# CCG Governing Body

**Thursday 11 July 2019, 14:00–17:30**

Garry Weston Library, Southwark Cathedral

## AGENDA

**PLEASE NOTE THAT THIS MEETING WILL BE AUDIO-RECORDED**

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<td>Chair’s Welcome</td>
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<td>14.05</td>
<td>Provider presentation</td>
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<td><strong>Partnership Southwark</strong></td>
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<td>14.30</td>
<td>Public open space</td>
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<td>14.50</td>
<td>Southwark showcase and patient story</td>
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<td><strong>Introductions and apologies for absence</strong></td>
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<td>14.55</td>
<td><strong>Southwark showcase: Bridges to Health and Wellbeing</strong></td>
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<td><strong>Patient story</strong></td>
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<td>Opening items</td>
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<td>Managing Director’s Report</td>
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## Items for Governing Body decision
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<td>Report of the CCG’s prime committees, including</td>
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<td>i. IGP Committee – revised terms of reference</td>
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<td>15.50</td>
<td><strong>Director of Public Health Annual Report</strong></td>
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<td><strong>Commissioning system reform in south east London - update</strong></td>
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<td><strong>Update on the latest CCG position:</strong></td>
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<td>i. Performance and quality</td>
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<td>i. Non-acute Assurance Report / SEL Assurance report</td>
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<td>ii. CCG Finance Report (M2) / SEL Finance Report M12</td>
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<td>iii. CCG BAF and Risk Report (M2) / SEL BAF</td>
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<tr>
<td>17.00</td>
<td>Any Other Business</td>
<td>Dr. Heaversedge</td>
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**Note:** Extended Public Open Space to be held 17:30-18:00

**Date of Next Meeting:** 12 September 2019
C CG GOVERNING BODY

9 May 2019

Cambridge House, 1 Addington Square, London SE5 0HF

Minutes

GOVERNING BODY MEMBERS PRESENT:

Dr Jonty Heaversedge (JH)  CCG Chair
Dr Noel Baxter (NB)  Clinical Lead
Andrew Bland (AB)  Accountable Officer
Dr Jane Cliffe (JC)  Co-Chair, Southwark LMC
Professor Ami David (AD)  Registered Nurse Member
Dr Robert Davidson (RD)  Clinical Lead
Linda Drake (LD)  Practice Nurse Member
Joy Ellery (JE)  Lay Member
Dr Emily Gibbs (EG)  Clinical Lead
Richard Gibbs (RGi)  Lay Member
Ross Graves (RGr)  Managing Director
Sam Hepplewhite (SH)  Director of Integrated Commissioning (item 9 onwards)
Malcolm Hines (MH)  Director of Finance
Dr Nancy Kuchemann (NK)  Clinical Lead
Genette Laws (GL)  Director of Commissioning, Southwark Council
Andrew Nebel (AN)  Lay Member
Usman Niazi (UN)  Chief Financial Officer
Dr Yvonneke Roe (YR)  Clinical Lead

IN ATTENDANCE:

Heather Gava (HG)  Interim Corporate Secretary

APOLOGIES:

Ian Abbs (IA)  Co-opted Member (Guy’s and St Thomas’ NHS Foundation Trust)
Professor Kevin Fenton (KF)  Strategic Director of Place and Wellbeing, Southwark Council
Robert Park (RP)  Lay Member
Dr Michael Khan (MK)  Secondary Care Doctor Member
Kate Moriarty-Baker (KMB)  Director of Quality & Chief Nurse
Stephen Whittle (SW)  Healthwatch Southwark

1 Chair’s welcome, introductions, and apologies for absence

JH welcomed all to the meeting, and in particular welcomed Linda Drake back to her first Governing Body meeting following her accident several months earlier. The apologies that had been received were noted. It was also noted that although Stephen Whittle had been unable to attend, a Healthwatch representative was present in the audience.
JH announced that regrettably there would be no extended public open space after the close of the meeting due to the need to hold a Part 2 meeting which would require the attendance of most of the Governing Body members.

JH informed the meeting that this was Dr Noel Baxter’s last Governing Body meeting, and on behalf of the Governing Body he thanked Dr Baxter for his contribution to quality improvement in Southwark during his tenure.

**Public open space**

Elizabeth Rylance-Watson, a Southwark resident, queried two sentences in the draft minutes of the previous meeting’s public open space:

- Firstly, in relation to the CQC report on Nexus, the statement that ‘these issues represented only a risk of low harm to patients, or none at all’.
- Secondly, in relation to Babylon GP at Hand, the statement that ‘the CCG had not approved any investment in the app’.

In response to the first query, it was agreed that the minutes should be amended to read ‘the issues identified had resulted in little or no harm to patients’. In response to the second query, AB confirmed the minute as correct. JH explained that the CCG had opted to invest in the eConsult app for use in Southwark.

Ms Rylance-Watson asked whether any Southwark residents were registered with Babylon GP at Hand. She also asked what the financial implications of this would be for the CCG and in particular she requested clarification of the £645K which had at one time featured within the CCG’s budget.

MH explained that the £645K was an estimate of the potential financial risk in 2018/19, based on the number of Southwark residents registered with Babylon. However, this did not represent an agreement to make any payments to Hammersmith and Fulham CCG, and no such payments had been made. The issue of how to manage the cost pressure being borne by Hammersmith and Fulham was a matter for that CCG and NHS England.

Ms Rylance-Watson asked whether Southwark residents who had registered with Babylon knew that they were no longer registered with their local GP. JH confirmed that this was now the case. He explained that in their first advertising campaign Babylon had not made it clear that patients would be deregistered from their local practices, and this had resulted in a complaint being made to the Advertising Standards Authority. The complaint had been upheld and subsequent advertisements had made it clear that patients would be deregistered.

It was noted that Hammersmith and Fulham CCG had commissioned an independent evaluation of the app, and Ms Rylance-Watson added that the MP for Hammersmith and Fulham had raised the issue in the House of Commons.

**Southwark Showcase: The Incredible Women Choir**

A short film was shown which demonstrated the value of the voluntary sector in supporting vulnerable women to develop confidence and establish new relationships within the community.
### Declarations of interest

Governing Body members were asked to declare any conflict of interest arising from the agenda, or any change to the register of interests. JE declared a new interest: she had recently been appointed as lay member on the NICE Guidelines Committee on Heart Valve Diseases and Treatment. No conflicts or other changes were declared, and the register was circulated for signing.

### Minutes of the meeting on 9 May 2019

The minutes were approved as an accurate record of the May meeting, subject to the amendment previously agreed during the public open space.

### Managing Director’s report

RGr presented this report which updated the Governing Body on recent developments, in particular Partnership Southwark, Primary Care Networks, CCG reform and the development of an Integrated Care System in south east London, 2019/20 contracting and budget plans, system resilience, the results of the 360° stakeholder survey, estates updates, and system-wide appointments.

In addition to outlining the main points contained in the report, RGr informed the meeting that NHS England had announced a £9m national programme aimed at patients who were at high risk of stroke. The programme built on a successful joint Southwark and Lambeth project which had resulted in an estimated 45 strokes per annum being avoided.

JH thanked RGr for his report, which was very positive given the challenges currently facing the CCG. In particular he commended the work of the Engagement Team in achieving a consistently high response rate to the stakeholder survey.

JE noted from the report that there was one area in the stakeholder survey where the CCG had a lower score than in previous years – the question relating to engagement with patients and the public when commissioning or decommissioning services. It was noted that responses to this question were provided by a very small number of participants but JH assured the meeting that the CCG would nevertheless act on the feedback received.

AB made the point that the development of Partnership Southwark was an integral part of the CCG reform programme, not a separate project.

RGi reiterated JH’s comment that the report was a very positive one, and drew the meeting’s attention to the paragraph on page five regarding the CCG’s excellent financial performance in 2018/19. The Governing Body commended this performance and expressed its thanks to all staff in the CCG.

GL noted and welcomed the shared ambition around children and young people which was highlighted in the Partnership Southwark section of the report. She also noted however that the section on system resilience focused on services for adults and RGr explained that this was because it reflected key standards included in the NHS Constitution. As the place-based organisation developed as part of the system reform agenda the type of information being reported to the Governing Body would also develop to reflect local priorities.

The Governing Body noted the Managing Director’s report.
## Final opening budget framework 2019/20

MH presented this report, which provided an update on the draft framework received by the Governing Body at its March meeting. The paper set out the work done to secure contracts for 2019/20 and to make QIPP savings in order to bring the CCG into a position where it would meet its breakeven financial control total in 2019/20, and mitigate any risks that might arise in-year. The paper had been considered in detail by the IGP Committee.

In particular it was noted that:

- Block contracts with a total value of some £300m had been signed with the CCG’s main acute providers, as well as with SLaM and Oxleas. Whilst this was a very satisfactory outcome it was noted that any increase in activity which exceeded the contracted tolerance levels could result in a financial risk to the CCG. The CCG had a further 50-100 smaller contracts in place, some of which had been volatile historically and these would be managed closely.
- The QIPP programme remained at £15.6m but the gap had reduced to £1.5m. MH and RGr were continuing to work with Heads of Service to close this gap. Regular QPP meetings were held within the CCG, and there were now additional meetings with AB and UN which took an overview of QIPP at SEL level.
- The CCG’s control total for 2019/20 was to break even and budgets had been set to achieve this.
- The opening reserves position was £4m.
- The national target for reducing running costs was expected to be met.

