>
<td>92% Q2</td>
<td>95%</td>
</tr>
</tbody>
</table>

### NHS Standard Contract

<table>
<thead>
<tr>
<th>Target</th>
<th>M4 14/15</th>
<th>M5 14/15</th>
<th>M6 14/15</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Discharge Letter - AMH</td>
<td>95.0%</td>
<td>96.0%</td>
<td>96.0%</td>
<td>95%</td>
</tr>
<tr>
<td>Discharge Letter - MHOA</td>
<td>100.0%</td>
<td>100.0%</td>
<td>75.0%</td>
<td>95%</td>
</tr>
<tr>
<td>A&amp;E breaches (4 hour wait)</td>
<td>18</td>
<td>13</td>
<td>2</td>
<td>&lt;4</td>
</tr>
<tr>
<td>A&amp;E breaches (6 hour wait)</td>
<td>20</td>
<td>16</td>
<td>20</td>
<td>&lt;11</td>
</tr>
<tr>
<td>Percentage of delayed discharges AMH</td>
<td>2%</td>
<td>1%</td>
<td>4%</td>
<td>&lt;7.5%</td>
</tr>
<tr>
<td>Percentage of delayed discharges MHOA</td>
<td>2%</td>
<td>8.2%</td>
<td>15.2%</td>
<td>&lt;7.5%</td>
</tr>
</tbody>
</table>

### Quarterly targets

<table>
<thead>
<tr>
<th>Q1 13/14</th>
<th>Q1 14/15</th>
<th>Q1 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Nutrition Screen - AMH</td>
<td>79%</td>
<td>85%</td>
</tr>
<tr>
<td>Inpatient Nutrition Screen - MHOA</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>CAMHS starting treatment &lt; 12 weeks</td>
<td>86%</td>
<td>84%</td>
</tr>
</tbody>
</table>

### Locally Agreed Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>M4 14/15</th>
<th>M5 14/15</th>
<th>M6 14/15</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA care plan - AMH</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Physical Health Checks - AMH</td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Gate kept - AMH</td>
<td>50%</td>
<td>100%</td>
<td>98%</td>
<td>95%</td>
</tr>
<tr>
<td>New patients offered HIV test - AMH</td>
<td>25%</td>
<td>25%</td>
<td>40%</td>
<td>30%</td>
</tr>
</tbody>
</table>

1. Physical Health - Severe Mental Illness
2. a) PBR - Red rules
3. b) PBR - Overdue assessments
3. Recovery
4. Discharge Documentation

### Quality & Safety

<table>
<thead>
<tr>
<th>Sls - notified Inc NEs (SWK only)</th>
<th>Q3 13/14</th>
<th>Q4 13/14</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints (SWK only)</td>
<td>15</td>
<td>14</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Adult safeguarding training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMH</td>
<td>76%</td>
<td>74%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>CAMHS</td>
<td>88%</td>
<td>88%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>MHOA</td>
<td>91%</td>
<td>88%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 2</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Grade 4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Notified Serious Incidents Q2 14/15

There were 2 Sls reported in Q2 14/15 and in Q1 14/15.
5. Performance and Quality and Safety Trackers
a. Monthly Performance Tracker

The best possible outcomes for Southwark people

10 | P a g e


### b. Quarterly Quality and Safety Tracker

<table>
<thead>
<tr>
<th>Quality and Safety</th>
<th>Organisation</th>
<th>Q1 11/14</th>
<th>Q4 11/14</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious incidents (notified) including never events</td>
<td>GST (Swk only)</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>KCH (all CCGs)</td>
<td>40</td>
<td>31</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>SLAM (Swk only)</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>GSTCH (Swk only)</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Mixed-sex accommodation</td>
<td>GST</td>
<td>0</td>
<td>4</td>
<td>10</td>
<td>5</td>
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<tr>
<td></td>
<td>KCH</td>
<td>211</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pressure ulcers (grade 2-4)*</td>
<td>GST</td>
<td>13 (G2 = 10 and G3 = 3)</td>
<td>15 (G2=11 and G3 = 4) Jan-Feb</td>
<td>3 (G2=3)</td>
<td>5 (G2=3)</td>
</tr>
<tr>
<td></td>
<td>KCH</td>
<td>38 (G2 = 11; G3 = 5; G4 = 2)</td>
<td>64 (G2=58; G3=5; G4=1)</td>
<td>3 (G2 = 4)</td>
<td>1 (G2 = 4)</td>
</tr>
<tr>
<td></td>
<td>SLAM</td>
<td>4 (G2 = 4)</td>
<td>G3=0 and G4=0 for Swk only</td>
<td>3 (G2 = 3)</td>
<td>G3=0 and G4=0 (SWK only)</td>
</tr>
<tr>
<td></td>
<td>GSTCH</td>
<td>0</td>
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<tr>
<td>Child safeguarding training Level 1</td>
<td>GST</td>
<td>97%</td>
<td>97%</td>
<td>93%</td>
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</tr>
<tr>
<td></td>
<td>KCH</td>
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<td>GSTCH</td>
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</tr>
<tr>
<td>Child safeguarding training Level 2</td>
<td>GST</td>
<td>87%</td>
<td>85%</td>
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</tr>
<tr>
<td></td>
<td>KCH</td>
<td></td>
<td>75%</td>
<td>77%</td>
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<tr>
<td></td>
<td>GSTCH</td>
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<td></td>
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<tr>
<td>Child safeguarding training Level 3</td>
<td>GST</td>
<td>84%</td>
<td>83%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>KCH</td>
<td></td>
<td>78%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GSTCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult safeguarding training (85%)</td>
<td>GSTCH</td>
<td>90%</td>
<td>87%</td>
<td>89% GST Trust wide</td>
<td></td>
</tr>
<tr>
<td>Complaints</td>
<td>GST</td>
<td>208</td>
<td>248</td>
<td>164</td>
<td>205</td>
</tr>
<tr>
<td></td>
<td>KCH</td>
<td>182</td>
<td>227</td>
<td>166</td>
<td>203</td>
</tr>
<tr>
<td>Falls (moderate to death)**</td>
<td>GST</td>
<td>3 major Oct - Nov</td>
<td>11 major</td>
<td>1 fracture (SWK only)</td>
<td>3 major (SWK only)</td>
</tr>
<tr>
<td></td>
<td>KCH</td>
<td>5 moderate</td>
<td>4 moderate and 3 major</td>
<td>1 major</td>
<td>1 major</td>
</tr>
<tr>
<td>7 day follow-up CPA service users</td>
<td>SLAM</td>
<td>98.2%</td>
<td>98.3%</td>
<td>99.0%</td>
<td>97.1%</td>
</tr>
<tr>
<td>IAPT - entered treatment</td>
<td>SLAM</td>
<td>2.9%</td>
<td>2.9%</td>
<td>3.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>IAPT - moving to recovery</td>
<td>SLAM</td>
<td>35.4%</td>
<td>41.3%</td>
<td>36.2%</td>
<td>37.8%</td>
</tr>
<tr>
<td>Dementia screening (Q1 - 55.1%)</td>
<td>SLAM</td>
<td>58.4%</td>
<td>57.8%</td>
<td>54.9%</td>
<td>57.6%</td>
</tr>
<tr>
<td>% offered Health Checks (20% annual)</td>
<td>SLAM</td>
<td>13.0%</td>
<td>8.4%</td>
<td>8.1%</td>
<td></td>
</tr>
<tr>
<td>% received (50% 14/15)</td>
<td>SCGG</td>
<td>13.6%</td>
<td>43.4%</td>
<td>37.0%</td>
<td></td>
</tr>
</tbody>
</table>

* RAG rating for pressure ulcers: G2 - no rating; G3 - amber; G4 - red
** RAG rating for falls: moderate - no ratings; major - amber; death - red
### c. Quality & Safety Dashboard – Keogh Indicators

<table>
<thead>
<tr>
<th>Category</th>
<th>King's Greenville St Thomas</th>
<th>GSTT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
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<tr>
<td>Cancer survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEAT: Privacy and dignity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaints about clinical aspects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ombudsman’s rating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEAT: Environment</td>
<td></td>
<td></td>
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<tr>
<td>PEAT: Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends and Family test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient voice comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Num. of harm incidents 'moderate, severe or death'</td>
<td>King's Greenville St Thomas</td>
<td>GSTT</td>
</tr>
<tr>
<td>Number of never events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting of patient safety incidents</td>
<td>King's Greenville St Thomas</td>
<td>GSTT</td>
</tr>
<tr>
<td>Medication errors</td>
<td></td>
<td></td>
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<tr>
<td>MRSA</td>
<td></td>
<td></td>
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<tr>
<td>C.diff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Harm’ for all four safety thermometer indicators</td>
<td>King's Greenville St Thomas</td>
<td>GSTT</td>
</tr>
<tr>
<td>Clinical negligence scheme payments</td>
<td>King's Greenville St Thomas</td>
<td>GSTT</td>
</tr>
<tr>
<td>Rule 43 coroner reports</td>
<td></td>
<td></td>
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<tr>
<td><strong>Workforce</strong></td>
<td></td>
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</tr>
<tr>
<td>WTE nurses per bed day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spells per WTE staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacancies – medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacancies – Non medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant appraisal rates</td>
<td></td>
<td></td>
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<tr>
<td>Agency usage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness absence – Overall</td>
<td></td>
<td></td>
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<tr>
<td>Sickness absence – Medical</td>
<td></td>
<td></td>
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<tr>
<td>Sickness absence – Nursing Staff</td>
<td></td>
<td></td>
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<tr>
<td>Sickness absence – Other staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff leaving rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff joining rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal – women receiving steroids</td>
<td>King's Greenville St Thomas</td>
<td>GSTT</td>
</tr>
<tr>
<td>Adult critical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes safety/effectiveness</td>
<td></td>
<td></td>
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<tr>
<td>PROMs safety/effectiveness</td>
<td></td>
<td></td>
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<tr>
<td>Joints revision ratio</td>
<td></td>
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<tr>
<td>Coronary Angioplasty</td>
<td></td>
<td></td>
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<tr>
<td>Peripheral vascular surgery</td>
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<tr>
<td>Carotid interventions</td>
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<tr>
<td>Acute MI</td>
<td></td>
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<tr>
<td>Acute stroke</td>
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</tr>
<tr>
<td>Heart failure</td>
<td></td>
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<tr>
<td>Lung cancer</td>
<td></td>
<td></td>
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<tr>
<td>Bowel cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip Fracture – mortality</td>
<td></td>
<td></td>
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<tr>
<td>Severe trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective surgery</td>
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<td></td>
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<tr>
<td><strong>Operational Effectiveness</strong></td>
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<td>RTT waiting times</td>
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<tr>
<td>Emergency readmissions</td>
<td></td>
<td></td>
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<tr>
<td>Cancer waits</td>
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<tr>
<td>A&amp;E waits</td>
<td></td>
<td></td>
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<tr>
<td>Cancelled operations</td>
<td></td>
<td></td>
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<tr>
<td>PDR Coding Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Leadership &amp; Governance</strong></td>
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<td></td>
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<tr>
<td>Changes to the Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of incidents reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality identified as a risk to quality</td>
<td>King's Greenville St Thomas</td>
<td>GSTT</td>
</tr>
<tr>
<td>Monitor Governance rating</td>
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<td></td>
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<tr>
<td>Monitor Financial Rating</td>
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<tr>
<td>CQC outcomes</td>
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</table>
6. Performance Variance and Assurance Information

The table below includes all key red- and amber-rated performance, quality & safety and financial domains included in the above dashboards. The table states the domain concerned, provides a synopsis of the matter arising and includes details of the forum in which the issue is addressed and monitored. This table is provided as a comprehensive overview and it is anticipated that CCG commissioners and committees should direct detailed questions to commissioning leads and and/or further reference the South East London Integrated Performance Reports or the reports listed in Section 1.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Synopsis of Issue</th>
<th>Current Status</th>
<th>SCCG</th>
<th>GST</th>
<th>KCH</th>
<th>GSTCS</th>
<th>SLaM</th>
<th>Forum Issue is Addressed</th>
<th>Date</th>
<th>Responsible CCG Officer and CCG Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
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<td></td>
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</tr>
</tbody>
</table>
| Financial over-performance | • Acute over-performance for M7 was -£1,273k.  
• Likely YEP of -£2,479k (M7 report).  
• See finance report in appendix 1. | YTD (M7) Position Acute -£1,273k | ✓    | ✓   | ✓   |       |      | KCH Acute Contract Monitoring Meeting | 3 December | Dr Jonty Heaversedge, Paul Jenkins, Gwen Kennedy and SLCSU Acute Contracting Team |
| Performance & Quality | KCH (Denmark Hill): Refer to the highlight report for more detail | KCH Den. Hill 93.9%  
KCH 90.9% (M6)  
Target 95% |       |     |     |       |      |      | KCH Acute Contract Monitoring Meeting | 3 December | Dr Jonty Heaversedge, Tamsin Hooton and SLCSU Acute Contracting Team |
<table>
<thead>
<tr>
<th>Issue</th>
<th>Synopsis of Issue</th>
<th>Current Status</th>
<th>SCCG</th>
<th>GST</th>
<th>KCH</th>
<th>GSTC</th>
<th>SLaM</th>
<th>Forum Issue is Addressed</th>
<th>Date</th>
<th>Responsible CCG Officer and CCG Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT admitted</td>
<td>Refer to the highlight report for more detail</td>
<td>SCCG 81.1%  KCH 75.0%  GST 84.9% (M6)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td></td>
<td>KCH Acute Contract Monitoring Meeting</td>
<td>3 December</td>
<td>Dr Jonty Heaversedge, Paul Jenkins and SLCSU Acute Contracting Team</td>
</tr>
<tr>
<td></td>
<td>SCCG</td>
<td>Admitted performance for Southwark CCG patients has been below the 90% target since July 2013.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>KCH</td>
<td>A planned failure of the admitted performance target on a monthly basis is expected to support backlog clearance.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>The trust is using a combination of outsourcing to private providers and additional elective capacity on the PRUH and Orpington sites. The trust is transferring some existing orthopaedic waiters, subject to patient agreement, to GST for treatment.</td>
<td></td>
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<tr>
<td></td>
<td>Progress against trajectory</td>
<td>Backlog reduced to 1,350 in October 2014 and is above trajectory.</td>
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<tr>
<td></td>
<td>GST</td>
<td>Both GST and KCH are implementing additional national RTT monies from July - November to further clear long waiting patients, this has resulted in a dip in performance at GST over the period.</td>
<td></td>
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<tr>
<td>Non admitted</td>
<td>GST</td>
<td>Non admitted performance at GST was 94.1% which was under the target of 95%.</td>
<td>GST 94.1% (M6)</td>
<td></td>
<td></td>
<td></td>
<td>GST Acute Contract Monitoring Meeting</td>
<td>5 December</td>
<td>Paul Jenkins and SLCSU Acute Contracting Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commissioners have agreed a planned failure against the RTT non-admitted target up to November to allow the trust to increase its outpatient activity.</td>
<td>Target 95%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Issue</td>
<td>Synopsis of Issue</td>
<td>Current Status</td>
<td>SCCG</td>
<td>GST</td>
<td>KCH</td>
<td>GSTCS</td>
<td>SLaM</td>
<td>Forum Issue is Addressed</td>
<td>Date</td>
<td>Responsible CCG Officer and CCG Clinical Lead</td>
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</tr>
</tbody>
</table>
| 52 weeks long waiters | Refer to the highlight report for more detail  
SCCG  
- There were four Southwark patients waiting more than 52 weeks on incomplete pathways in M6; five less than in M5.  
KCH  
- There were 37 patients waiting more than 52 weeks on incomplete pathways in M6 compared to 79 in M5.  
- The trust keeps long waiters under regular clinical review to ensure there is no clinical risk to patients.  
- The CCG applies a contractual financial penalty each month for patients still waiting over 52 weeks. This has been implemented since April 2013 in line with national arrangements. | | SCCG 4  
KCH 37  
GST 2 (M6)  
Target 0 | ✓ | ✓ | ✓ | KCH Acute Contract Monitoring Meeting | 3 December | Dr Jonty Heaversedge, Paul Jenkins and SLCSU Acute Contracting Team |
| Cancelled Operations – 28 days | KCH  
- The number of cancelled operations (28 days) at KCH has reduced significantly in Q2 2014/15 to 64 from 92 in Q1 2014/15.  
- The Trust has been a national outlier for cancelled operations.  
- The number of cancelled operations is symptomatic of the on-going bed capacity and emergency admissions pressures at the trust.  
GST  
- The number of cancelled operations (28 days) at GST has also reduced in Q2 2014/15 to 7 from 8 in Q1 2014/15. | | KCH 64  
GST 7 (Q2)  
Target 0 | | | KCH Acute Contract Monitoring Meeting | 3 December | Dr Jonty Heaversedge, Paul Jenkins and SLCSU Acute Contracting Team |
| Cancer 31 days – First definitive | GST  
- Performance was 94.6% in September, slightly under the target of 96%.  
- Performance for Q2 was above target at 96.2. | | GST 94.6% (M6)  
Target 96% | ✓ | | GST Acute Contract Monitoring Meeting | 5 December | Paul Jenkins and SLCSU Acute Contracting Team |
<table>
<thead>
<tr>
<th>Issue</th>
<th>synopsis of issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 62 days – GP referral</td>
<td>Refer to the highlight report for more detail</td>
</tr>
<tr>
<td>GST</td>
<td>• Performance has improved from 73.2% in M5 to 76.4% in M6.</td>
</tr>
<tr>
<td></td>
<td>• 62 day pathway performance at GST is associated with receipt of tertiary</td>
</tr>
<tr>
<td></td>
<td>referrals as well as some patients with pathways within the trust.</td>
</tr>
<tr>
<td>KCH</td>
<td>• Trust wide performance deteriorated from 81.4% in M5 to 79.2% in M6,</td>
</tr>
<tr>
<td></td>
<td>however performance at Denmark Hill was above target at 89.4% in M6.</td>
</tr>
<tr>
<td>8 Minute Ambulance Response Time</td>
<td>Refer to the highlight report for more detail</td>
</tr>
<tr>
<td>SCCG</td>
<td>• 8 minute ambulance response time performance has reduced again to 61.9% in</td>
</tr>
<tr>
<td></td>
<td>M6.</td>
</tr>
<tr>
<td></td>
<td>• Under performance has resulted partially from the continuing reduction in</td>
</tr>
<tr>
<td></td>
<td>capacity (vacancies), but also due to the significant reduction in the ability</td>
</tr>
<tr>
<td></td>
<td>for the trust to secure temporary resources to fill the capacity gap.</td>
</tr>
<tr>
<td></td>
<td>• Through the winter funding allocations, central funding has been made available</td>
</tr>
<tr>
<td></td>
<td>to support both local schemes and pan London initiatives to improve responsiveness,</td>
</tr>
<tr>
<td></td>
<td>appropriate conveyances and top-line performance</td>
</tr>
<tr>
<td>FFT – A&amp;E Response rates</td>
<td>GST • The A&amp;E response rate has been below the 15% target since July.</td>
</tr>
<tr>
<td></td>
<td>• The trust has highlighted that if response rates do not improve the trust may</td>
</tr>
<tr>
<td></td>
<td>fail the Q4 CQUIN target and lose the associated income.</td>
</tr>
<tr>
<td></td>
<td>• A new receptionist has now been recruited which should improve performance.</td>
</tr>
<tr>
<td></td>
<td>• The trust introduced an interactive text messaging system to capture feedback</td>
</tr>
<tr>
<td></td>
<td>from 1 October to boost response rates</td>
</tr>
<tr>
<td>Mixed sex accommodation</td>
<td>GST • There were three breaches in M6</td>
</tr>
<tr>
<td></td>
<td>• This was due to delayed step down from critical care.</td>
</tr>
<tr>
<td></td>
<td>• Although guidance from NHSE has stated that trusts do not have to submit this</td>
</tr>
<tr>
<td></td>
<td>type of MSA breach to unify, GST have continued reporting these patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Status</th>
<th>SCCG</th>
<th>GST</th>
<th>KCH</th>
<th>GSTCS</th>
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<th>Forum Issue is Addressed</th>
<th>Date</th>
<th>Responsible CCG Officer and CCG Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCCG 61.9%</td>
<td></td>
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<td></td>
<td>Urgent Care Working Group Meeting</td>
<td>-</td>
<td>Paul Jenkins</td>
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<tr>
<td>GST 76.4%</td>
<td>KCH 79.2%</td>
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<td>GST Acute Contract Monitoring Meeting</td>
<td>5 December</td>
<td>Dr Jonty Heaversedge, Paul Jenkins and SLCSU Acute Contracting Team</td>
</tr>
<tr>
<td>GST 5.1%</td>
<td>(M6)</td>
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<td>GST CQRG Meeting</td>
<td>18 December</td>
<td>Jacquie Foster</td>
</tr>
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<td>GST 3</td>
<td>(M6)</td>
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<td>GST Acute Contract Monitoring Meeting</td>
<td>5 December</td>
<td>Paul Jenkins and SLCSU Acute Contracting Team</td>
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<td>Target 85%</td>
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<td>Target 75%</td>
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<td>Target 15%</td>
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<td>Target 0</td>
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<tr>
<td>Issue</td>
<td>Synopsis of Issue</td>
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<td>SCCG</td>
<td>GST</td>
<td>KCH</td>
<td>GSTCS</td>
<td>SLaM</td>
<td>Forum Issue is Addressed</td>
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<tr>
<td>HCAIs — C.diff</td>
<td>Refer to the highlight report for more detail</td>
<td>GST 5 (M6)</td>
<td>✔</td>
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<td>GST CQRG Meeting</td>
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<td></td>
<td>GST</td>
<td>• The trust recorded five C.diff cases in M6 which was above the target of three. • An external review was undertaken by Public Health England on 7 August. The report made some recommendations for improvement that are currently being considered.</td>
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<tr>
<td>Falls</td>
<td>KCH Denmark Hill all CCGs</td>
<td>KCH DH 1 major GST 3 fractures (Q2 14/15) Target 0</td>
<td></td>
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<td></td>
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<td>KCH Safer Care Forum</td>
</tr>
<tr>
<td></td>
<td>• There was one fall that resulted in major injury in Q2 2014/15. This was reviewed at the Safer Care Forum on 15 September and action plans will be reviewed in December. • The trust has rolled out beds which can be lowered to the ground across high risk wards. The trust has also laid out crash mats around beds in high risk wards.</td>
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<td>GST Southwark only</td>
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<td></td>
<td>• There were 3 falls that resulted in a fracture in Q2 14/15 for Southwark patients. • Lambeth CCG will be leading the review of these incidents. • The trust is focusing improvement on high risk areas; Acute Medicine; Cardiovascular &amp; Haematology &amp; Oncology. • The trust is trying to reduce incidence by introducing a new falls pathway.</td>
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<td>GST Serious Incident Committee (fall resulting in death) and the joint GST acute and Community Health Services CQRG (falls resulting in major injury)</td>
<td>18 December</td>
</tr>
<tr>
<td></td>
<td>Pressure ulcers</td>
<td>KCH 4 x G3 GST 1 x G3 (Q1 14/15) Target 0</td>
<td></td>
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<td></td>
<td>KCH Safer Care Forum</td>
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<tr>
<td></td>
<td>KCH Denmark Hill all CCGs</td>
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<td></td>
<td>• There were four grade 3 pressure ulcers reported in Q2 2014/15, one more than in Q1 2014/15. • The trust have a number of improvement plans including; introducing tissue viability champions; improving staff training and improving documentation.</td>
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<td></td>
<td>• There was one grade 3 pressure ulcer reported in Q2 2014/15 for Southwark patients. • Lambeth CCG will be leading the review of this incident. • Weekly meetings with risk and TVN team take place to establish cause where attributable and if avoidable.</td>
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<td>GST Serious Incident Committee and the joint GST acute and Community Health Services CQRG</td>
<td>18 December</td>
</tr>
<tr>
<td>Issue</td>
<td>Synopsis of Issue</td>
<td>Current Status</td>
<td>SCCG</td>
<td>GST</td>
<td>KCH</td>
<td>GSTCS</td>
<td>SlaM</td>
<td>Forum Issue is Addressed</td>
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</table>
| KCH Denmark Hill all CCGs | There were two grade 4 pressure ulcers reported in Q2 2014/15, the same number reported in Q1 2014/15. These will be reviewed at the November Safer Care Forum.  
  The trust is trying to reduce incidence by using memory foam backed braces to ensure patients can be turned. The trust is also trialling a pressure ulcers passport; a buddying system which involves pairing permanent staff with agency staff to train agency staff to escalate concerns; and implementing preventative measures in low risk wards. | KCH DH  
  2 x G4  
  (Q2 14/15)  
  Target 0 | | | | | | | |
| Diagnostic waits > 6 weeks | Refer to the highlight report for more detail  
  GST  
  Diagnostic waits performance has increased at GST from 3.54% in M5 to 3.85% in M6.  
  Endoscopy accounts for the majority of the patients waiting over 6 weeks. Plans are in place to reduce the waiting time for special BRAVO endoscopy tests and also sleep studies for children.  
  KCH  
  Performance at Denmark Hill has improved from 1.71% in M5 to 1.42% M6. | GST 3.85%  
  SCCG 1.97%  
  (M6)  
  Target <1%  
  KCH DH  
  1.42%  
  (M6)  
  Target <1% | | | | GST Acute Contract Monitoring Meeting  
  KCH Acute Contract Monitoring Meeting | 5 December  
  3 December | Dr Jonty Heaversedge, Paul Jenkins and SLCSU Acute Contracting Team |
| IAPT – Moving to Recovery | Refer to the highlight report for more detail  
  Moving to recovery  
  Note: There have been a greater number of high intensity patients being seen by the IAPT service.  
  The recovery rate has reduced from 38.8% in M5 to 35.1% in M6.  
  The service has recently started to treat more patients with LTCs - this cohort is complex and difficult to treat. The CCG is exploring how to improve recovery rates for this cohort through its quality meetings with the provider. | SLaM 35.1%  
  (M6)  
  Target 50% | | | | | | 27 November | Paul Jenkins |
<table>
<thead>
<tr>
<th>Issue</th>
<th>Synopsis of Issue</th>
<th>Current Status</th>
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<th>GST</th>
<th>KCH</th>
<th>GSTCS</th>
<th>SLaM</th>
<th>Forum Issue is Addressed</th>
<th>Date</th>
<th>Responsible CCG Officer and CCG Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia diagnosis rate</td>
<td>Refer to the highlight report for more detail</td>
<td>SLaM 57.6% (M6) Target 59.1%</td>
<td>✓</td>
<td>MHOA Sub Group meeting</td>
<td>27 November</td>
<td>Paul Jenkins</td>
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<td></td>
<td>SLaM</td>
<td>The dementia diagnosis rate against expected prevalence was 57.6% in M6 against a target of 60.5%.</td>
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<td>Some of the diagnoses made by the Southwark and Lambeth Memory Service (SLMS) in 2014/15 have not currently been added to the Southwark dementia register.</td>
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<td>27 patients were removed from the Southwark dementia register when a care home contract was transferred from a Southwark practice to a Lambeth practice.</td>
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<tr>
<td>A&amp;E breaches</td>
<td>There were 20 x 6 hour breaches trust wide in M6. Two Southwark patients waited over 6 hours.</td>
<td>SLaM 20 x 6 hours (M6) Target &lt;11</td>
<td>✓</td>
<td>Urgent Care Mental Health Sub Group meeting</td>
<td>24 November</td>
<td>Paul Jenkins</td>
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<td>Funds that had been committed to fund additional consultant cover have now been made re-current.</td>
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<td>The mental health team have spent time visiting and observing the A&amp;E department.</td>
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<td>Commissioners will be picking up issues of breaches in A&amp;E and ED at the Urgent Care MH Sub Group meeting on Monday 24th November.</td>
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<tr>
<td>Employment Assessments - AMH</td>
<td>Performance for Q2 was 92% against a target of 95%.</td>
<td>SLaM 92% (Q2) Target 95%</td>
<td>✓</td>
<td>SLaM QIPP and Core Contract Meeting</td>
<td>27 November</td>
<td>Paul Jenkins</td>
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<td>The AMH CAG has reviewed the data and has identified that there are recording issues related to the completion of the Recovery and Support Plans and the Summary of Need forms which meant that some assessments which are completed have not been recorded.</td>
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<td>The CAG is undergoing a data check with teams which will be completed by 15 December so that data issues are resolved – this is expected to feed through into reporting in January and February 2015.</td>
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<td>This will be monitored via Pathway performance meetings to ensure the data check is complete and thereafter to ensure performance is maintained</td>
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<tr>
<td>Inpatient nutrition screening</td>
<td>Inpatient nutrition screening was below target for each quarter in 2013/14 and is below target in Q2 2014/15.</td>
<td>AMH 84% (Q2) Target 95%</td>
<td>✓</td>
<td>SLaM QIPP and Core Contract Meeting</td>
<td>27 November</td>
<td>Paul Jenkins</td>
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<td>The Nutrition screens were raised at the Acute Pathway Performance meeting where team managers were to ensure that all current patients have a screen completed by the end of the month (October), where possible screenings are undertaken within 12hrs and 72hrs of admission and weekly auditing is supported by reports on Insight.</td>
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<td>SLaM</td>
<td>Forum Issue is Addressed</td>
<td>Date</td>
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</table>
| Delayed discharge – MHOA | • 15.2% of discharges were delayed for MHOA in Q2 2014/15.  
• SLaM have been working in conjunction with partners in housing / social services and the private care sector to support quicker discharge.  
• SLaM are increasing community support service to care homes to enable them to accept patients who would normally be rejected by those services. This additional support will help move patients out of SLaM wards and cut the length of ward stays. | MHOA 15.2% (Q2) Target <7.5% | ✔ | ✔ | ✔ | ✔ | ✔ | SLaM QIPP and Core Contract Meeting | 27 November | Paul Jenkins |
| CAMHS starting treatment < 12 weeks | • Performance in Q2 has improved from 84% in Q1 to 88%. | SLaM 88% (Q2) Target 90% | ✔ | ✔ | ✔ | ✔ | ✔ | SLaM QIPP and Core Contract Meeting | 27 November | Paul Jenkins |
### 7. Southwark CCG Finance Report (M7)