GL noted that commissioning intentions for 2020/21 would be articulated in the coming six months and that as Partnership Southwark developed these would be commissioning intentions for the local system and would require at least some alignment of resources.

The Governing Body commended the work of all involved in establishing the CCG’s budget for 2019/20 and asked MH to convey their thanks to all concerned, in particular to the members of the ICDT.

**The Governing Body:**

- approved the financial framework for 2019-20;
- approved the control total target of achieving breakeven in year;
- noted the work being done to achieve the CCG’s financial position;
- noted the actions being taken to agree additional QIPP, some disinvestment, and limited investment, to ensure commissioning and financial targets would be achieved for the next few years; and
- agreed to recommend these budgets to the Council of Members at its meeting in May.

## SEL IGP – review of pilot phase and next steps

RGr presented this report, which was seeking the Governing Body’s approval for an extension to the scope of the South East London Integrated Governance and Performance Committee. The proposals had previously been considered by the CCG’s own IGP Committee and at a Governing Body seminar. The proposals reflected the evolving differentiation between matters requiring consideration across SEL as a whole and those

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Chair: Dr Jonty Heaversedge  
Accountable Officer: Andrew Bland  
Managing Director: Ross Graves  
The best possible health outcomes for Southwark people  

Governing Body 11.7.19-11/07/19  
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which were best considered at borough (place) level.

There was a brief discussion about reporting on quality under the proposed arrangements, and it was noted that whilst the scope of the SEL IG&P in relation to quality was clearly restricted to in-scope areas only, this was an area which could be expected to develop further.

Referring to the quorum rule at paragraph 7.1, RGi noted that the quorum required both the SEL and the Lambeth CFOs but made no provision for either to be represented by a designated deputy.

**The Governing Body agreed to:**
- Extend the SEL IG&P's scope to cover the full range of acute indicators (including A&E), Transforming Care and quality as an area of business at an SEL level function.
- Approve delegation to SEL IG&P decision-making powers relating to all acute performance, Transforming Care and collaborative finance (i.e. all in-scope areas).
- Approve the attached Terms of Reference of the committee, including retaining its current membership and extending its remit to include the decision-making powers in Section 4 of the terms of reference.
- Review the amended terms of reference for the Southwark IG&P.
- A further review of the SEL IG&P after six months.

**Update on the latest CCG position**

**Performance**

RGr presented the system performance update. This focused on key performance standards, and the full reports had been considered in detail by the SEL Integrated Governance and Performance Committee. The update covered accident and emergency performance, the 18-week referral to treatment target, diagnostic waits, the three cancer waits standards, and the performance of the London Ambulance Service (LAS) against the Ambulance Response Programme targets.

RGr highlighted the main points by category and provider, indicating where performance had improved or declined. Where performance had declined, he outlined the reasons for this, and where possible the measures put in place by providers to address them. A&E performance at King’s continued to give cause for concern and the key elements of the Trust’s A&E Performance Improvement Plan were highlighted. It was noted that diagnostic waits had seen a significant spike in demand over December and January, resulting in a deterioration in performance, but the position had since improved. The two-week cancer wait standard had been narrowly missed in February, but performance against the 31 day standard had been 100%. Performance against the 62 day standard was still below the level required, but was an improvement on the previous month’s.

AB noted the figures for 52 week waits on page 4 of the presentation and informed the meeting that King’s was now achieving reductions in the numbers of patients waiting over 52 weeks, in line with expectations. There were still some 52 week waiters at GSTT, but these were patients with complex long-term conditions and the number was unlikely to fall. It was...
noted that diagnostic capacity could be a concern going forward. It was also noted that the 
provider oversight meetings held between NHS Improvement and individual trusts that were 
in special measures were now being expanded to include all providers and to take a system-
wide view.

Quality

NB presented the update on behalf of KMB, highlighting the main quality issues and the work 
being undertaken to address these. The work of the Clinical Quality Review Groups was 
summarised, as was inspection activity by the CQC. It was noted that the Friends and Family 
test was undergoing a national review because of poor response rates nationally. It was also 
noted that publication of the arrangements for safeguarding children would take place by the 
end of June. The presentation also included details of serious incidents and never events.

RD informed the meeting that in addition to the CQC inspections detailed in the presentation, 
both of the boroughs Federations had been subject to inspection. The initial feedback was 
positive.

Finance

MH presented a brief overview of the Finance Report for M12. The audit of the year-end 
accounts was underway and, subject to the outcome of the audit, the CCG had delivered all 
of its financial targets for 2018/19. The CCG was now forecasting a surplus of £1.275m, 
compared with the control total surplus of £989K. This was a slightly higher forecast than had 
been reported previously. It was noted that running costs were forecast to come in £257K 
below budget and that this trend was expected to continue, enabling the CCG to meet the 
20% reduction target by April 2020. 97% of the QIPP programme of £16.5m had been 
delivered.

There was no significant change from the position reported at the last Governing Body 
meeting: The CCG remained on course to achieve its financial targets for 2018/19, with a 
high-level summary of performance against key budget areas included in the presentation.

The Governing Body commended MH and his team for this excellent set of results.

Risk

JH presented a brief overview of the CCG’s Board Assurance Framework (BAF) and 
accompanying heat map, focusing on extreme risks, new risks, closed risks, and risks that 
had been escalated or de-escalated. It was noted that the BAF was scrutinised in detail at 
each meeting of the CCG’s IGP Committee. It was also noted that the CCG’s corporate 
objectives had been refreshed and translated into smart actions for the CCG. The objectives 
would be used to underpin appraisals and objective-setting for staff.

The Governing Body noted the updates on the latest CCG position for performance, 
quality, finance and risk.

Report of the CCG’s prime committees

The Governing Body noted the prime committees’ report.
Minutes of SEL/CCG committees

The Governing Body noted the minutes of the following meetings:

- Audit Committee (December 2018, March 2019)
- Commissioning Strategy Committee (March 2019)
- Engagement and Patient Experience Committee (April 2019 - draft)
- Integrated Governance & Performance Committee (February and March 2019)
- Joint Commissioning Strategy Committee (February 2019)
- Our Healthier South East London Board (January 2019)
- Primary Care Commissioning Committee (January 2019)
- South East London Integrated Governance & Performance Committee (March 2019)

Any other Business

There was no other business.

Public Open Space

JH invited comments and questions from members of the public.

Bob Skelly, a Southwark resident, referred to a recent television report in which a GP had stated that she was seeing 100 patients a day. He asked whether GPs in Southwark were seeing 100 patients a day, which was three times the safe limit. JH responded that whilst he had no firm evidence on which to base his reply, he felt that no Southwark GPs were seeing 100 patients a day, and LD concurred with this view. JC informed the meeting that the GP in the television report had been including telephone triages in the 100 patients.

Elizabeth Rylance-Watson expressed concern that the refreshed risk register and Board Assurance Framework did not include workforce-related risks. She urged the CCG to undertake a systematic analysis of future workforce needs. JH assured Ms Rylance-Watson that KMB had undertaken a significant amount of work in this area, but stressed that current workforce planning was very complex matter given the system reform agenda and the requirements of the NHS Long Term Plan.

Mr Skelly asked about plans for PCNs, and whether this meant amalgamating practices into a single borough-wide practices. JH explained that whilst the current focus was on general practice, PCNs would be multi-disciplinary and would include for example district nurses, health visitors, and mental health professionals. SH added that the move to PCNs was not the same thing as mergers of GP practices.

Close of meeting

As the meeting closed JH reminded those present that this had been Dr Noel Baxter’s last Governing Body meeting in public. He paid tribute to Dr Baxter’s contribution to quality improvement and its focus on clinical effectiveness, stating that it was important that his legacy should continue. Dr Baxter was warmly applauded by those present.

The meeting closed at 16.40.
Date of the next Governing Body Meeting:
14.00-17.30, 11 July 2019, Garry Weston Library, Southwark Cathedral.
Managing Director’s Report

11 July 2019

1. South east London is first area in London to join NHS England and Improvement’s third wave of Integrated Care Systems

Our Healthier South East London (SEL Sustainability and Transformation Partnership - STP) has been announced as the first area of London to join the third wave of the national Integrated Care System (ICS) programme. ICSs bring together local health and care organisations and local councils to re-design care and improve population health, through shared leadership and action.

The south east London health and care system is complex; south east London’s “System of Systems” approach helps us to bring together or integrate services at the right level (neighbourhood, borough and south east London) to have the greatest impact on improving health outcomes. We also believe that we can only address significant financial, performance and quality challenges in south east London through collaborative effort.

Becoming an ICS is an important part of our response to the NHS Long Term Plan and the announcement is a further step on the journey. This step is aligned to the six CCGs in SEL’s intention to merge CCGs to a south east London footprint from April 2020. Through this model, we will create enhanced partnership arrangements for commissioning health and care in each borough.

By working across organisational barriers, health, care and voluntary and community sector teams can put patients’ and residents’ needs first. In Southwark, health and social care organisations are already working together in our Local Care Partnership, Partnership Southwark. This is our alliance between Southwark CCG, Southwark Council, Guy’s and St Thomas’ NHS FT, South London and the Maudsley NHS FT, Improving Health Limited, and Quay Health Solutions CIC. From July, Kings College Hospital NHS FT have also joined the Partnership Southwark Leadership Team.