See Appendix 1 for full M7 Finance Report

<table>
<thead>
<tr>
<th>Budget</th>
<th>Annual Budget (£k)</th>
<th>Variance to Month 7 (£k)</th>
<th>Predicted End of Year (£k)</th>
<th>Best Case F/cast Year End Var'ce (£k)</th>
<th>Worst Case F/cast Year End Var'ce (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>209,842</td>
<td>-1,273</td>
<td>-2,479</td>
<td>-521</td>
<td>-2,949</td>
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<tr>
<td>Client Groups</td>
<td>73,636</td>
<td>760</td>
<td>0</td>
<td>159</td>
<td>-1,500</td>
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<td>Community and Primary Health Services</td>
<td>34,363</td>
<td>64</td>
<td>92</td>
<td>200</td>
<td>0</td>
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<tr>
<td>Prescribing</td>
<td>31,046</td>
<td>151</td>
<td>0</td>
<td>425</td>
<td>-426</td>
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<tr>
<td>Corporate Costs</td>
<td>6,227</td>
<td>140</td>
<td>166</td>
<td>240</td>
<td>66</td>
</tr>
<tr>
<td>Earmarked Budgets and Reserves</td>
<td>15,374</td>
<td>159</td>
<td>2,221</td>
<td>0</td>
<td>4,809</td>
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<tr>
<td>Planned Surplus</td>
<td>5,972</td>
<td>3,484</td>
<td>5,972</td>
<td>5,972</td>
<td>5,972</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>376,460</strong></td>
<td><strong>3,484</strong></td>
<td><strong>5,972</strong></td>
<td><strong>6,475</strong></td>
<td><strong>5,972</strong></td>
</tr>
</tbody>
</table>
8. Glossary of Performance Indicators

52 weeks long waiters (0) - The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period – Acute and SCCG

A&E breaches (4 hour wait) (3/month) - Number of breaches in the A&E 4-hour wait due to mental health services - SLaM

A&E breaches (6 hour wait) (10/month) - Number of breaches in the A&E 6-hour wait due to mental health services - SLaM

A&E waits (95%) - Percentage of patients who spent 4 hours or less in A&E - Acute

Adult safeguarding training (80%) – The proportion of staff who have achieved the required level of adult safeguarding training – All providers

Ambulance HAS compliance (90%) - All acute trusts to ensure that patient handover times are recorded via the Patient Handover Button on the Hospital-based alert system (HAS) for 90% of all hospital turnovers - Acute

Ambulance Response 8 minutes Red 1 (75%) - Presenting conditions that may be immediately life threatening and the most time critical and should receive an emergency response within 8 minutes irrespective of location - SCCG

Ambulance Response 8 minutes Red 2 (75%) - Presenting conditions that may be life threatening but less time critical than Red 1 and should receive an emergency response within 8 minutes irrespective of location - SCCG

Ambulance Response 19 minutes (95%) - Presenting conditions, which may be immediately life threatening and should receive an ambulance response at the scene within 19 minutes irrespective of location in 95% of cases - SCCG

Ambulance wait > 60 minutes (0) - The number of handover delays of longer than 60 minutes - Acute

Assertive Outreach (TBC) - Number of new referrals to the Assertive Outreach service - SLaM

Births/midwife (1:28) – The Royal College of Midwives recommends a ratio for national planning (i.e. based upon expected national birth rate) of 28 births : 1 w.t.e. midwife for hospital births – Acute

Bookings<13 weeks (90%) - The percentage of women who have seen a midwife or a maternity healthcare professional for health and social care assessment of needs, risks and choices before 13 weeks of pregnancy - Acute

KCH figures do not take into account the number of referrals of women who are already more than 13 weeks into their pregnancy.

GST measure their compliance with this target slightly differently to other trusts. They have a target booking number each month based on predicted births in 6 months time and hence if they exceed this target their performance is in excess of 100%. Due to their case mix and referrals of complex cases from elsewhere, this measurement has been agreed.

C Diff (trajectory) - Number of Clostridium difficile infections for patients aged 2 or more on the date the specimen was taken - Acute

CAMHS starting treatment < 12 weeks (90%) - Percentage of looked after children referred to CAMHS services to be assessed and start treatment within 12 weeks of referral - SLaM
CAMHS Transition CPA - % of cases transitioned to AMH with CPA review 6 months prior to 18th birthday - SLaM

CAMHS Transition Planning - % of cases with evidence of transition planning prior to 18th birthday - SLaM

Cancelled Ops 28 days (0) - All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient’s treatment to be funded at the time and hospital of the patient’s choice - Acute

Cancer 2 week GP referral (93%) - Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer - Acute and SCCG

Cancer 2 weeks breast symptoms (93%) - Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected - Acute and SCCG

Cancer 31 days first definitive treatment (96%) - Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from ‘date of decision to treat’) - Acute and SCCG

Cancer 31 days subsequent treatment (drug) (98%) - Percentage of patients receiving subsequent treatment for cancer within 31 days, where that treatment is an Anti-Cancer Drug Regimen - Acute and SCCG

Cancer 31 days subsequent treatment (radiotherapy) (94%) - Percentage of patients receiving subsequent treatment for cancer within 31 days, where that treatment is a Radiotherapy Treatment Course - Acute and SCCG

Cancer 31 days subsequent treatment (surgery) (94%) - Percentage of patients receiving subsequent treatment for cancer within 31 days, where that treatment is a Surgery - Acute and SCCG

Cancer 62 days first definitive treatment by a Consultant (85%) - Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status - Acute and SCCG

Cancer 62 days GP referral (85%) - Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer - Acute and SCCG

Cancer 62 days referral NHS screening (90%) - Percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service - Acute and SCCG

Child safeguarding training (80%) – The proportion of staff who have achieved the required level of children safeguarding training – All providers

Complaints (Trajectory) - Number of new formal complaints received in quarter - All providers

Control of Medicines – The number of medication errors - GSTCH

CPA 7 Day Follow Up (95%) – The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days – SCCG

CPA care plan (95%) – Percentage of patients who have been given their CPA care plan - SLaM

Dementia - Ensure appropriate recording of the needs of people with Dementia referred to community services - GSTCH

Dementia diag rate (1,077 - a proportion of 67% against an expected prevalence of 1607) - Dementia diagnosis rate – SCCG and SLaM
Diagnostic wait > 6 weeks (99%) - The percentage of patients waiting 6 weeks or more for a diagnostic test – Acute and SCCG

Discharge Documentation - This CQUIN applies to the discharge of patients from AMH services (excluding triage), as well as community forensic services, MHOA, CAMHS, and LD to primary care services. The CQUIN measures the % of users whom when being discharged from secondary mental health service have the following documentation sent to their GP within 7 working days of discharge - SLaM

Discharge Letter (95%) - Percentage of patients to which a discharge letter has been sent to their GP within 1 week of discharge - SLaM

Dressings (trajectory) - Adherence to dressings of those prescribed and recommended – GSTCH

Early Intervention (TBC) - Number of new cases of psychosis served by Early Intervention teams - SLaM

Employment assessments (95%) - Percentage of service users on CPA to have an employment assessment - SLaM

End of life care

- To show evidence of co-ordinated End of Life Care by the continued use of the Co-ordinate My Care electronic EOLC register.

- Patients who have chosen to die in their own home should routinely benefit from the sustained quality offered by the Liverpool Care Pathway - GSTCH

Falls (minimal – major falls are amber rated, falls resulting in death are red rated) – Incidence of falls resulting in injury – Acute and GSTCH

Friends & Family - The Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with follow-up questions, can drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by NHS patients and service users.

The test asks the following standardised question: “How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?”

Patients will use a descriptive six-point response scale to answer the questions with the following response categories:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don’t know

The scoring methodology being adopted will be based on the underlying ‘Net Promoter Score’ calculation, which was considered to be the most effective at delivering the benefits of the Friends and Family Test outlined above.

Proportion of respondents who would be extremely likely to recommend (response category: “extremely likely”)

MINUS
Proportion of respondents who would not recommend (response categories: “neither likely nor unlikely”, “unlikely” & “extremely unlikely”).
Gate-kept (TBC) - Percentage of inpatient admissions gate-kept by the crisis resolution / home treatment team - SLaM

Home Treatment Episodes YTD (TBC) - Number of episodes served by Home Treatment teams - SLaM

IAPT % moving to recovery (50%) - The proportion of people who complete treatment who are moving to recovery – SLAM and SCCG

IAPT % receiving (6,289 against 41,929) - The proportion of people entering treatment (target 5,241 annually) against the level of need in the general population (the level of prevalence addressed or 'captured' by referral routes 41,929) – SLAM and SCCG

Inpatient Nutrition Screen (95%) - Percentage of inpatients who have had a full nutrition screen - SLaM

Last Minute Cancelled Ops - Number of last minute cancelled elective operations for non clinical reasons - Acute

Mixed-sex accommodation (0) - All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3 - Acute and SLaM

Mortality - Summary Hospital-level Mortality Indicator (SHMI) (<1)- Gives an indication for each hospital trust in England whether the observed number of deaths within 30 days of discharge from hospital were higher than expected, lower than expected or as expected when compared to the national baseline.

Higher than expected mortality rate > 1
As expected mortality rate = 1
Lower than expected mortality rate < 1

MRSA - Number of cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia - Acute and SCCG

Near Time Patient Experience (TBC) - Replacement of annual patient experience survey with near time patient experience - GSTCH

Never Events (0) - Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

New patients offered HIV test (30%) - Percentage of new patients with the ability to consent that are admitted to AMH and ADD inpatient services offered a HIV test - SLaM

NHS Health Checks offered (20% of eligible population) - Percentage of eligible people who have been offered an NHS Health Check in 2012/13. The Department of Health target stipulated that the Health Check Programme was a five year rolling programme where 20% of the eligible population should be offered a Health Check each year - SCCG

NHS Health Checks received (Locally agreed target of 50%) - Percentage of eligible people that have received an NHS Health Check in 2014/15. This is the proportion of people who received an NHS Health Check from 20% of the eligible population - SCCG

NICE – The number of NICE guidance awaiting response – Acute

Notified Serious Incidents (0) – The total number of Serious Incidents notified to the CCG, a review of the SI investigation report may result in a de-escalation which may therefore result in an adjusted total figure – All providers
**Patient received copy of care plan (95%)** - Percentage of patients who have been given a copy of their CPA care plan - **SLaM**

**Patient Safety Thermometer** –

1. To collect data on pressure ulcers.
2. To develop a service development plan at Q2 outlining the work planned to reduce the number of pressure ulcers and report at Q4 on progress.

**PbR red rules** - Proportion of initial cluster allocations adhering to red rules - **SLaM**

**PbR overdue assessments** - Proportion of open cluster episodes within review period – **SLaM**

**Percentage of delayed discharges (>7.5%)** - Percentage of delayed discharges from inpatient care as per the monitor definition - **SLaM**

**Physical Health Checks (95%)** - Percentage of service users who have been in SLaM hospital/long-term health care for more than one year that have had a physical health check in the last 12 months - **SLaM**

**Pressure Ulcers** (Grade 2 are not rated; Grade 3 are rated amber; Grade 4 are rated red) - Number of pressure ulcers in quarter – **All providers**

**Pts with learning disabilities** - Ensure appropriate treatment of patients with learning difficulties i.e. making reasonable adjustments where necessary and to ensure appropriate recording of the needs of people with learning disabilities referred to community services - **GSTCH**

**Public and Pt Engagement** - To show evidence of involving patients and the public in relation to service delivery including service changes or new service proposals - **GSTCH**

**Recovery** - The Recovery and Support plan is a recovery focussed plan that seeks to place the service user at the centre of the care/support planning process whereby they are supported to define their own goals based on their personal needs and aspirations - **SLaM**

**RTT admitted (90%)** - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis – **Acute and SCCG**

**RTT incomplete pathway (92%)** - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period - **Acute and SCCG**

**RTT non-admitted (95%)** - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period - **Acute and SCCG**

**Safeguarding adults and children** - To ensure that Community services comply with all relevant Safeguarding Acts for both vulnerable adults and children and comply with the Safeguarding policies as detailed in the contract - **GSTCH**

**Smoking cessation training (33%)** - Percentage of relevant inpatient & community staff working at SLaM for over 6 months to have undertaken smoking cessation level 1 training - **SLaM**

**Smoking quitters** – Number of clients of NHS Stop Smoking Services who report that they are not smoking four weeks after setting a quit date – **SCCG**

**Summary care records** - Proportion of patients on CPA where the summary care record has identified gaps in health screening in the last year or the patient is not registered with a GP – **SLaM**
Total C-section (<26% for KCH and < 27% for GST) – Elective and non-elective caesarean sections as a percentage of all births - Acute

Transition care plans - All young people aged 17 have transitional care plans indicating agreed clinical diagnosis and future treatment requirements and that the NHS and Local Authority commissioners are notified of transition patients in line with local protocol - GSTCH

VTE risk assessment (90%) - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool – Acute
# CCG Governing Body

13 November 2014

## ENCLOSURES L-P

**Minutes of CCG Committees**

<table>
<thead>
<tr>
<th>CCG DIRECTOR RESPONSIBLE:</th>
<th>Andrew Bland Chief officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP CLINICAL LEADS RESPONSIBLE:</td>
<td>Dr Jonty Heaversedge</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Various Authors, Southwark CCG</td>
</tr>
<tr>
<td>INVOLVEMENT REQUIRED FROM THE CCG GOVERNING BODY:</td>
<td>Minutes of CCG Committees, sub-boards and groups are provided for information</td>
</tr>
<tr>
<td>SUMMARY:</td>
<td>Minutes of CCG committees are provided for information</td>
</tr>
<tr>
<td>KEY ISSUES</td>
<td>Not applicable</td>
</tr>
<tr>
<td>INVOLVEMENT</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

## RECOMMENDATIONS:

The CCG Governing Body Group is asked to:

Note the minutes included in Enclosures L-P

## CCG DIRECTOR’S CONTACT

Name: Andrew Bland  
E-Mail: andrew.bland@nhs.net

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*Chair: Dr Jonty Heaversedge*  
*Chief Officer: Andrew Bland*
Southwark Integrated Governance & Performance Committee
Minutes of the meeting held on 30 October 2014
Room 132, Tooley Street.

MINUTES

Present:
Robert Park (RP) Lay Member, SCCG – Committee Chair
Malcolm Hines (MH) Chief Financial Officer, SCCG
Kieran Swann (KS) Head of CCG Planning and Assurance, SCCG
Rob McCarthy (RMc) AD Acute Contracting Team, SECSU (items 1-7)
Omar Al-Ramadhani (OA) Planning & Assurance Manager, SCCG
Andrew Bland (AB) Chief Officer, SCCG (items 6-12)
Jacquie Foster (JF) Head of Quality and Organisational Development, SCCG
Paul Jenkins (PJ) Director of Integrated Commissioning, SCCG (items 4-17)
Dr Noel Baxter (NB) Clinical Lead, SCCG
Dr Nancy Küchemann (NK) Clinical Lead, SCCG

In Attendance:
Harprit Lally (HL) Extended Access Programme Manager, SCCG (item 12)

Apologies:
Dr Jonty Heaversedge (JH) Chair, SCCG
Dr Adam Bradford (ABr) Clinical Lead, SCCG
Dr Kate Harvey (KH) Consultant, Lambeth & Southwark Public Health
Sec-Chan Hoong (SCH) Acting Manager, Healthwatch Southwark
Dr Alison Furey (AF) Consultant, Lambeth & Southwark Public Health
Sheetal Mukkamala (SM) Corporate Governance Manager, SCCG
Dr Tushar Sharma (TS) Clinical Lead, SCCG
Dr Richard Gibbs (RG) Lay Member, SCCG
Diane French (DF) Lay Member, SCCG
Harriet Agyepong (HA) Head of Acute Performance Management, SECSU
Catherine Worsfold (CW) Corporate Governance Manager, SCCG
Gwen Kennedy (GK) Director of Quality and Safety, SCCG
Jacques Mizan (JM) Clinical Lead, SCCG
Dr Yvonekke Roe (YR) Clinical Lead, SCCG
<table>
<thead>
<tr>
<th>1.</th>
<th><strong>Introduction and Apologies</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Chair welcomed members and attendees to the meeting. Apologies were noted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.</th>
<th><strong>Declaration of Interest</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All members were asked to declare any conflicts of interests specific to the business on the agenda - none were declared.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.</th>
<th><strong>Minutes of the Previous Meeting</strong></th>
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<tbody>
<tr>
<td></td>
<td>The minutes were noted to be an accurate record.</td>
</tr>
<tr>
<td></td>
<td>Progress made against actions have been recorded in the appended action log.</td>
</tr>
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<tr>
<th>4.</th>
<th><strong>CCG Risk Register &amp; BAF (M6)</strong></th>
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<tbody>
<tr>
<td></td>
<td>KS introduced the report and highlighted that the Board Assurance Framework (BAF) had been revised with a focus on reviewing the descriptions of risk controls and assurances to fully describe the progress of risk management. He highlighted that the BAF had been updated with input from CCG directors and senior managers. The committee welcomed the new format.</td>
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<tr>
<td></td>
<td>KS highlighted that two new risks had been added to the risk register and two risk scores had been de-escalated resulting in six extreme risks for the CCG. The two new extreme risks were; risk to patient safety and care quality from contractual breach of London Ambulance Service (LAS) not achieving performance standards for response rates or hospital handover; and failure to develop a joint strategy for prevention of ill-health, health promotion and well-being.</td>
</tr>
<tr>
<td></td>
<td>MH assured the committee that additional funds were being made available to improve Referral-to-Treatment (RTT) and LAS performance. He highlighted that significant improvements were being seen in A&amp;E performance at Denmark Hill.</td>
</tr>
<tr>
<td></td>
<td>RP asked for more information on how the extreme risk ‘failure to develop a joint strategy for prevention of ill-health, health promotion and well-being’ was being mitigated. JF highlighted that the CCG Senior Management Team (SMT) had discussed developing work matrices for programme boards to ensure that work is joined up and to reduce duplication. KS expressed his concern that the current strategic framework was too broad in its focus and commented that unspecified objectives do not support partner organisations identify their respective and combined contributions to improving health and wellbeing. RP highlighted that a number of senior managers were newly in post and time should be given for them to develop effective working relationships.</td>
</tr>
<tr>
<td></td>
<td>The committee noted the Risk Register &amp; BAF and recommended it to the Governing Body for approval.</td>
</tr>
</tbody>
</table>
### CCG Finance Report (M7)

MH introduced the report and assured the committee that the CCG was on track to meet its annual targets. He updated the committee that King’s College Hospital NHS Foundation Trust (King’s) had received £1.97m tranche 1 winter resilience funding and £4.97m tranche 2 winter resilience funding. He said that there was some financial pressure on acute contracts and the CCG was on track to achieve the required surplus of just under £6m at year end.

MH explained that a provisional year end agreement had been reached with South London and Maudsley NHS Foundation Trust (SLaM) and that sign off on the year end position will be agreed before Christmas and he assured the committee that the CCG was progressing the same set of discussions with King’s and Guy’s and St. Thomas’ NHS Foundation Trust (GSTT). He added that reaching agreement on year end positions on these three contracts would give assurance on around three quarters of the budget.