The aim of Partnership Southwark is to accelerate the development of integrated, community-based care, with the governance and accountability to deliver shared outcomes across primary, mental health, social care and community services, through the direction of a pooled resource and collective decision making, at a pace and scale that would not be possible under current structures and arrangements.
2. Long Term Plan Response – public engagement across south east London

NHS England published the Long Term Plan in January 2019, setting out the vision for transforming health and care across the country over the next ten years. The plan describes how in the future health and care will be more joined up across all of our services; more likely to be delivered digitally or in the community, rather than in hospital; and more prevention focussed and personalised for patients.

Each of the 42 STPs areas across England will be responding to the Long Term Plan in the autumn with their local plans for implementing this vision for health and care, including describing how they will work as an Integrated Care System. Nationally Healthwatch have been funded to support each of the STPs to engage with their local populations with regard to Long Term Plan implementation and in south east London this has been delivered through undertaking a survey across the six boroughs which will report in mid-July.

To enhance the Healthwatch led engagement in south east London, we have commissioned additional bespoke support across the ICS to run events to engage with the public on how we implement the Long Term Plan. This engagement will build on existing local and SEL wide engagement and will focus on six key topic areas highlighted in both the Long Term Plan and London’s Vision for Health and Care. The six topic areas are:

- Getting the best start in life: We will be discussing questions including how much time should the NHS spend working with primary schools?
- Children and young people’s mental health: We will be discussing questions including should GPs be trained to help young people in how they use social media?
- Access to services: We will be discussing questions including: How can we better support you so you can access the right care at the right time?
- Improving hospital appointments that do not involve an overnight stay: We will be discussing questions including when would you like the hospital doctor to give you a ring?
- Social isolation and working with charities: We will be discussing questions including what services in the community should we prioritise?
- Services working together: We will be discussing questions including how much difference should there be between health and social care budgets?

Discussion won’t be limited to these topics alone and each question is intended as a starting point to open conversations about what matters to people. To ensure that we engage widely across all of SEL, as well as having in depth discussions, engagement activities will take place in all of the in six boroughs through a combination of:

- Six borough focused events during July – each event will cover the six topic areas above and allow for discussion on how we take forward the implementation of the LTP both locally and across SEL
Six topic focused events across south east London – each inviting people from across SEL to have an in-depth conversation on one of the above topic areas. These events will take place across SEL, either directly before or after the borough event.

- Outreach engagement – targeted smaller discussions in all boroughs, ensuring we capture the views of our seldom heard groups.
- An online survey – for those who wish to respond but can’t get to an event.

All events will be supported by the ICS team and CCG and system leaders across the SEL ICS. Details for all events will be advertised through both OHSEL and the CCGs websites.

3. Developing Primary Care Networks in Southwark

On the 31 January 2019 the new National GP contract was published which provided a clear and compelling narrative for investment and development of general practice over the next five years. It provides a framework for additional investment and workforce to support general practice to become more resilient and prepared to meet the future needs of the population.

A fundamental building block of the new contract is the development of PCNs, which is intended to dissolve the historic divide between primary and community health services.

The core characteristics of the Primary Care Networks will be:

- Practices working together and with other local health and care providers, around natural local communities that make sense geographically, to provide co-ordinated care through integrated teams embedded within a place based model of care and support.
- Providing care in different ways to match different people’s needs.
- Focus on prevention, patient choice and self care, supporting our populations to make choices about their care and look after their own health and wellbeing.
- Use of data and technology to assess population health needs and health inequalities, to inform, design and deliver practice and population scale care models and support clinical decision making.
- Making best use of collective resources across practices and other local health and care providers to allow great resilience, more sustainable workload and access to a larger range of professional groups.

In Southwark we are in a good position to respond positively to the new contract as it will support and enable our model delivery of community-based care which we have been working on during the past two to three years. In Southwark we will have two Primary Care Networks from 01 July 2019, one covering the North of the Borough and one covering the South of the Borough. Each Primary Care Network will be working with their member practices to recruit clinical directors who will lead the development of the networks with the wider health and care system.
4. Care Quality Commission inspection report on King’s College Hospital NHS Foundation Trust

On 12 June 2019, The Care Quality Commission (CQC) published its report on King’s College Hospital NHS Foundation Trust, following an inspection in January and February 2019. The report is available on the CQC website. The CQC is the independent regulator of health and adult social care in England. Their role is to ensure that hospitals and other healthcare providers deliver services that are safe, effective, caring, responsive, and well-led.

The Trust received an overall rating of ‘requires improvement’. The report recognises improvements including maternity, end of life care and regarding patients with mental health conditions at King’s College Hospital (Denmark Hill). However there are areas that require focused attention in terms of patient care, staff morale and running the hospitals more effectively and efficiently. The most significant of these is in the emergency department at the Princess Royal University Hospital (PRUH) which has been rated as inadequate.

Health service commissioners in south east London are working extremely closely with the Trust, its new Chief Executive and Chair and with NHS regulators to ensure that the necessary improvements are made and the best possible care is provided to patients. Action plans are in place to both address the safety and quality concerns in the emergency department at the PRUH and the overall improvements that are needed. The leadership of the Trust has changed since the inspection and the new leadership is taking the report extremely seriously and is fully committed to ensuring appropriate action to address the issues raised.

5. System resilience

Accident and emergency 4-hour standard

Performance for both GSTT and KCH has remained below the 95% national standard for patients being treated, admitted, transferred or discharged within 4 hours.

Both trusts have developed performance improvement plans to deliver their trajectory for improving performance against the 4 hour standard and link to the SEL strategy for improvement in non-elective services.

KCH has established three performance improvement workstreams focused on “front”, “middle” and “back” of hospital functions with actions around: improving flow in the emergency department, acute assessment, improving site management, improving length of stay and discharge processes on inpatient wards.
GSTT actions are focused on addressing three elements: LAS handover and rapid assessment, flow, and discharge and transfer. In addition, there are projects related to the Urgent Care Centre, looking at assessment, capacity and the environment. The final focus is staffing demand, with both a clinical and administrative focus.

Monthly performance meetings with both trusts are in place to review progress against the trust specific trajectories and ICDT Team members attend internal trust meetings relating to A&E performance delivery.

**Integrated Urgent Care (formally NHS 111)**

The launch of the new SEL 111 Integrated Urgent Care (IUC) service began on the 29 January 2019 and was completed on 08 May 2019. Calls answered within 60 seconds performance has improved since the launch of the new service. The proportion of 111 calls resulting in ambulance dispatch or referral to an ED or UTC has remained low through the launch period.

May 2019 call volumes were 4.73% above forecast with 38,642 people in SEL using the service.

**London Ambulance Service**

In April 2019, LAS met Category 1, 2 and 3 ambulance response time targets for SEL. However, LAS was not able to achieve the Category 4 ambulance response time (3 hours) for Bexley, Lewisham and Southwark CCGs. Across the 6 CCGs, LAS continues to struggle in maintaining targets mainly in Bexley due to the lack of an acute Trust in the borough.

Regular meetings are held with LAS at a pan London and local level to ensure response time targets are being met.

**Referral to treatment (RTT) standard**

RTT performance for Southwark CCG in April 2019 was 82.9%, which was below the trajectory of 83.7%, but a marginal improvement in performance from 82.5% in March 2019. The number of patients waiting over 52 weeks for elective care was 44, a reduction from 50 in March 2019. Of these, 36 occurred at KCH and 8 at GSTT. Specialties with 52 week waits were: general surgery (19), gynaecology (1), ophthalmology (1), trauma and orthopaedics (19), and other (4).

KCH performance against the 18 week standard in April 2019 was 77.5% and there were 170 patients on the waiting list over 52 weeks. GSTT performance against the 18 week standard was 86.5% and there were 42 patients on the waiting list for over 52 weeks. The
main specialties with long waiters at KCH are orthopaedics and bariatrics, and at GSTT are GMS (Upper GI & colorectal) and cleft surgery.

Performance improvement plans are embedded and form part of the monthly performance meetings with the trusts. There is a focus on reducing the size of waiting list, which is linked to the implementation of planned care strategies by south east London CCGs.

Across south east London, CCGs have a range of community services in place but data suggests that many referrals are bypassing these services and being sent straight to secondary care. Focused work has taken place with practices to promote services, raise awareness of referral routes and work with secondary care and NHS Digital on improvements to e-RS to better highlight locally commissioned services.

Evidence suggests that less than half of advice and guidance requests through e-RS or Consultant Connect result in a referral being made to these services by GPs, and work is underway with acute providers to continually increase coverage across specialties whilst ensuring that response rates remain good.

Cancer waits

Southwark CCG met the national two week wait standard of 93.0% in April 2019, achieving 93.7% for all cancers. This is an improvement from March 2019. Southwark CCG did not quite meet the target of 85% for cancer 62-day performance in April 2019, achieving 84.9%. In April 2019 there were five cancer 62 day breaches for NHS Southwark CCG.

KCH 62-day performance was 78.7% and two week wait performance was 93.4%. GSTT 62 day performance was 70.3% and two week wait performance was 94.2%.