NB asked for an update on King’s financial position. MH explained that the CCG was considering appropriate financial support for King’s. NK asked how the committee could be assured on the impact of additional funds. MH responded that there are detailed plans about how the trust will use the money.

The committee noted the report and were assured of the CCG’s financial position.

### Acute Contract Demand and Capacity Summary Report (M6)

RMc presented the report and explained that the M6 position showed the same trends as previous months. He explained that as of M6, there was no overspend on King’s and GSTT acute contracts. He highlighted that there was a slight overspend on emergency, however this was partially positive as there had been a large partial delivery of Quality Improvement Productivity Prevention (QIPP).

NB asked what was driving critical care over performance particularly if elective activity had been reducing. RMc explained that it was difficult to predict critical care activity and over performance may have been influenced by emergency activity.

RP asked what was driving the increase in pressure ulcers at King’s. NB assured the committee that a number of improvement plans being taken forward by the trust to reduce incidence. JF added that interventions in some areas of the trust were making a difference.

NK highlighted in the report that a quality alert had been raised regarding the referral process and long waits for bariatric surgery at King’s. She asked what was driving the long waiters. RMc explained that the long waits could be due to general capacity issues which are reflected nationally and he assured the committee that waits are coming down slowly. More information will be brought to the next meeting regarding clock stops – **Action RMc**.

The committee noted the content of the report.
AB provided an update on key performance areas for acute services. For A&E performance he explained that King’s Denmark Hill has improved significantly and is now performing in the top five sites in London. He added that the Princess Royal University Hospital (PRUH) site performance was below the national standards but it had been exceeding the locally agreed trajectory up until 21 September.

On to RTT performance, AB explained that King’s Denmark Hill is aiming to reach a sustainable position to consistently meet the admitted RTT target and eliminate 52 weeks waiters by 1 December by reducing admitted backlog to 1,200. He noted that the trust may have difficulty treating 10-20 long waiters by 1 December.

AB provided an update on diagnostics performance and highlighted that under performance for Southwark patients was being driven mainly by endoscopy at GSTT and paediatrics gastrology at Denmark Hill. He assured the committee that cancer performance for Southwark patients was above target for all main indicators.

JF highlighted that recently GSTT was under-target in some performance areas including admitted RTT. AB explained that a planned failure on RTT performance had been agreed with the trust in the context of backlog clearance that performance shall return to target in December. RMc gave an update on diagnostics at GSTT and explained that waiting lists had increased due to staff leave over the summer which effected endoscopy and non-obstetric ultrasound. He assured the committee that the trust has a trajectory to achieve the 1% target by 1 January, although this was regarded as high risk. NB highlighted that concerns were raised at the recent North Locality Meeting that GSTT about following up endoscopy results. This will be raised and followed up at GSTT CQRG meetings - Action JF. RMc assured the committee that the South East Commissioning Support Unit (SECSU) is closely monitoring performance at GSTT.

PJ asked for more assurances on acute performance recovery plans. AB suggested that the committee should look at A&E and RTT recovery plans at Denmark Hill in some further detail. It was agreed that these would be brought back to the next meeting - Action CSU.

NK provided an update on Improving Access to Psychological Therapies (IAPT) performance and assured the committee that the service was on track to meet the year end activity target. She explained that the recovery rate was under target and this was being affected by the high proportion of high intensity patients entering treatment. She assured the committee that waiting times had reduced since June and were now around 14 weeks.

JF highlighted that four never events have so far occurred in Q3 at King’s.

RP suggested that the committee looks in detail in mental health and children’s in the new year.

The committee noted the content of the report.
Report from Quality and Safety Programme Board

JF presented the report and provided feedback on provider Clinical Quality Review Group (CQRG) meetings. She explained that the King’s meeting focused on the trust’s responsibility to act upon Duty of Candour requirements and she assured the committee that the trust’s approach was seen as particularly good practice. She also fed back that the meeting discussed quality in the emergency department and that the CCG had sought assurance that quality had not been affected by high activity levels. JF assured the committee that the CQRG heard there had not been any tangible impact on quality.

JF highlighted that the GSTT meeting also focussed on the trust’s approach to Duty of Candour and the SLaM meeting focused on suicide following a national audit on the area.

NB highlighted that work was being done by the CSU to align data from the groups and to identify what information is more useful. He added that it was planned that all data will go into one source to reduce overlap and duplication from other boards.

AB explained that a Care Quality Commission (CQC) inspection of King’s will be taking place in January 2015 [subsequent to this meeting it became known that the time for the CQC inspection will likely take place in early 2015/16] and that the committee should review a commissioner evidence document at the next meeting and feed recommendations into the Governing Body – Action KS.

The committee noted the content of the report and the progress made.

Updated Terms of Reference

i) IG&P Committee
The committee agreed the terms of reference.

ii) Quality and Safety Programme Board
The committee agreed the terms of reference.

CCG Training and Development Policy

MH presented the document and explained that it sets out formal policy covering issues like eligibility for development and training and arrangements for re-imbursements.

In response to a question from NK, MH explained that the policy does apply to Governing Body members and it will be amended to make this explicit.

The committee approved the policy subject to this amendment.
KS presented the plan and explained that its development was an objective in the CCG Business Plan. He explained that the plan aims to define sustainability; detail the CCG’s aims and commitments to sustainability; provide examples of sustainability in existing strategies and plans; and set out a series of actions to ensure Southwark CCG acts to improve sustainability. He added that the plan considered both the CCG’s sustainability related to our own operations and also the way that through commissioning we ensured providers took action to ensure sustainability. The plan should be considered during procurements and be reflected in the CCG Procurement Policy.  
JF asked for more details on how lead officers will be allocated and how the policy will be publicised. MH explained that it will be publicised through the staff newsletter which will detail the CCG’s approach.  
| 12. | **Extended Primary Care Service Risk Assessment**  
Harprit Lally (HL) presented the paper which provides an update on the mobilisation of the Extended Primary Care Service in south Southwark; outlines the CCG assurance process in place to authorise service mobilisation; and describes the risks raised during the assurance process and agreed mitigations in place. She asked that the committee review and sign off the actions in place to manage the risks identified.  
AB queried the status of recruitment taking into account the timescale i.e. new arrangements to be in place on 11th January. HL explained there were on-going discussions with Improving Health Limited (IHL) regarding this and the level of assurance required by the CCG at the 15 December gateway meeting had been made clear. It was recognised that any plans must factor in notice periods, reference requests, CRB checks and other factors. An updated recruitment plan including how the transition would be managed, was to be provided by IHL in the next week.  
In response to a query regarding the liability and risk associated with a delay in signing off the APMS contract; PJ explained that NHS England have delegated authority for the APMS contract to the CCG and the CCG is continuing to clarify responsibilities. He added that there are some outstanding issues which will be resolved over the next week.  
HL highlighted that practice agreements had been finalised with IHL facilitating the return of signed agreements.  
HL assured the committee that service policies and protocols have been reviewed and a further meeting between IHL and GK had been held to review progress – it had been agreed that finalised documents addressing any outstanding issues would be submitted by 8 December; however there were no significant concerns with protocols in place.  
In response to a query from RP, HL clarified that the exit strategy referred to on page 7 relates specifically to the arrangements in place to manage the transition for clinical staff post 11 January and also relates to project and operational management arrangements in anticipation of |
<p>| | |</p>
<table>
<thead>
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<tr>
<td>a reduction in support from the core Challenge Fund Programme team.</td>
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<tr>
<td>AB noted the need to clearly document all risks within the CCG and project risk registers. It was agreed a further update would be brought back to the next IGP meeting – <strong>Action PJ/HL</strong></td>
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<tr>
<td><strong>The committee agreed to sign off the actions in place to mitigate the risks highlighted during the assurance process.</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Non-Recurrent Investment in London Ambulance Service</strong></td>
</tr>
<tr>
<td>13.</td>
<td>PJ presented the report and highlighted that LAS are at a critical point in terms of recovery planning against significant pressure in performance. He explained that the report recommends that the CCG contribute £650k as part of the London funding request on non-recurrent resilience funding on workforce, recruitment and safety. He added that south east London CCGs have supported the proposal for investment but with a number of conditions.</td>
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<tr>
<td></td>
<td>AB asked the committee to note that the additional investment will help LAS stabilise its performance in 2014/15 and further recovery planning is required.</td>
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<tr>
<td></td>
<td><strong>The committee approved the investment.</strong></td>
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<tr>
<td></td>
<td><strong>Constitutional Amendment for Co-commissioning – NHSE Guidance</strong></td>
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<tr>
<td>14.</td>
<td>The committee approved the constitutional amendment</td>
</tr>
<tr>
<td></td>
<td><strong>CCG Procurement Policy</strong></td>
</tr>
<tr>
<td>15.</td>
<td>MH presented the policy and thanked DF for her contribution in amending the policy.</td>
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<tr>
<td></td>
<td><strong>The committee approved the policy.</strong></td>
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<tr>
<td></td>
<td><strong>Information Governance Steering Group Report and Minutes</strong></td>
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<tr>
<td>16.</td>
<td>The committee noted the minutes.</td>
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<tr>
<td></td>
<td><strong>Any Other Business</strong></td>
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<tr>
<td>17.</td>
<td>There were no items of any other business.</td>
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</table>
COMMISSIONING STRATEGY COMMITTEE
6th November 2014
160 TOOLEY STREET

Present:

Members:

Andrew Bland (AB) CCG Chief Officer
Jonty Heaversedge (JH) Chair & CCG Clinical Lead
Noel Baxter (NB) Clinical Lead for Quality Review Group
Obi Ezeji (OE) CCG Clinical Lead
Alison Furey (AF) Consultant in Public Health
Richard Gibbs (RG) Lay Member
Sian Howell (SH) CCG Clinical Lead
Paul Jenkins (PJ) Director of Integrated Commissioning (Interim)
Malcolm Hines (MH) Chief Financial Officer
Gwen Kennedy (GK) Director of Quality & Safety
Nancy Kuchemann (NK) CCG Clinical Lead
Kathy McAdam-Freud (KMcA) LMC representative
Jacques Mizan (JM) CCG Clinical Lead
Kieran Swann (KS) Head of Planning and Assurance
Robert Park (RP) CCG Clinical Lead
Yvonneke Roe (YR) CCG Clinical Lead
Tushar Sharma (TS) CCG Clinical Lead
Tan Vandal (TV) Governing Body Secondary Care Doctor

In attendance:

Vicky Bradding (VB) Minutes
Rosemary Watts (RW) CCG Head of Membership, Engagement & Equalities

Apologies:

Adam Bradford (ABr) Clinical Lead for Quality Review Group
Linda Drake (LD) GB Practice Nurse
Diane French (DF) Lay Member
Ruth Wallis (RW) Director of Public Health
Ami David (AD) GB Registered Nurse Member
1. **Declaration of Interests**

The register of interests was circulated. No changes were reported.

RG stated that he has discussed the Conflict of Interest process with JH and noted the issues relating to procurements items. He stated his view that for the procurement items on the agenda, it would not be necessary for members to leave the room when discussing both IAPT and Prime Minister’s Challenge Fund as JH would ask committee members to declare any specific interests relating to these two items. This was done and is recorded as follows:

<table>
<thead>
<tr>
<th>PM’s Challenge Fund</th>
<th>IAPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>JH</td>
<td>Not conflicted in Southwark, Counsellor not employed at practice</td>
</tr>
<tr>
<td>NB</td>
<td>Practice is a member of Quay Health Solutions, Practice based counselling provided at surgery, Counsellor self employed</td>
</tr>
<tr>
<td>YR</td>
<td>Involved in Improving Health, Practice based counselling provided at surgery, Counsellor self employed</td>
</tr>
<tr>
<td>SH</td>
<td>Salaried GP therefore no direct interest, Salaried GP in practice that provides a practice based counselling service, Husband is lay unpaid chair of Social Enterprise providing IAPT in East London</td>
</tr>
<tr>
<td>TS</td>
<td>Salaried GP therefore no direct interest, Salaried GP in practice that provides a practice based counselling service</td>
</tr>
<tr>
<td>JM</td>
<td>Salaried GP therefore no direct interest, Salaried GP in practice that provides a practice based counselling service</td>
</tr>
<tr>
<td>OE</td>
<td>Practice is a member of Quay Health Solutions, Practice based counselling service not provided</td>
</tr>
<tr>
<td>NK</td>
<td>Practice is a member of Quay Health Solutions, Practice based counselling service provided</td>
</tr>
<tr>
<td>KMCF</td>
<td>Practice is a member of Quay Health Solutions, Practice based counselling service provided</td>
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</table>

No other committee members declared specific interests.
2. Minutes of Previous Meeting

The minutes of the previous meeting held on 2\textsuperscript{nd} October 2014 were agreed to be a correct record with the following amendments:

Attendance: RP was not present. He had sent apologies.

Matters Arising & Action Tracker: KCH Urgent Care Service - delete first sentence under this action as not accurate.

3. Matters Arising and Action Log

**KCH Urgent Care Service** – PJ stated that the number of patients being redirected from the KCH Emergency Department will inform the service specification. An update will be provided at the next meeting – **ACTION PJ**.

**Patient Referral Checklists**- JH highlighted that review by medicines management committee is only part of the process in signing off patient referral checklists. He proposed that any clinical pathways should be referred to him and he will re-direct as appropriate and inform the CSC. NB highlighted that these may increase and suggested that a specific group be established to oversee these. SH asked that we agree a process for sign-off and MH suggested that work could be carried out jointly with Lambeth CCG. It was agreed that there should be further discussion at the IGP or Quality and Safety Programme Board to develop an appropriate process for signing-off similar checklists and protocols - **ACTION KS to discuss with GK**.

**Fitness for Surgery**. On the agenda.

**Extended Primary Care Access** – Risk assessments are under development and will be shared with committee members once complete. **ACTION GK**.

**Programme Boards Update** On the agenda.

4. Minutes and Reports from Locality Groups

**Joint North Southwark (September & October)** – TS updated members on the discussion at the meeting. JH highlighted the importance of ensuring that actions arising are followed up. SH stated that an Action Tracker is produced and she will check that these
are followed through. NB suggested that top line actions should be e-mailed to each practice. NK proposed that the minutes be sent out promptly after each meeting with the key actions highlighted – ACTION RW.

South Southwark (September and October) – YR updated members with the discussion at both meetings.

5. IAPT Procurement

PJ presented the item and reminded the committee that in December 2013 they had agreed to re-procure talking therapies services. PJ outlined the objectives of the procurement and explained the process. He drew members’ attention to the issues that have arisen during the initial phase of the procurement that related to liabilities and transfer arrangement for practice staff affected by the proposed procurement. PJ asked the committee for a view on the options included in the paper. He stated that the preferred option is to defer invitations to tender for six months to allow practices to regularise the employment status of their counsellors by accessing independent legal advice.

PJ stated that a recent Employment Tribunal in Lambeth had ruled in favour practice-based counsellors who had successfully argued that that they were employees rather than self-employed contractors and therefore had additional rights of employment protection. PJ stated that the pattern of work of Lambeth counsellors is very similar to counsellors working at GP practices in Southwark. MH stated that TUPE rules apply when a service is tendered and this could result in the successful bidder assuming liability for counsellors currently working at Southwark practices. MH recommended that more time should be allowed so that individual practices can get the right employment advice and so that details of potential liabilities could be made clear to potential bidding organisations.

KMCA welcomed the recommendation and highlighted the importance of practices being able to understand their legal position in the light of employment tribunals in Lambeth. She said that clear guidance is required on employment status and asked what legal advice had been used by practices in Lambeth and whether the CCG did help practices with legal fees incurred. MH said he will find out and advise PJ, who would share this information – ACTION MH and PJ.

KMCA asked if BMA legal advice would be sufficient for practices. NK thought that advice from the BMA would be welcome but that it might not be sufficient. AB requested LMC support on this for practices which was agreed. AB stated that the CCG is not permitted to purchase of legal advice on employment status of member practice staff. He did suggest
the CCG is able to point practices in the right direction to obtain advice and PJ was asked to do this.

JH queried whether six months deferment will be long enough and suggested that it is important for clinical leads to ensure that all practices know their position. AB stated that the period should be limited. JH enquired whether there are any other issues. PJ stated that six months deferment will enable clarity, allow the specification to be refined and provide a period for engagement.

NK asked whether the delay would be perceived negatively by member practices, AB stated that Richard Proctor, Chair of the Council of Members, had highlighted the need for the CCG to quickly communicate about this decision.

Committee members discussed the new model of IAPT provision and suggested that IT and adequate premises were important and that current lack of space is an issue. The importance of consistency in staff was also flagged. JH stated that it is important the service specification picks all these things up. AB highlighted that another challenge will integrating the service into new neighbourhood ‘hubs’.

The CSC agreed that Option 3 to defer invitations to tender for six months be supported.

Availability of advice and support regarding the employment status of practice based counsellors will be looked at and relayed to member practices.

An update in two months will be provided to the Committee – ACTION PJ.

6. PM’s Challenge Fund Implementation

PJ reported that commissioning extended access to primary care will go live in south Southwark on 11th November. The new provider – IHL – is expected to attain confirmation of CQC registration within the week and further assurance work has been carried out looking at risk and patient safety. SH thanked PJ, HL and HS for their hard work and AB endorsed this.

GK reported that she had reviewed the key risks and the mitigations in place. She highlighted that extending access to primary care is a key initiative and there will be continual review overseen by her directorate as part of the usual CCG quality review process.
RP enquired about communication about these changes within the local press. SH stated that she is being interviewed by the South London Press. AB stated that a communications pack has been produced and he has alerted the Chair of the Local Authority Overview & Scrutiny Committee about the changes to services. A press release and information brochures will be shared with CSC for information – ACTION RW.

NK asked whether the change in service would be confusing to patients living between south and north Southwark localities as there would be a different model in the north. SH assured her that the new model in the north would be very similar, although the timing for implementation would mean that there was not an immediate consistency. JH emphasised the importance that communications from both north and south localities to patients are clear and consistent. SH confirmed that this had been considered in the Programme Board.

The committee noted the update on Extended Primary Care Access.

7. Evelina Integration Programme

PJ updated the committee on the proposed model and approach by the Children and Young People’s Health Partnership (CYPHP) to improve the health and wellbeing of local children and young people. JH stated that the model will be presented to the CCG Governing Body next week by the Evelina team and invited committee member to make any prior comments.

NK stated that the business case is secondary care heavy with no mention of health visiting or school nursing teams, or how mental health and parenting issues can be addressed. RP highlighted the lack of reference to public health and preventative intervention in the document, although he acknowledged the intention to promote healthy living is indicated.

AB stated that a partnership approach with Lambeth is required. Lambeth GPs have responded positively to the work of the programme to date.

JH highlighted that some of the statements included in the business case do not match with what is actually happening and there is a need highlight this whilst encouraging the positive aspects of the proposal. RP highlighted that the performance of services the CCG commissions for children are not monitored in the same way as they are for other KPI areas, such as the ‘Top 8’. SH agreed and also suggested that the NHS reorganisation has dispersed responsibility for commissioning children’s services.
JH stated that this proposal should go some way to enable a clinical associate role for children to be put in place. He requested that committee members articulate their questions to the Evelina team on 13 November.

8. **Special Educational Needs & Disabilities (SEND) update**

GK updated the committee on progress against the SEND reforms. She stated that statutory duties of the CCG are clearly defined and work is being carried out to ensure that the right procedures are in place. She explained the work also being carried out with the local authority. A SEND designated medical officer (DMO) is required and this has been flagged as a cost pressure. In answer to a query from TV on requirements for a DMO, GK stated that this would likely be a community paediatrician and she anticipated that one session per week would be required.

GK explained the programme of work between health and education services in the local authority to identify precise roles for each of the organisations in the SEND work.

The committee noted the progress report.

9. **Programme Board Updates**

Lead directors and programme board Chairs gave updates on the work of their programme boards:

**Engagement.** JM reported that the board has established a broad direction of travel and he described an appetite to be innovative in their work plan. RW stated that work is now being carried out on dividing responsibilities and the use of IT in CCG engagement. JM stated that it is recognised that the CCG cannot succeed in isolation and it is important that work is carried out collaboratively. He Healthwatch Southwark are represented as a member of the programme board and that the next meeting is on 4th December.

**Primary Care.** SH stated that this group has evolved from the Primary Care Steering Group with work continuing to take forward extending primary care access and work force development. She said that a successful pharmacy event has been held and another one is planned for January looking at supporting the minor ailments scheme. AB highlighted the importance of aligning issues through the assurance process and
stated that the work being undertaken by the CCG with general practice is under close scrutiny.

**Community Resilience and Prevention.** YR reported that the board has spent its first two meetings reviewing public health data, information and the evidence base in order to better understand some of the important health issues in Southwark. The board would now seek to identify a focussed list of priorities and develop proposals for health improvement.

**Quality and Safety.** GK highlighted that the terms of reference for this programme board requires it to report into the Integrated Governance & Performance Committee. A CCG Quality and Safety work plan is being developed and will be agreed at the next meeting on 11 November.

**Mental Health & Parity of Esteem.** NK informed the committee that three meetings and one workshop have been held. JH suggested that it was important the programme board looked at strategic developments and balanced this with their role overseeing the day-to-day delivery of mental health contracts.

**Integrated Care and Neighbourhood Working.** PJ reported that a workshop has been held but that there are a number of forums already in place for integrated care. JH stated that there is focus on how these interact to ensure the community perspective is considered and from this an informed view can be made on how services can be commissioned to ensure greater integration.

10. **Items for Information**

The committee noted the minutes of the Medicines Management Committee (June 2014)

**Fitness for Surgery Update.** TV welcomed the approach detailed in the update. He queried whether conversations had also taken place with the anaesthetists about the proposed patient pathway as they decide whether a patient is fit for surgery. NB similarly suggested that conversations with the surgical teams who are responsible for the patient post-operation should also take place.

GK stated that it would be necessary to ensure that a pathway like this was rolled-out consistently across provider trusts. Proper debate is required to ensure ownership and it is important that this work progresses swiftly. JH reflected on the different ways to roll out the
Fitness for Surgery pathway and he highlighted the important focus on the role played by secondary care in the promotion and smoking cessation.

11. **Any Other Business**

RW requested that the Co-Commissioning event next Tuesday is promoted. An engagement pack was tabled for members to read through.

12. **Date of Next Meeting:** Thursday 4 December 2014
#### NHS Southwark Clinical Commissioning Group

#### Engagement and Patient Experience Committee

**Minutes of meeting held on 20 November 2014 5-8pm**

**Room GO2B, 160 Tooley Street SE1 2QH**

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<tr>
<th>PRESENT</th>
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<tbody>
<tr>
<td>Jacques Mizan</td>
<td>JM</td>
<td>GP Clinical Lead/ NHS Southwark CCG – Acting Chair</td>
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<tr>
<td>Rosemary Watts</td>
<td>RW</td>
<td>Head of Membership, Engagement and Equalities NHS Southwark CCG</td>
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<tr>
<td>Abimbola Puddicombe</td>
<td>AP</td>
<td>Borough and Walworth Locality Patient Participation Group</td>
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<td>Ela Kwasny-Spechko</td>
<td>EK-S</td>
<td>Peckham and Camberwell Patient Locality Participation Group</td>
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<td>Nadia Crichlow</td>
<td>NC</td>
<td>Bermondsey and Rotherhithe Locality Patient Participation Group</td>
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<td>John King</td>
<td>JK</td>
<td>Dulwich and Nunhead Patient Locality Patient Participation Group</td>
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<td>Barry Silverman</td>
<td>BS</td>
<td>Borough and Walworth Locality Patient Participation Group</td>
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<td>Malcolm Hines</td>
<td>MH</td>
<td>Chief Financial Officer – NHS Southwark CCG</td>
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<tr>
<td>Obi Ezeji</td>
<td>OE</td>
<td>GP Clinical Lead/ NHS Southwark CCG</td>
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<td>Rhiannon Hughes</td>
<td>RH</td>
<td>Blackfriars Advice Centre</td>
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<tbody>
<tr>
<td>Nina Martin (minutes)</td>
<td>NM</td>
<td>Locality Programme Support Officer, NHS Southwark CCG</td>
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<tr>
<td>Nigel Smith</td>
<td>NS</td>
<td>Head of Pathway Commissioning</td>
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<tr>
<td>Laura Brannon</td>
<td>LB</td>
<td>Membership and Engagement Manager – NHS Southwark CCG</td>
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<th>APOLOGIES</th>
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<tbody>
<tr>
<td>Rosemarie Barber</td>
<td>RB</td>
<td>Bermondsey and Rotherhithe Locality Patient Participation Group</td>
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<tr>
<td>Diane French</td>
<td>DF</td>
<td>Peckham and Camberwell Locality Patient Participation Group</td>
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<tr>
<td>Andrew Rice</td>
<td>AR</td>
<td>Forum for Equality and Human Rights in Southwark</td>
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<tr>
<td>Andrew Bland</td>
<td>ABI</td>
<td>Chief Officer – NHS Southwark CCG</td>
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<tr>
<td>Yvonneke Roe</td>
<td>YR</td>
<td>GP Clinical Lead/ NHS Southwark CCG</td>
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<tr>
<td>Adam Bradford</td>
<td>ABr</td>
<td>GP Clinical Lead/ NHS Southwark CCG</td>
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<tr>
<td>Paul Jenkins</td>
<td>PJ</td>
<td>Director of Integrated Commissioning - NHS Southwark CCG</td>
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1. **Introduction and Apologies**

   The Committee was advised that Jacques Mizan (JM), clinical lead and member of the Governing Body will chair today’s meeting as apologies received from Diane French (EPEC Chair).