Trusts have developed action plans to deliver their 62-day trajectory including a SEL recovery plan specifically focusing on shared pathway actions and performance.

The SEL recovery plan has been agreed between commissioners and trusts with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly. Actions include: Full roll out of the telephone assessment clinic model for 100% of appropriate lower GI patients by Q4; Full utilisation of TP (transperineal) biopsy in outpatients; Full utilisation of One Stop and Straight to Test pathways for key tumour sites.

Individual trusts complete Root Cause Analysis of all patients that are treated beyond 62 days, for IPT (Inter Provider Transfers) patients this is a joint exercise between relevant trusts. Findings are shared at the relevant SEL tumour group (clinically led meetings), and summary findings are shared more widely to ensure that current actions match the emerging issues.
6. System-wide leadership changes

Appointment of Amanda Pritchard as NHS Chief Operating Officer and Chief Executive of NHS Improvement

NHS England and Improvement has announced the appointment of the current Chief Executive of Guy’s and St Thomas’ NHS Foundation Trust, Amanda Pritchard, as NHS Chief Operating Officer and Chief Executive of NHS Improvement. Amanda will take up the role on 31st July and Ian Abbs, the Trust’s Chief Medical Officer, will perform the role of interim Chief Executive.

I am sure you will join me in congratulating Amanda, who has played a significant role in the collaborative leadership of south east London’s Sustainability and Transformation Partnership (Our Healthier South East London) and development of our vision for becoming an Integrated Care System. We will miss Amanda’s contribution but we already work closely with Ian Abbs and look forward to continuing the important work of the STP with Ian.


Appointment of Andrew Eyres to new role to lead integration of health and social care in Lambeth

I am delighted to update the Governing Body that NHS Lambeth CCG and the London Borough of Lambeth have appointed Andrew Eyres as Strategic Director: Integrated Health and Care in a new joint role, to oversee Lambeth Together, the ongoing improvement and integration agenda of health and care services in the Borough. The role will span the Local Authority Adults and Care Directorate and from 01 April 2020, the leadership of borough commissioning within the proposed South East London CCG.

Andrew has been Accountable Officer of NHS Lambeth CCG since April 2013 and since June 2017 has also held the role of Accountable Officer of NHS Croydon CCG. Prior to this Andrew was Interim Chief Executive of Lambeth Primary Care Trust.

Andrew will take up this new position on 01 October 2019, at which point Andrew Bland will become Interim Accountable Officer for NHS Lambeth CCG, alongside his current roles as ICS lead and Accountable Officer for Bexley, Bromley, Greenwich, Lewisham and Southwark CCGs. Sarah Blow will become Interim Accountable Officer for NHS Croydon CCG, alongside her current role as Senior Responsible Officer for the South West London Health and Care Partnership and Accountable Officer for Merton, Kingston, Richmond, Sutton and Wandsworth CCGs.
NHS Southwark CCG
Operating Plan 2019/20

21 June 2019
v 1.4

The best possible health outcomes for Southwark people
## Operating Plan 2019/20: Contents

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Introduction and context

The best possible health outcomes for Southwark people
What is an Operating Plan?

The Operating Plan is an assurance document which sets out how the CCG plans to improve the health and wellbeing of people living in our borough by meeting mandatory requirements set by NHS England. The requirements set for CCGs originate from the government’s annual Mandate to NHS England.

This Operating Plan sets out our locally-defined response to national requests. It can be read as a declaration of the CCG’s commitment to meet national requirements; establish the extent of our ambition for the improvement of certain performance and outcome indicators; and provide a view of the programmes of work underway and planned to ensure these improvements happen. The Operating Plan also summarises the CCG’s financial plan, full details of which are provided in the CCG’s Budgetary Framework 2019/20.

This document sets out the Southwark component of the detailed submissions made by South East London Commissioning Alliance on behalf of all six SEL CCGs to NHS England in March 2019.

The overarching purpose of CCG operating plans is for the NHS in aggregate (through commissioner, provider and STP plans) to set out a clear trajectory to deliver on the NHS Mandate, implement the NHS Long Term Plan; drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards.

Refreshing the CCG’s Operating Plan for 2019/20

NHS Operational Planning and Contracting Guidance 2019/20 gave instruction that every NHS trust, NHS foundation trust and clinical commissioning group (CCG), will need to agree organisation-level operational plans which combine to form a coherent system-level operating plan. This will provide the start point for every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) to develop five-year Long Term Plan implementation plans, covering the period to 2023/24.
Next Steps On The NHS Long Term Plan

On 7 January, the NHS Long Term Plan (formerly known as the 10-year plan) was published setting out key ambitions for the service over the next 10 years. The NHS Long Term Plan has the following over-arching themes:

1. Making sure everyone gets the best start in life
2. Delivering world-class care for major health problems
3. Supporting people to age well

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how the NHS can overcome the challenges it faces, such as staff shortages and growing demand for services, by:

• **Doing things differently**: we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as ‘primary care networks’, to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as ‘Integrated Care Systems’, to plan and deliver services which meet the needs of their communities.

• **Preventing illness and tackling health inequalities**: the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.
• **Backing our workforce**: we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

• **Making better use of data and digital technology**: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’, better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

• **Getting the most out of taxpayers’ investment in the NHS**: we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS’ combined buying power to get commonly used products for cheaper, and reduce spend on administration.

Locally we will continue to develop strategies setting out how we intend to take the ambitions that the NHS Long Term Plan details, and work together with stakeholders across Southwark and the wider South East London area to turn them into local action to improve services and the health and wellbeing of our communities.
Approach to 2019-20 Planning

Operational Planning 2019-20 & 2019-24

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) are now developing and implementing their own strategies for the next five years. These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

For Southwark we have recognised that our strategy, the Southwark Five Year Forward View, and its supporting programmes, are very strongly aligned with the NHS Long Term Plan and give us a strong foundation on which to build our plans for the next five years.

- **April 2019** – Southwark CCG has developed and signed off a one-year budget and financial framework and contributed to an STP level operating plan for FY **2019-20**
- **June 2019** – Southwark CCG signs off its one-year operating plan for FY **2019-20**
- **Autumn 2019** – STPs will publish five-year local plans for **2019-24**.

* A Plan on a Page for the south east London STP’s response to the NHS Long Term Plan is included as an Appendix.
Responding to the NHS Long Term Plan in the context of our development towards becoming an Integrated Care System
Our 2019-20 Planning Builds On Existing Work And Is Part Of A Journey To Become An Integrated Care System

We have positioned our 2019/20 planning as a transitional year, pending the development of our SEL response to the Long Term Plan in Autumn 2019.

Our contracting form has been developed with system improvement in mind, with a shift away from PBR as a key outcome of our work with system partners on our Aspirant ICS work programme.

Key 2019/20 areas of focus are:

• **Priorities and deliverables** – a consistent set of SEL wide commissioning intentions and priorities for 2019/20 – these reflect the outcome of our system work above and have been endorsed by the Our Healthier South East London Board. **We use these as a framework for our Southwark CCG Operating Plan.**

• **System Improvement Plan** – this will set out the commitments the SEL system has made in its 2019/20 Operating Plan in relation to performance and financial improvement, recovery and sustainability, recognising 2019/20 represents Year 1 of a longer term sustainability programme

• **ICS development programme** – SEL has agreed an ICS roadmap and key commitments for 2019/20 that will support the development of our SEL ICS in terms of underpinning system architecture and delivery models.
In the context of developing our South East London ICS ‘System Of Systems’
We have positioned our 2019/20 planning as a transitional year, pending the development of our System Improvement Plan to support our ICS maturity and the SEL response to the Long Term Plan in Autumn 2019.

The Plan focuses on progressing our system priorities and deliverables, building on the 2016 STP Plan, progressing our ICS Roadmap priorities and developing our system ICS maturity and ways of working.

**Positioning of our plan**

**Performance improvement**
- Commitments in relation to performance improvement and sustainability – across U&EC, RTT, cancer, MH and TCP
- Commitment to delivering agreed performance trajectories; this will require a combination of pathway redesign in and out of hospital, operational grip and management, demand and capacity management
- Our System Improvement plan will set out plans to improve performance in more detail, to support our ICS development and maturity rating

**Financial improvement**
- Important commitments in relation to our 2019/20 year end financial position
- Our commitments assume the delivery of significant cost out for both commissioners and providers; this will require a combination of internal action to deliver CIPs, and system action to implement agreed pathway improvements, proactively manage demand and optimise available capacity

**Improved health outcomes and service improvements**
- Our commissioning intentions seek to secure deliverables, consistent with national Long Term Plan priorities and local priorities across:
  - Prevention
  - Primary care at greater scale
  - UEC
  - Planned care
  - Cancer
  - Mental health
  - Community services
  - Children and young people
  - Maternity
  - Specialised services

**Enabling strategies and deliverables**
- The reset Enabler Board will ensure that we are proactively pursuing all opportunities across our infrastructure including:
  - Pathology
  - Digital
  - Prescribing and meds management
  - Back office
  - Estates
  - Productivity

**SEL has adopted an STP wide approach to planning for 2019/20 to ensure collective development and agreement of planning assumptions, investment decisions and priority setting across the system.**

**Key assumptions**

**Activity:** We have adopted a consistent approach and methodology to developing bottom up activity assumptions. Our objective for 2019/20 is to contain activity growth through demand management and to manage activity more efficiently through agreed care pathway transformation and efficiency.