   Meeting Chair welcomed members and attendees to the meeting and all apologies were noted. The process and the ground rules for the meeting were explained. All were reminded that they could make comments or feedback on ‘Post It’ notes if there was not enough time to ask questions when discussing an item. These would be collected at the end of the meeting and incorporated into the minutes.

   All members were asked to declare any conflicts of interests relating to the business on the agenda or changes to the conflict of interest register. The declaration of interest register was circulated for members to update as necessary.

   No conflicts of interests were declared to any of the business on the agenda.

2. **Minutes and Matters Arising: Our healthier South East London**

   Malcolm Hines (MH) advised that a new format for logging and tracking actions has been developed and this will be used from today and for future meetings.

   The minutes of the meeting were agreed subject to the following corrections:
   - P2 Introduction and Apologies - Declarations of Interests updates—Barry Silverman is now a member of the NHS England London Primary Care Transformation Board
   - P2 – Introduction and Apologies – Last line of last paragraph to read: “BS expressed concerns that this way forward had previously been proposed but had not had too much support”.

   **Health and Wellbeing Board** - Rosemary Watts (RW) updated that she will soon be making contact with the new Officer leading the 1000 lives project. She advised the Committee that the new Head will be invited to present at either the January or March EPEC meeting.

   **Post-it note comment on ensuring patients’ rights are fed into the review of the patient referral service**—BS enquired of the timescale for presenting of this review to EPEC.

   Pursuant to discussions, MH assured that the report will be presented to EPEC and further clarification will be provided if needed.
Actions: Circulate the review of the patient referral service accompanied by an executive summary to EPEC (CCG).

Invite Jill Solly – Head of Primary/Secondary care interface to EPEC – The Committee was updated that this action has been postponed as it was felt that a broader understanding of the issues needed to be more fully explored. The Committee was informed that a discharge audit is presently being conducted at King’s. We are presently awaiting the findings and actions which may arise from the audit. If after reviewing the findings there are still issues, Jill Solly will be invited to the meeting.

All agreed that the main issue around discharge summaries relates to variation in the correspondence between primary and secondary care and that the communications trail should end with patients being informed of all aspects of their care and discharge.

Developing the patient voice in Southwark – RW advised that dates will soon be agreed to resume this training and the aim is to carry this out in either February or March.

BS suggested opening up the training to sixth formers in order to motivate and equip a younger audience to lend their voice to shaping health services.

RW updated that outreach is part of the remit of the new Membership and Engagement Manager, Laura Brannons’ (LB) workplan who will explore how to engage with younger people

Rhiannon Hughes (RH) put forward some suggestions for reaching out to younger audiences. She advised that Blackfriars Advice Centre (BAC) have recently started producing radio programmes with the aim of giving their clients a voice to speak out and educate and inform the general public. BAC works with resonance radio 104.4 [http://resonancefm.com/](http://resonancefm.com/)

For engaging with younger people she also suggested Reprezent radio [http://www.reprezent.org.uk/](http://www.reprezent.org.uk/).

Other suggestions she put forward for reaching out to a younger audience included via art colleges and the Peckham Platform. She also added that the South London Gallery engages with young people through a variety of youth work programmes that they run and it may be worth linking in with this organisation as well.
Action: CCG Engagement team and BAC representative to meet to
discuss ways of taking these suggestions forward (LB, RH)

John King (JK) also suggested targeting young people contemplating
healthcare as a profession.

3. Issues from member groups and organisations.

3.1 Dulwich and Nunhead and Peckham and Camberwell

JK updated on the key discussions and observations at their last meeting
- The last meeting was not very well attended.
- There are still two south locality vacancies on EPEC. The aim was to
  hold elections at the September locality meeting, but due to low
  attendance there was not a wide enough practice representation to
  make this feasible.
- The group received an update on neighbourhood working and the
  extended access service from David Pink – Operations Manager of
  Improving Health Limited.
- A representative from Improving Health will again update at the South
- The key issue for the locality is increasing its EPEC representation.

Ela Kwasney-Spechko (EK-S) updated as follows:
- There remains the ongoing concern about practices not notifying
  patients of results of tests when these come back negative. EK-S
  expressed concern that her practice does not notify patients when tests
  return normal or negative. There was a general consensus from the
  group that patients would like to be notified either way.

Obi Ezeji (OE) updated that general practice will find it highly resource
intensive to notify patients when results are normal.

A robust discussion ensued around this matter. Patient representatives
agreed that all tests should not be treated the same. The meeting
agreed that clinicians need to see this issue from the patients’
perspective as waiting for certain test results can provide some anxiety
to patients. Not hearing back either way only serves to prolong this
anxiety.

The Chair advised that this concern forms part of the on-going
discussion on out of hospital diagnostics and further advised that a
system is presently being rolled out that will allow patients to access
their test results online. He updated that Patient Online will soon be rolled out in Southwark.
BS cautioned about patients who may not be able to use the electronic system.

3.3 Bermondsey and Rotherhithe
NC fed back the key discussions at the 12 November joint north Southwark locality PPG. The Committee was updated that the Bermondsey and Rotherhithe and Borough and Walworth localities will be meeting jointly going forward. Key messages from the this meeting:
- Low turnouts at PPGs remain a prime concern.
- Strategies for increasing participation at PPGs were discussed.
- The group continued discussion on electronic and virtual engagement. Discussion ensued around this and committee felt that this might encourage participation from a younger age group.
- The group received an update on neighbourhood working and the extended access service from Carol McPaul, Quay Health Services representative.
- The joint north Southwark locality has agreed to meet four times per year rather than six.

3.4 Healthwatch Southwark
RW updated on behalf of Healthwatch and advised as follows:
- Healthwatch are holding their public forum meeting on Saturday 22 November and advised that both herself and Paul Jenkins, the CCG’s Director of Integrated Commissioning will be attending. The event is entitled ‘Healthwatch Southwark: One Year On’, the venue will be Pembroke House, 80 Tatum Street, SE17 1QR.

Post meeting note: Healthwatch Southwark submitted update on present and future work via email post meeting:
- Aarti Gandesha the new Healthwatch Southwark Manager has started
- HW Southwark hosted a public forum event in November to mark ‘Healthwatch One year On’. This was well attended with great feedback on our work and our priorities.
- Priorities: around GP access to wind down report due. We are carrying forward our other priorities:
  - Mental Health (with a focus on CAMHS)
  - Sexual Health and HIV testing and care
  - Social Care
- We have been targeting engagement activities borough wide by holding information stalls in different localities, promoting HW Southwark and
inviting members of the public to share their experiences of using health and social care.

- Our engagement plan includes an engagement event once a week, a focus group once a quarter and Public Forums once a quarter.
- Regional representation with South East London Healthwatch is continuing and we are collaborating on training with Lewisham. Our Enter and View training for CAMHS is scheduled for 17 January 2014.
- Two clinicians from overseas who are currently students at the South Bank University will be joining us for a placement in February and will support us in our engagement work.
- Our next Focus group will be in January around social care and issues carers have regarding health and social care services.

4 Patient Experience deep dive report

The Planning and CCG Assurance Manager, Omar Al-Ramadhani (OA-R) presented and led discussion on the final draft of the Patient Experience deep dive report that went to the Integrated Governance and Performance (IGP) meeting. He advised that the aim of the report is to review how the CCG uses patient experience information to inform service design and improve the quality and safety of NHS services used by Southwark patients. He drew the Committee’s attention to the report’s recommendations (p 24) and asked for the Committee’s endorsement of these recommendations and its suggestions on how to take these forward.

BS commented that while potentially useful, at present it seems impractical as no mention is made of patient complaints. He expressed concern that quality reports tend to highlight only what aspects of a service are working well and feels it is important to include and incorporate whether incidents in hospitals are reported to commissioners and how these are addressed. He proposed that presenting a few examples of this to the Committee will be helpful.

In response, OA-R updated that a patient experience dashboard is presently being developed and also informed that quality review meetings are carried out. Nigel Smith (NS) also advised that once poor performance is identified and reported providers are required to prepare remedial action plans to address this.

MH further reassured that the Clinical Quality Review Group (CQRG) meets regularly for each provider Trust, chaired by CCG clinical lead. He advised that
at these meetings, cases of poor performance are dealt with in detail.

OE further added that quality assurance is also dealt with at a broader level at Governing Body meetings with the setting of performance indicators.

**Actions:**
- A review and report on actions taken to be brought to the committee in six months
- London Patient insight dashboard to be added to the agenda of March EPEC.

### 5. Engagement and Programme Board update

Meeting Chair updated that the first meeting of the Engagement Board was held on 16 October and comprised a multi-disciplinary group.

By way of context, RW further updated that in order for the CCG to better streamline its portfolio of work it has developed six programme boards: Building resilient communities and prevention, Integrated care and neighbourhood working, Mental health and parity of esteem, Primary and community care delivery, Quality, safety and performance (QSP) and Engagement to shape and improve services. QSP reports to the Integrated Governance and Performance Committee (IGP). The Engagement Board to EPEC and the rest report to the Commissioning Strategy Committee (CSC).

The committee was asked to review and agree the intended areas of focus of the Engagement Programme Board and to provide some suggestions on innovative methods of engagement which can be potentially used in future work and sources of community expertise that might support this work.

RH suggested exploring forums such as the Peckham Platform and Art Assassins. Pursuant to discussions it was agreed that the CCG Engagement team and RH would meet to take this forward.

**Action:** Further explore and discuss platforms that the Engagement Board could use in taking forward engagement work (CCG and BFC rep)

BS commented that the paper focusses on how the work will go forward but feels it is unclear on what the deliverables and outcome of the programme of work will be. He also raised the issue of appointments to the programme boards and suggested a system of democratic appointment similar to that of NHS England.
Other Committee members added that even though different groups appoint and recruit differently, they can still achieve their outcomes and deliverables.

MH further added that the CCG approach is to get people engaged and advised if Committee members know of people who would like to get involved, please feed this back and they can be followed up and be encouraged to engage.

Regarding the programme aim of “Connecting” – Item c - “We will work actively to identify not only those who are least heard but those who are least heard and have most need”, John King (JK) asked how will this group be identified.

RH suggested linking in with those groups that her organisation works with. These include people in temporary housing finding it hard to register with a surgery, people who are in overcrowded accommodation and do not receive bills in their names finding it hard to access services. She also added that they see multiple clients who live in the same location who have similar health issues such as damp which cause breathing issues.

Discussions ensued around least heard groups and it was agreed that discussions will continue outside this meeting between the CCG and the Blackfriars Advice Centre about identifying and listening to those who are least heard.

5 Engagement in Commissioning Intentions – 2015/16

Nigel Smith (NS) – CCG Head of Pathway Commissioning, presented and led discussion on the paper. The Committee was asked to make proposals on how to get meaningful patient engagement on the proposed CCG commissioning intentions.

BS advised of the need to be clear on objectives and affordability.

The Committee was advised that each of the previously mentioned programme boards is currently developing their commissioning intentions and work programmes for 2015. Once these are confirmed the expertise of the Engagement Board will be required to ensure there is a high standard of engagement. To provide assurance of engagement, EPEC will be updated on progress.
OE suggested accessing patients at locality level to get their views on proposed commissioning intentions. Others commented that given that attendance at locality meetings varied, it might be useful to engage people at the practice level.

The Committee agreed that the language used needs to be simplified and presented in a more straightforward manner as this will facilitate easier conversations.

6 Co-commissioning Primary Care
MH updated the Committee on progress to date and asked the Committee to make suggestions on ways in which to engage with patients. He advised that the Department of Health has proposed that CCGs work with National Health Service England (NHSE) from April 2015 to co-commission primary care. The options suggested are:

- Greater involvement in NHSE decision-making
- Joint decision making by NHS England and CCGs
- CCGs taking on delegated responsibilities from NHS England.

He added that to date engagement has focussed on member practices via a discussion board on our members and staff zone, a September Council of Members meeting, practice locality meetings and a practice engagement event on 11 November. An additional practice engagement meeting is planned for December 10 at the Millwall Football Club.

BS advised of the need to make the distinction between primary care and general practice.

MH confirmed that though the proposal says “co-commissioning of primary care”, it actually refers to general practice. He emphasised that the performance management of general practices will not come back to the CCG but rather only the day to day contracting.

8 Any Other Business
The Committee’s attention was drawn to the NHS Confederation’s poster on “What the public thinks about the future of the NHS”. EK-S commented that it would be useful to have information such as this translated into different languages.
Flyers promoting the “Our Healthier south east London” engagement event on 3 December were circulated to the Committee as well as a write up entitled “You said, we did”.

**Date of next meeting 16 January 2-5, Room G02B, Tooley Street.**
## Outstanding Actions from 20 November 2014 EPEC meeting

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<tr>
<th>Agenda item</th>
<th>Action Point</th>
<th>Update</th>
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<tr>
<td>Minutes and Matters arising: Post it note comment on ensuring patients’ rights are fed into the review of the patient referral service</td>
<td>Circulate the review of the patient referral service accompanied by an executive summary to EPEC.</td>
<td></td>
<td>January 2015</td>
<td>CCG</td>
<td>Action in progress</td>
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<tr>
<td>Minutes and Matters arising: Developing the patient voice in Southwark</td>
<td>CCG Engagement team and BAC representative to meet to discuss ways of taking this forward</td>
<td></td>
<td>January/February 2015</td>
<td>LB, RH</td>
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| Patient experience deep dive report | - A review and report on actions taken to be brought to the committee in 6 months  
- London Patient insight dashboard to be added to the agenda of the March EPEC. | | May 2015  
March 2015 | O-AR | Action in progress |
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<td>LB</td>
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<td>Matters arising</td>
<td>Urgent care: PJ and JK to liaise outside of this meeting to incorporate patient’s perspective on the urgent care work.</td>
<td>October</td>
<td>PJ/JK</td>
<td>Open</td>
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<td>Engaging and communicating with patients about the development of extended primary care access</td>
<td>Test and capture patients’ view on their understanding of the extended service pathway.</td>
<td>October</td>
<td>HS</td>
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<td>Developing Integrated services</td>
<td>Re-visit the 2015/16 delivery/implementation timescale.</td>
<td>October</td>
<td>JY</td>
<td>Open</td>
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<td>Developing Integrated services</td>
<td>Circulate plan of work to take the integration agenda forward and ensure that the voluntary sector informs the dialogue</td>
<td>October</td>
<td>JY</td>
<td>Open</td>
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<tr>
<td>Developing Integrated services</td>
<td>Link the integration work to the Carer’s strategy</td>
<td>October</td>
<td>JY</td>
<td>Open</td>
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<tr>
<td>Developing Integrated services</td>
<td>Information and best practice examples on social prescribing to be circulated to JY and RW</td>
<td>October</td>
<td>DF</td>
<td>Closed</td>
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<tr>
<td>Next Meeting date</td>
<td>Re-schedule November meeting date</td>
<td>October</td>
<td>NM</td>
<td>Closed</td>
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<tr>
<td>Introductions</td>
<td>Representative from Community Action Southwark / voluntary sector to be confirmed to replace Andy Boaden.</td>
<td>September</td>
<td>RW</td>
<td>Closed</td>
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<tr>
<td>Carry forward Action</td>
<td>Health and Well Being Board – work so far and plans for the future to be a future agenda item</td>
<td>September</td>
<td>RW</td>
<td>Open</td>
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<tr>
<td>Post it note comment from previous meeting-BS comments on ensuring patients rights are adhered to be fed into the review of the patient referral service</td>
<td>JH reported discussion at the Governing Body meeting. It was agreed that this action is kept open to ensure that BS comments are fed into the review RW will forward BS comments to AY.</td>
<td>September</td>
<td>RW</td>
<td>Closed</td>
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<tr>
<td>Mental Health Strategy</td>
<td>Healthwatch representation on Mental Health Programme Board Under review</td>
<td>September</td>
<td>RA</td>
<td>Closed</td>
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<tr>
<td>Issues from member groups</td>
<td>Jill Solly Primary/Secondary care Interface to be invited to a future meeting.</td>
<td>November</td>
<td>RW</td>
<td>Closed</td>
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<tr>
<td>Developing the patient voice in Southwark</td>
<td>Details of anyone requiring training to be notified to NM</td>
<td>September</td>
<td>ALL</td>
<td>Open</td>
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Dulwich Programme Board
Minutes of the meeting held on 27 November 2014
160 Tooley Street

**Present:**
- Robert Park: Chair and Lay Member, SCCG (RP)
- Malcolm Hines: Chief Financial Officer, SCCG (MH)
- Rebecca Scott: Programme Director – Dulwich, SCCG (RS)
- John King: EPEC Patient Representative (JK)
- Neetu Vohra: Service Manager – Administration, Facilities and Performance, GSTT (NV)
- Olufemi Osonuga: Associate Clinical Lead - SCCG (OO)
- Martin Saunders: Healthwatch Southwark (MS)
- Eugene Prinsloo: Community Health Partnerships (EP)
- Simon James: NHS Property Services (SJ)
- Roger Durston: Associate Clinical Lead (RD)
- Catherine Webster: Capital Investment Manager – NHSPS (CW)
- Brenda Allen: Admin Support, SCCG (BA)

**Apologies:**
- Paul Jenkins: Director of Integrated Commissioning - SCCG

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<thead>
<tr>
<th>Action</th>
<th>1 Welcome and introductions</th>
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<tr>
<td></td>
<td>Members introduced themselves.</td>
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<tr>
<th>Action</th>
<th>2 Conflicts of Interest</th>
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<tr>
<td></td>
<td>No changes to the current register of interest were reported.</td>
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<th>Action</th>
<th>3 Minutes and Matters Arising</th>
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<td></td>
<td>The minutes of the meeting held 23 October 2014 were agreed to be a correct record. With the exception of the third paragraph from the bottom on page 2. RP said he raised “assessing time value of money” at the previous meeting and his note on residual risk had been discussed. It was agreed that RS would write up the notes of that discussion for the next meeting and put it on the agenda with RP’s note. The final minutes of the meeting held on 24 July 2014 were noted.</td>
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<th>Action</th>
<th>4 Programme Director’s Report</th>
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<td></td>
<td>RS informed the members that the final site option appraisal was submitted to the PAU on the 7 November and they had come back with some points for clarification. RS said she had met with the Commissioning Support Unit to resolve the financial questions and the only outstanding item was on the management of hard and soft FM costs. RS noted that she expected this work to be completed shortly and returned to the NHSE PAU. It had been discussed at the Pipeline Group on the 21st November and passed for consideration at the Finance, Investment, Procurement</td>
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Chair: Dr Jonty Heaversedge

The best possible health outcomes for Southwark people

Chief Officer: Andrew Bland
and Assurance Committee on the 8 December. It will then go to the Asset and Investment Committee at NHS PS on the 17 December.

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<th>6. <strong>Procurement Strategy</strong></th>
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<td>EP informed members that alongside the work on the site options appraisal there is also a separate piece of work which is considering how the development will be funded and built. The two DoH property companies have been asked to jointly develop a model that will assess whether a capital or a debt funded route represents best value for public money. This is work that has been supported by BDO. It is now close to completion, and will be reviewed by NHS England’s PAU before going to the NHS PS AIC in December.</td>
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<td>CW</td>
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<td>If the project is to be debt funded then the building will be procured by CHP, and if it is to be capital funded then the procurement will be led by NHS PS. It was confirmed that both organisations are committed to the delivery of the project as quickly as possible. There is already a project plan ready should this be a debt funded project, and CW confirmed that in the event that NHS PS lead then she would produce a similar timeline.</td>
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<td>EP</td>
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<td>RP said our challenge is to demonstrate and assure the Governing Body and public that we have achieved the best value for money, and that the deal we have is fair and reasonable. RP asked when there will be a recommendation and was told by the end of next week. EP to keep the CG updated.</td>
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<td>JK asked for assurance that there is no threat to the project. MH replied there is none at all. EP said that for a LIFT build we are looking at a 12 month period for business case development to Stage 2 and financial close. CW said that were it to be a capital funded development it would follow a slightly different process with an outline and then a full business case. RD supported RP’s concern and said it was crucial to be able to explain why decisions were being made and why so we could demonstrate that clarity and transparency.</td>
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<th>7 <strong>Participants’ Requirements</strong></th>
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<td>RS presented the revised “Participants Requirements” paper and asked the group for their support. She noted that she had not received any further comments since the previous meeting.</td>
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<td>RD</td>
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<td>RP asked who is responsible for the overall management of the centre- making sure that the service model works for local practices and patients and maximising the utilisation. RD said he thought that this would be a future role for “Improving Health” and that we will need to explore how that can be made to work. RS said she would add an extra paragraph to the paper that covered the local aspiration for proactive management.</td>
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<td>RS</td>
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<td>JK updated the members on the South Southwark Locality meeting where Improving Health had presented, and said they had come across very well in the face of close questioning.</td>
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<th>8 <strong>Agreement between the Commissioners and the Procuring Authority</strong></th>
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<td>RS updated members and went through the draft letter to the procuring authority. She said we need to clarify the costs and the affordability envelope and she invited questions from the group. None were raised. RS then produced the draft affordability enveloped and updated members on the process of reaching a figure which would be a figure within which the building should cost. It was agreed that the</td>
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<td>Overall costs of a new building should be less than those of the old building. MH said he would want any additional resources required to be set against services rather than the building. RS said that further work was needed before the figure could be confirmed. MH explained that it may be possible to reduce the on-going revenue implications of the centre through introducing a bullet payment of up to 30% of the build costs. MH also noted that all current sources of funding need to be available in the future. He also said that depreciation on the old building would continue after vacation but before the disposal so there would be a short period of double running.</td>
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| **9 Appointment of Architects** | RS
|
| RS informed members that 5 sets of architects had been interviewed and a preferred architect chosen but not appointed. She hoped this would be done after Christmas. RP asked if this had been a consensus view of the panel members and RS confirmed that is was. |
| **10 Update on wider site issues** | RS
|
| SJ explained that there were on-going discussions with the Education Funding Agency about there being both primary and secondary education facilities on the surplus part of the site. The EFA have indicated that they wish to purchase as much of the site as possible. He said in addition to setting aside a sufficient space for a new centre they also needed to safeguard existing services as well as seeking to accommodate the needs of the EFA. He confirmed that they were discussing a phased approach to disposal, with the EFA taking ownership of the surplus part of the site to the north-east in the first instance. This would be followed by the consolidation of services into the central buildings to release the far western part of the site also for use by the EFA. Only once the new health centre was complete and occupied would the remaining part of the site be disposed of. SJ talked through an aerial view of the site and explained the 3 phases to the members. RP asked if these plans could jeopardise the development of the health centre, but SJ confirmed that no disposal could take place without our approval so those plans are safeguarded. A discussion over the construction process for schools took place in particular reference to noise and site access for construction vehicles. The discussion touched on the use of any pedestrian access via Jarvis Road, and it was confirmed that this access would be protected irrespective of other developments on the rest of the site. There was also a discussion about how to ensure that more vulnerable patients visiting the health centre felt safe. |
| **11 Communications** | MH/RP/RS
<p>|
| MH updated the members on various meetings, which will be taking place and he said the decisions should be made by Christmas. He said he expected to take a paper to the January Governing Body meeting and asked that he, RS and RP put a paper together asking the Governing Body to agree to the on-going development of the business case. RP agreed. Also at that stage the architects could be formally appointed. |</p>
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<td><strong>12</strong></td>
<td><strong>Any other business</strong></td>
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<td>RS reported that the CCG had gone out to tender for technical support in the further development of the business case. She said that as a result Sweet UK had been identified as the preferred bidder and asked for the members to support this. The chair said he had reviewed the ratification report and confirmed he was happy for MH to sign this off. Members supported this.</td>
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<td>It was agreed not to have a meeting in December and to keep to the original date in January.</td>
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<td><strong>Date of next meeting – 22 January 2015 – 132A&amp;, 169 Tooley Street</strong></td>
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MH/RS