**Capacity:** Our operational plans link activity and capacity – our expectation and assessment is that we have sufficient capacity in 2019/20 to meet our planned level of activity. We have concrete plans in place to address a number of capacity constraints through agreed capacity changes.

**Finance:** Our plans include expected growth and a range of new cost pressures. These drive a financial gap compared to available resource – significant savings will be required in year to manage the resulting financial gaps. We have agreed aligned incentive contracts with all providers to remove barriers to integrated care.
Local strategic vision:  
The Southwark Five Year Forward View

Southwark CCG and Southwark Council in 2015 developed a local vision for health and social care in Southwark: 2016/17 to 2020/21 to transform local NHS and care services in the borough. Both the CCG and Council together with local stakeholders agreed that we should be working toward establishing a health and care system that works to improve health and social care outcomes for Southwark people, instead of simply focusing on maintaining current service arrangements.
Local strategic vision: The Southwark Five Year Forward View

So far we have joined together some commissioning arrangements (as a Partnership Commissioning Team) and are working to set-up contracts that focus on improving outcomes for local populations rather than the quantity of activity delivered. The greater integration of commissioning across Council and CCG being developed as part of CCG and system reforms will enable us to accelerate this and to move towards a focus on a ‘Southwark Pound’.

In parallel, health, care and VCS organisations have begun working together in the borough to deliver services more effectively, embed new ways of working, and ensure care and support is centred around the needs of individuals and local populations. We have made much progress and many of the building blocks we need for integrated population-based care are in place; however, these are not always joined up or coordinated to deliver the best impact.

Partnership Southwark, our Local Care Partnership, is bringing this work together, making sure it is aligned and effective, and moving the system forward at pace. Aligning with the ambitions of the Southwark Five Year Forward View and NHS Long Term Plan, Partnership Southwark seeks to drive more joined up population-based strategic commissioning and robust place-based delivery models.

Over the next 2 to 3 years, health and care services will transition to the delivery of integrated population-based care through Partnership Southwark. Services and support will be population focused; delivered within and across neighbourhoods of 30 to 50k people. This model will enable groups of practices within Primary Care Networks to work in partnership with community services, social care and other providers of health and care services around the needs of a geographically coherent population.

Neighbourhoods will maximise utilisation of estate and other community assets, embrace a culture of continuous improvement and learning, harness and diversify the workforce to better meet needs, embed a culture that welcomes authentic community and patient/service user partnership, and make better use of data and technology.
Over the next two to three years, health and care partners across Southwark will change the way services are commissioned and delivered in the borough.

Within Partnership Southwark we want to do things differently, with and for, our local communities.

We will work with partners beyond health and care to tackle the causes of inequalities and prevent illness, and improve our use of data and digital technology so we can be more proactive in our approach to delivering care and support.
Partnership Southwark is underpinned by three key work programmes

Working with local people and frontline staff to co-design and develop Southwark’s 
**neighbourhood model** to better join up care and support within the community, and 
respond to the health and wellbeing needs of local populations.

**Formalising collaborative alliance arrangements** enabling system partners (initially 
Southwark CCG, GSTT, SLAM, GP federations, and Adult Social Care) to deliver 
integrated primary and community-based health and care.

**Joining up strategic commissioning** between the Council and CCG which, over time, 
will move towards a **population-based approach to commissioning for outcomes** 
using **Bridges to Health and Wellbeing** segmentation framework.

This will build on work we have done to date; providing a foundation to go further 
faster in delivering tangible benefits for local people and reducing pressure on the 
system.
Southwark system partners have agreed our system transformation priorities for Southwark over the next two years

- Accelerating the development of neighbourhoods supporting circa 30,000 – 50,000 people. These neighbourhoods will involve primary, community and social care, wider council (e.g. housing) and the VCS; and improved joined up care and support for people with complex health, care and wellbeing needs.
  - Helping more people with long-term conditions/frailty to be supported in the community and their own home, which will reduce unnecessary time spent in hospital.
  - Providing focused support for residents of care homes and nursing homes to ensure better outcomes and reduce avoidable hospital admissions.
  - Supporting people with mental health issues in a primary and community care setting, reducing the need for people with stable moderate to severe mental health to be seen unnecessarily in specialist mental health services.
  - Increasing focus on prevention and self-management, supporting people to live healthier for longer and working to prevent deterioration.
  - Improve our population health analytics capability to better understand and proactively respond to population need at a neighbourhood and place-based level by sharing and linking data.

- Supporting people to have greater control over their own health and wellbeing, and connecting people and services so that care is delivered as close to home as possible, streamlining pathways, and clustering services where appropriate within neighbourhoods.

- Developing our approach for children and young people bringing together work within the Children and Young People’s Health Partnership (CYPHP) and the development of population-level outcomes using Southwark Bridges to Health and Wellbeing.
We are in the process of detailed planning and mobilisation against each of our system priorities. As a core partner within Partnership Southwark, our key deliverables for FY 2019-20 link to our commissioning priorities and our journey towards becoming an Integrated Care System across south east London.

1. Moving from a Memorandum of Understanding to a formal Alliance agreement, continuing to develop and expand the scope and membership of the alliance throughout the year

2. Mobilising our Southwark Strategic Partnership Board which will be the senior Board overseeing our Local Care Partnership arrangements; interfacing with the Health and Wellbeing Board and SEL ICS

3. Planning and agreeing commissioning intentions which drive deeper integrated working focused on populations and outcomes rather than services and activity, and sharing of resources and risk across the system. Where appropriate testing and shadowing these approaches during the year:
   - Neighbourhood based care coordination and wellbeing for people with long-term conditions, frailty and dementia
   - Primary and community mental health
   - Children and young people

4. Updating the plans for our Neighbourhood Model to reflect the key role of Primary Care Networks, the evolving role of GP Federations, and importantly how other community based, social and voluntary services work in an integrated way within our neighbourhood geographies

5. Planning and rolling out the contract specifications associated with the PCN Direct Enhanced Services in a way that enables and supports the development of the Partnership Southwark neighbourhood model

6. Establishing and mobilisation a shared model and plan for population health analytics that supports better understanding of population need and enables anticipatory care at both a borough and neighbourhood level.
Delivery of key operating plan priorities in 2019-20

The best possible health outcomes for Southwark people
1. Primary Care

The NHS Long Term plan commits to an increase in investment in primary medical and community services. This investment will fund expanded community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices. These expanded neighbourhood teams will comprise of a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists joined by social care and the voluntary sector. This will result in the creation of fully integrated community based health care. To compliment and support this new way of working there will be a significant focus on quality improvement.

**Primary Care Networks**  The CCG will:

- Actively support the establishment of Primary Care Networks (PCNs) by continuing to work with member practices and the two federations in the North and South of the Borough to implement the optimal delivery model and appoint the clinical directors.
- Ensure that the PCNs are provided with data analytics for population segmentation and risk stratification based on national data, complemented with local flows, to allow them to understand in depth their populations' health and care needs for symptomatic and prevention programmes by putting arrangements in place through the two federations and local trusts for Primary Care Networks to access this data and information.

**Digital**  The CCG will:

- Ensure that all GP practices are technically enabled to provide all the functionality that will be offered through the NHS App, as part of the Digital Primary Care transformation plan to ensure it is available to 100% of the population by 1 July 2019.
- Start to explore the operational support needed for primary care staff to utilise the NHS App as a ‘digital front door’, and to start discovery works on video consultation functionality in preparation for 2020/21 when this will be a patient right.
- Continue to support primary care staff with embedding digital working into their daily routines to maximise positive patient experience.
1. Primary Care (cont.1)

Workforce and resilience  Transformation of the NHS workforce is being driven at a national level through the NHS People Plan. This has been published in interim draft with a full five year plan to follow later during 2019. To support this in the short term during 2019-20, the CCG will:

- Ensure that Local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become more sustainable.
- Recruit our share of an additional 5,000 doctors and maximise the impact of the over 5,000 other health professionals already recruited since the GPFV was published as part of the multidisciplinary workforce, using all available channels and initiatives.
- Maximise retention of experienced, effective staff (doctors, nurses and other health professionals), with specific actions and focus in areas which have greatest workforce challenges and with roles where attrition is highest
- Deliver the GP nursing plan including working with HEE and higher education institutions to support nurses to choose primary care as a first destination and to retain experienced nurses already working in primary care
- Ensure that clinical pharmacists are recruited into practices in line with approved applications for the clinical pharmacist programme
- Ensure all staff in primary care settings have access to the support of a training hub and capacity to participate in training programmes.

Estates  The CCG will:

- Continue the planned investment in upgrading local primary care facilities, ensuring completion of the pipeline of Estates and Technology Transformation Fund (ETTF) schemes and other STP primary care capital schemes.
- Key deliverables for 2019-20 include:
  - Launch of Dulwich Health Centre
  - Progressing development of community hubs at the Aylesbury, Canada Water and Elephant & Castle.
1. Primary Care (cont.2)

**Access**  The CCG will:

- Continue providing extended access to general practice services, including at evenings and weekends, for 100% of the population, 365 days. Appointments are delivered from two locations in Southwark: Spa Medical Centre and Lister Primary Care Centre. Opening times are 8am-8pm seven days a week (including bank holidays)
- Work with providers and patients to transfer the extended access provision to PCN provision linking with the extended access DES to ensure patients are able to access additional GP practice services in their local area
- Integrate extended access with other services at scale to deliver value for money and efficiencies and support compliance with national core requirements to maximise capacity, availability and utilisation of appointments for 100% of the population. The CCG will also work with the providers to deliver the London core recommendations for extended access through a challenge session and regular contract monitoring.

The CCG will continue to support connectivity by keeping in touch with all doctors in the locality, whether they are working on a sessional or substantive basis through the locality meetings, the GP forum, weekly GP communications and internet based information.
2. Mental Health

The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years. Key deliverables in 2019/20 include:

- By March 2020 IAPT services should be providing timely access to treatment for at least 22% of those who could benefit (people with anxiety disorders and depression)
- At least 50% of people who complete IAPT treatment should recover
- At least two thirds (66.7%) of people with dementia, aged 65 and over, should receive a formal diagnosis
- At least 75% of people referred to the IAPT programme should begin treatment within six weeks of referral
- At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral
- At least 56% of people 14-65 experiencing their first episode of psychosis should start treatment within 2 weeks
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral
- Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories
- At least 60% people with a severe mental illness should receive a full annual physical health check
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services
- Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21.

The further deliverables for mental health outlined in the technical annex to the Operating Plan guidance must also be delivered during 2019/20, most notably for: perinatal mental health; all age crisis and liaison services; 50% of early intervention in psychosis services graded at level 3; and reducing suicides.
2. Mental Health (cont.1)

Southwark CCG will work with partners to achieve the following deliverables for mental health:

- Demonstrable improvement across the key national performance standards in relation mental health services – to include IAPT and CAMHS (access targets, eating disorder access and the link across CAMHS and tier 4 beds)
- Improvements in our acute pathway – including the development of collaborative and networked approaches across providers to do so
- Further integration of CMHTs with primary care networks through the development of integrated provider arrangements i.e. local Provider Alliances
- Continuing our improvement work and flow initiatives to support the management of mental health patients in crisis or requiring emergency care – including psychiatric liaison services, on site MH presence in SEL A&E departments and the transfer of patients in to community or bed based services from A&E in a timely manner
- Ensuring the implementation of best practice pathway and bed management for MH patients – to mirror acute based approaches and to include Red to Green days and focused work to support discharge to assess pathways and optimised discharge
- Development of approaches to support the development of the SEL Integrated Care System for Mental Health – to include reviewing arrangements for the management of complex placements
- Section 117 – through integrated working across partners to achieve efficiencies, improve quality and recovery.

Locally our delivery of mental health and wellbeing priorities is through the implementation of our Joint Mental Health and Wellbeing Strategy. The Strategy has the following implementation workstreams:

- Wellbeing, Information, Advice and Support in the Community
- Primary Care and IAPT
- Averting Crisis and reducing suicide
- Children and Young People’s Services
- Implementing the Dementia care pathway
- Recovery, Volunteering and Employment
- Prevention and Mental Health Promotion.
2. Mental Health (cont.2)

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<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral</td>
<td>865</td>
<td>865</td>
<td>865</td>
<td>865</td>
</tr>
<tr>
<td>Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral</td>
<td>1,096</td>
<td>1,096</td>
<td>1,096</td>
<td>1,096</td>
</tr>
<tr>
<td>Percentage who received their first treatment appointment within 6 weeks of referral</td>
<td>75.0%</td>
<td>75.0%</td>
<td>75.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Percentage who received their first treatment appointment within 18 weeks of referral</td>
<td>95.1%</td>
<td>95.1%</td>
<td>95.1%</td>
<td>95.1%</td>
</tr>
</tbody>
</table>

CCGs are required to ensure that 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. This standard applies to adults. The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2019/20.

<table>
<thead>
<tr>
<th>IAPT – Roll-out</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people who receive psychological therapies</td>
<td>1,992</td>
<td>2,097</td>
<td>2,201</td>
<td>2,307</td>
</tr>
<tr>
<td>Number of people who have depression and/or anxiety disorders</td>
<td></td>
<td></td>
<td>41,930</td>
<td></td>
</tr>
<tr>
<td>Percentage of people who have depression and/or anxiety disorders receiving psychological therapies</td>
<td>4.75%</td>
<td>5.0%</td>
<td>5.25%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

CCGs are required to ensure that at least 19% of people with anxiety and depression access treatment by Quarter 4 of 2019/20. The CCG is planning to meet this target.
2. Mental Health (cont.3)

The above table shows the trajectory for expansion of EIP services in line with the Mental Health Five Year Forward View so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.

<table>
<thead>
<tr>
<th>IAPT – Recovery Rate</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved &quot;caseness&quot; and at final session did not).</td>
<td>577</td>
<td>577</td>
<td>577</td>
<td>577</td>
</tr>
<tr>
<td>The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment</td>
<td>1,153</td>
<td>1,153</td>
<td>1,153</td>
<td>1,153</td>
</tr>
<tr>
<td>Percentage who finish treatment having attended at least two treatment contacts, excluding those not at clinical caseness at initial assessment</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

CCGs are required to ensure that at least 50% of people completing treatment are moving to recovery. The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2019/20.

<table>
<thead>
<tr>
<th>EIP – Psychosis treated with a NICE approved care package within 2 weeks of referral</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals to and within the Trust with suspected first episode psychosis or at ‘risk mental state’ that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Number of referrals to and within the Trust with suspected first episode psychosis or at ‘risk mental state’ that start a NICE-recommended care package</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Percentage that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.</td>
<td>57.9%</td>
<td>57.9%</td>
<td>57.9%</td>
<td>57.9%</td>
</tr>
</tbody>
</table>

The above table shows the trajectory for expansion of EIP services in line with the Mental Health Five Year Forward View so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
2. Mental Health (cont.)

Dementia access standards

<table>
<thead>
<tr>
<th></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>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of People</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnosed (65+)</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
<td>1,037</td>
</tr>
<tr>
<td>Estimated dementia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>prevalence (65+ Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(CFAS II)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

A national dementia tool provides the CCG and each general practice member with a predicted number of people on registered lists estimated to have dementia. CCGs are required to maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, so that those thought to have dementia are referred for diagnosis, diagnosed, and then added to their registered practice’s dementia register for on-going management and care planning.

Building on strong performance and significant investment over previous years, the trajectories above show this being met throughout 2019/20.

* Please note that our deliverables for Children’s mental health are set out in Section 4.
3. Maternity

Through the Long Term Plan, the NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. In order to do so, the CCG and STP partners will:

• Support roll out the Saving Babies Lives Care Bundle (SBLCB) across every maternity unit in England in 2019. We will also support the establishment of Maternal Medicine Networks, which will further ensure women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy.
• Support implementation of recommendations from the National Maternity Review: Better Births through Local Maternity Systems. By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative.
• Continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.
• Improve access to postnatal physiotherapy to support women who need it to recover from birth.
• Continue to improve how the NHS learns lessons when things go wrong and minimise the chances of them happening again.

Maternity digital care records are being offered to 20,000 eligible women I 20 accelerator sites across England, rising to 100,000 by the end of 2019/20. By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices.

The Long Term Plan will improve access to and the quality of perinatal mental health care for mothers, their partners and children by:

• Increasing access to evidence-based care to benefit an additional 24,000 women per year by 2023/24, in addition to the extra 30,000 women getting specialist help by 2020/21.
• Maternity outreach clinics will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.
4. Children

During 2019-20 we will continue to implement our Southwark and STP children’s services priorities and to ensure that our broader commissioning intentions – across prevention, U&EC, planned care, mental health and community based care – include an appropriate and dedicated focus on children’s services to secure improvements in access and population outcomes.

As a CCG we will work with Southwark Council and local partners to implement the findings of our Joint Review of CAMHS services. We will work through Partnership Southwark to develop an integrated approach to CYP services with a 2019-20 focus on **protecting vulnerable children (0-18 years) – keeping families strong; and maternity and children services (up to 5 years) including those with specialist or complex needs.** During 2019-20 Southwark CCG will work with partners to achieve the following operating plan deliverables:

**In hospital**
- The implementation of agreed planned care approaches – referral support, referral triage, in hospital pathway outpatient redesign and transformation – across children’s services.

**Out of hospital services**
- The continued development of admission avoidance and supported discharge services for children, building on an at home model – including a specific focus on respiratory and asthma admissions avoidance

**Mental health and eating disorders services for children and young people**
- Action to secure the delivery of CAMHS access rate targets and recovery across SEL (34% by March 2020 and 35% by 2021) and underpinning data flow requirements. Recovery action supported by service redesign including work across providers to determine optimal delivery models, access criteria and capacity, supported by wider prevention approaches that target emotional health and well being.
- Commission community eating disorder (ED) teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and reduce suicide rates by 10% against the 2016/17 baseline.
4. Children (cont.1.)

The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)

<table>
<thead>
<tr>
<th>Children accessing ED services – routine</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral (rolling 12 months)</td>
<td>30</td>
<td>32</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Number of CYP with a suspected ED (routine cases) that start treatment (rolling 12 months)</td>
<td>31</td>
<td>33</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Percentage starting within 4 weeks of referral</td>
<td>96.8%</td>
<td>97.0%</td>
<td>97.2%</td>
<td>97.2%</td>
</tr>
</tbody>
</table>

The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)

<table>
<thead>
<tr>
<th>Children accessing ED services - urgent</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral (rolling 12 months)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Number of CYP with a suspected ED (urgent cases) that start treatment (rolling 12 months)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Percentage starting within 4 weeks of referral</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Evidence based eating disorder services are effectively provided locally and cited in the guidance. As the main provider of services in South East London, South London and Maudsley NHS Foundation Trust have developed a seven borough proposal. This includes how local community eating disorders services will be enhanced in line with new guidance to meet waiting and access standards for eating disorder services for children and young people.

We have supported further the development of the already established community-based eating disorder service, by enhancing existing provision and opening the service to self-referrals and online resources for early assessment.
4. Children (cont.2.)

<table>
<thead>
<tr>
<th>Children accessing NHS funded community services</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Annual 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of individual children and young people aged 0-18 receiving treatment by NHS funded community services in the reporting period.</td>
<td>884</td>
<td>443</td>
<td>396</td>
<td>384</td>
<td>2,107</td>
</tr>
<tr>
<td>Total number of individual children and young people aged 0-18 with a diagnosable mental health condition.</td>
<td>6,196</td>
<td>6,196</td>
<td>6,196</td>
<td>6,196</td>
<td>6,196</td>
</tr>
<tr>
<td>Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>34.0%</td>
</tr>
</tbody>
</table>

The national ambition is that at least 34% will access services during 2019/20. CCGs are required to ensure there are more high-quality mental health services for children and young people. The CCG has modelled that 2,107 children with a diagnosable condition will access evidence-based services by April 2020, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT). This represents 34.0% of the total number of individual children and young people aged 0-18 with a diagnosable mental health condition.

<table>
<thead>
<tr>
<th>Children Waiting more than 18 weeks for a wheelchair</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Percentage</td>
<td>92.3%</td>
<td>92.3%</td>
<td>92.3%</td>
<td>92.3%</td>
</tr>
</tbody>
</table>
5. Urgent and Emergency Care

Every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care (SDEC). This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third. The SDEC model should be embedded in every hospital, in both medical and surgical specialities, with all Type 1 Emergency Department (ED) providers expected to deliver SDEC at least 12 hours per day, seven days a week, by September 2019.

The planning guidance highlights the following deliverables for 2019/20:

- The existing NHS Constitution standards remain in force until new clinical standards for urgent and emergency care are set out in the Clinical Standards Review, to be published in spring 2019, tested in the first half of the year, and implemented from October 2019.

- Ambulance services should ensure they meet ambulance response time constitutional standards as set out below: Category 1: 7 minutes (mean), 15 minutes (90th centile); Category 2: 18 minutes (mean), 40 minutes (90th centile); Category 3: 120 minutes (90th centile); Category 4: 180 minutes (90th centile).

- No one arriving by ambulance should wait more than 30 minutes from arrival to hospital handover.
Southwark CCG will work with partners to achieve the following deliverables for Urgent & Emergency Care across South East London:

**In hospital offer**

- Urgent and emergency care transformation initiatives as part of our System Improvement Plan, focused on:
  - Clinically led front door streaming and admissions avoidance, increased utilisation of same day emergency care models operating 7 days a week, including a comprehensive frailty assessment and acute frailty mode, best practice internal flow initiatives (SAFER care bundles, Red to Green days and criteria led discharge) to reduce length of stay.

**Out of Hospital offer**

Standardising our out of hospital provision (recognising this is a multi year objective) with a 2019/20 focus on:

- Optimised access to GP extended access from A&E, admission avoidance services for GPs, LAS and A&E, services that target high intensity users and that manage patients with multiple long term conditions, targeted support to Care Homes, full access to Discharge to Assess pathways to include bridging capacity, community based alternatives for key conditions and a review of therapy services to ensure therapists are placed at all required stages of the U&EC in and out of hospital pathway.
- Agreed standards for response times and admission from Accident and Emergency services to mental health services though the mainstreaming of our 2018/19 flow initiatives and wider pathway redesign.
- Working with LAS and system partners to maximise demand management and admission avoidance plans and pathway changes, whilst continuing to secure improved LAS response and handover times.
- Rolling out our new 111 service and linking it with our 999 and Urgent Treatment Centre provision to provide a comprehensive urgent and emergency response offer operating alongside our A&Es.
5. Urgent and Emergency Care (cont.2)

Southwark CCG is committed to work with the trust to implement at a local level the commitments made as part of the STP. The data below is for all patients attending King’s College Hospital (KCH) emergency department (both at Denmark Hill and PRUH sites) and is the trajectory the trust agreed to in their 2019/20 Operating Plan.

In 2019/20 Trusts directly submitted their A&E trajectory to NHS England.

<table>
<thead>
<tr>
<th>A&amp;E waits at KCH</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &gt; 4 hours</td>
<td>5,572</td>
<td>5,268</td>
<td>4,687</td>
<td>4,273</td>
<td>3,622</td>
<td>3,395</td>
<td>3,137</td>
<td>2,790</td>
<td>2,785</td>
<td>2,905</td>
<td>2,390</td>
<td>2,591</td>
</tr>
<tr>
<td>Total Attendances</td>
<td>22,526</td>
<td>24,469</td>
<td>23,571</td>
<td>24,089</td>
<td>22,006</td>
<td>22,760</td>
<td>23,416</td>
<td>23,543</td>
<td>23,838</td>
<td>24,832</td>
<td>20,780</td>
<td>23,759</td>
</tr>
<tr>
<td>Percentage &lt; 4 hours</td>
<td>75.3%</td>
<td>78.5%</td>
<td>80.1%</td>
<td>82.3%</td>
<td>83.5%</td>
<td>85.1%</td>
<td>86.6%</td>
<td>88.1%</td>
<td>88.3%</td>
<td>88.3%</td>
<td>88.5%</td>
<td>89.1%</td>
</tr>
</tbody>
</table>
6. Planned Care

The NHS Long Term plan commits to shorter waits for planned care. Cataract extraction, joint replacements and other planned surgery all help people stay independent and yield important quality of life gains.

Under the Long Term Plan, the local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list. The phasing of this improvement will partly be shaped by the availability of staff to expand treatment capacity in hospitals, and will be determined annually through the planning guidance process.

The ability of patients to choose where they have their treatment remains a powerful tool for delivering improved waiting times and patient experiences of care. The NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity.

Patients will continue to have choice at point of referral and anyone who has been waiting for six months will be reviewed and given the option of faster treatment at an alternative provider, with money following the patient to fund their care.

The ability of patients to choose where they have their treatment remains a powerful tool for improving waiting times and patient experiences of care. Southwark CCG will work with partners to achieve the following deliverables for Planned Care across South East London:

**In hospital offer**

- Performance improvement to secure the sustained delivery of performance standards in line with operating plan trajectories, across long waiters, over 18 week waits and waiting list size

- Implementation of new Evidence Based Interventions policy to support clinical effectiveness.
6. Planned Care (cont.1)

In hospital offer (cont.)

- Outpatient transformation initiatives as part of our System Improvement Plan, focused on: Roll out of advice and guidance alongside robust referral assessment services to get the patient to the right place first time, redesign of new outpatient services (shift to straight to test, virtual appointments and one stop appointments), redesign of follow up services (shift to patient initiated follow ups and from face to face to virtual appointments).
- Continued development of our orthopaedic network and the establishment of new clinical networks for urology and dermatology services
- The development of a comprehensive acute planned care strategy – which will address the wider issues such as demand and capacity, productivity and efficiency, unwarranted variation and configuration options for elective provision – this will be taken forward in 2019/20 alongside specific pathway improvements.

Out of hospital offer

- Referrals optimisation at the point of potential referral - a variety of mechanisms are in place to support this with locally developed approaches to ensure operating plan referral rates are consistently met
- The implementation of community based alternatives – to support the repatriation of activity from acute to community based settings. Key areas of agreed delivery in 2019/20 are - ophthalmology, kidney disease, ENT, dermatology, cardiology and MSK.

Diagnostics

- Agreed performance improvement targets to reduce waiting times and improve access
- Diagnostic strategy – to be completed in 2019/20 to support a sustainable demand and capacity plan for the future
- Interim capacity management of 2019/20 – agreed SEL approach to managing capacity shortfalls with a STP wide outsourcing approach.
A more significant annual increase in the number of elective procedures compared with recent years means commissioners and providers should plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2020 than in March 2019 and, where possible, they should aim for it to be reduced.

Percentage waiting to start treatment who have been waiting less than 18 weeks

<table>
<thead>
<tr>
<th>Incomplete pathways</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete Pathways &lt; 18 weeks</td>
<td>20,706</td>
<td>21,144</td>
<td>21,373</td>
<td>21,818</td>
<td>22,149</td>
<td>22,359</td>
<td>22,805</td>
<td>22,857</td>
<td>22,984</td>
<td>23,538</td>
<td>23,773</td>
<td>23,758</td>
</tr>
<tr>
<td>Total Incomplete Pathways</td>
<td>24,747</td>
<td>25,190</td>
<td>25,369</td>
<td>25,722</td>
<td>25,983</td>
<td>26,084</td>
<td>26,436</td>
<td>26,370</td>
<td>26,390</td>
<td>26,822</td>
<td>26,973</td>
<td>26,870</td>
</tr>
<tr>
<td>Percentage</td>
<td>83.7%</td>
<td>83.9%</td>
<td>84.2%</td>
<td>84.8%</td>
<td>85.2%</td>
<td>85.7%</td>
<td>86.3%</td>
<td>86.7%</td>
<td>87.1%</td>
<td>87.8%</td>
<td>88.1%</td>
<td>88.4%</td>
</tr>
</tbody>
</table>

The national 2019/20 ambition is to sustain the waiting list at March 2019 levels in March 2020. The trajectories above show a reduction in the number of people on the waiting list.

Number of patients waiting more than 52 weeks for treatment

<table>
<thead>
<tr>
<th>52 weeks</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathways &gt;52 Weeks</td>
<td>46</td>
<td>40</td>
<td>34</td>
<td>27</td>
<td>21</td>
<td>11</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The national 2019/20 ambition is for the number of patients waiting more than 52 weeks for treatment at March 2019 be halved by March 2020. The trajectories above show that the CCG has planned to surpass this ambition, with no patients waiting more that 52 weeks by March 2020.
### Diagnostics

<table>
<thead>
<tr>
<th>Diagnostic test waiting time</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients waiting &gt;6 weeks for diagnostics</td>
<td>304</td>
<td>327</td>
<td>360</td>
<td>401</td>
<td>352</td>
<td>301</td>
<td>261</td>
<td>217</td>
<td>163</td>
<td>119</td>
<td>83</td>
<td>48</td>
</tr>
<tr>
<td>Total number waiting</td>
<td>4,983</td>
<td>4,995</td>
<td>5,047</td>
<td>4,809</td>
<td>4,573</td>
<td>4,770</td>
<td>5,147</td>
<td>5,317</td>
<td>4,653</td>
<td>4,964</td>
<td>5,048</td>
<td>5,056</td>
</tr>
<tr>
<td>Percentage</td>
<td>6.1%</td>
<td>6.5%</td>
<td>7.1%</td>
<td>8.3%</td>
<td>7.7%</td>
<td>6.3%</td>
<td>5.1%</td>
<td>4.1%</td>
<td>3.5%</td>
<td>2.4%</td>
<td>1.6%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

NHS England has set a national ambition for a maximum of 1% of patients should wait 6 weeks or more for a diagnostic test. The trajectory above shows the plan to achieve this during 2019/19.
The NHS’s goal for 2019-20 is to advance delivery of the National Cancer Strategy to promote better prevention and earlier diagnosis and deliver innovative and timely treatments to improve survival, quality of life and patient experience by 2020/21. The CCG continues to work with the trusts, the Accountable Cancer Network and Transforming Cancer Services Team to promote earlier identification of and treatment for cancer.

We will work with STP partners to progress the following shared objectives for SEL:

- To progress our STP cancer plan – focus on improved early detection and diagnosis of cancer, improved cancer survivorship and recovery care and support.
- To secure pathway improvements across SEL to support the treatment of patients suspected of having, and diagnosed with, cancer in line with national waiting times standards.
- To continue to develop our Accountable Cancer Network to take shared responsibility for the delivery of cancer services and outcomes.

The following slides show the operational and activity plan requirements for the CCG to deliver during 2019-20. The planning guidance highlights the following deliverables for 2019/20:

- Ensure all eight waiting time standards for cancer are met, including the 62 day referral-to-treatment cancer standard. The ‘10 high impact actions’ for meeting the 62 day standard should be implemented in all trusts, with oversight and coordination by Cancer Alliances.
7. Cancer (cont.1)

• All providers must start to collect the 28-day Faster Diagnosis Standard data items in 2019/20, in preparation for the introduction of the Standard in 2020. Organisations, working through their Alliances, should use the data items to improve time to diagnosis, in particular for lung, prostate and colorectal cancers.

• From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer.

• Extend lung health checks (already piloted in Manchester and Liverpool).

• From 2019, we will start the rollout of new Rapid Diagnostic Centres (RDCs) across the country.

• All providers must start to collect the 28-day Faster Diagnosis Standard data items in 2019/20, in preparation for the introduction of the Standard in 2020. Organisations, working through their Alliances, should use the data items to improve time to diagnosis, in particular for lung, prostate and colorectal cancers.

• Implement a stratified approach for follow up for breast cancer in 2019 and prostate and colorectal cancers in 2020 (expanding to all cancers which are clinically appropriate in 2023).

• From 2019, begin to introduce the quality of life metric – the first on this scale in the world – to track and respond to the long-term impact of cancer.
7. Cancer (cont.2)

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet the 93% target for its patients throughout 2019-20.

<table>
<thead>
<tr>
<th>Cancer waiting times: 2 week wait</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 2 weeks</td>
<td>911</td>
<td>941</td>
<td>1,037</td>
<td>1,038</td>
<td>1,001</td>
<td>912</td>
<td>1,077</td>
<td>1,017</td>
<td>877</td>
<td>951</td>
<td>970</td>
<td>970</td>
</tr>
<tr>
<td>Total number waiting</td>
<td>979</td>
<td>1,011</td>
<td>1,115</td>
<td>1,116</td>
<td>1,076</td>
<td>980</td>
<td>1,157</td>
<td>1,093</td>
<td>943</td>
<td>1,022</td>
<td>1,043</td>
<td>1,043</td>
</tr>
<tr>
<td>Percentage</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.0%</td>
<td>93.0%</td>
<td>93.0%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.0%</td>
<td>93.0%</td>
<td>93.1%</td>
<td>93.0%</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet the 94% target for its patients throughout 2019-20.

<table>
<thead>
<tr>
<th>Cancer waiting times: 31 day first treatment</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 31 days</td>
<td>77</td>
<td>87</td>
<td>96</td>
<td>95</td>
<td>87</td>
<td>69</td>
<td>100</td>
<td>81</td>
<td>77</td>
<td>96</td>
<td>76</td>
<td>85</td>
</tr>
<tr>
<td>Total number waiting</td>
<td>80</td>
<td>90</td>
<td>99</td>
<td>98</td>
<td>90</td>
<td>71</td>
<td>104</td>
<td>84</td>
<td>80</td>
<td>99</td>
<td>79</td>
<td>88</td>
</tr>
<tr>
<td>Percentage</td>
<td>96.3%</td>
<td>96.7%</td>
<td>97.0%</td>
<td>96.9%</td>
<td>96.7%</td>
<td>97.2%</td>
<td>96.2%</td>
<td>96.4%</td>
<td>96.3%</td>
<td>97.0%</td>
<td>96.2%</td>
<td>96.6%</td>
</tr>
</tbody>
</table>

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet the 94% target for its patients throughout 2019-20.

<table>
<thead>
<tr>
<th>Cancer waiting times: 62 day GP referral</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 62 days</td>
<td>6</td>
<td>9</td>
<td>9</td>
<td>12</td>
<td>13</td>
<td>5</td>
<td>15</td>
<td>6</td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Total number waiting</td>
<td>6</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>14</td>
<td>5</td>
<td>16</td>
<td>6</td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Percentage</td>
<td>100.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>92.3%</td>
<td>92.9%</td>
<td>100.0%</td>
<td>93.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>90.9%</td>
</tr>
</tbody>
</table>

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet the 85% target for its patients throughout 2019-20.

In addition to the trajectories included above, the **CCG is planning to deliver all national Cancer Waiting Times targets for treatment-specific pathways and for patients referred via national screening programmes.**
8. Transforming Care

NHS Southwark CCG, as part of the South East London Transforming Care Partnership (TCP), will continue to work with partners to deliver NHS England's Transforming Care Programme. The partnership will jointly deliver the three programme outcomes in their sub-regional areas:

1. Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
2. Improved quality of life for people in inpatient and community settings
3. Improved quality of care for people in inpatient and community settings.

Southwark CCG will work with partners to achieve the following deliverables for Transforming Care across South East London:

- **Inpatient Services**: continue to provide dedicated case management support to expedite discharge pathways in order to support people to return to the community as soon as clinically viable, deliver against LeDeR, STOMP and STAMP national programmes.

- **Admission prevention**: drive improved Dynamic Risk Registers process, increase rates of LD Annual Health Checks and Community Care and Treatment Reviews (CTRs). Deliver Positive Behaviour Support and Autism Awareness training to local SEL workforce groups.

- **Community Capacity**: deliver additional ASD support services (SLAM and Oxleas services recently mobilised), define and deliver new care models within the community, expand Lambeth’s Without Walls offering, deliver a tri-borough BBG Intensive Community Support offering (focused on keeping placements viable, minimising risk of admission and supporting transition to the community), implement Housing Strategy review recommendations.

- **Enablers**: SEL-wide Memorandum of Understanding (MOU) between SEL CCGs, Local Authorities and Specialised Commissioning, to drive collaboration and the accelerated mobilisation of services commissioned at scale, making the TCP more agile and able to respond to the needs of the local population. Harness experience of workforce specialists to ensure that SE London LD/ASD health and care providers have access to the workforce capability and capacity required to provide quality care services. Engage with SE London stakeholders to raise awareness of the TCP, increase participation in the programme and shape future activities. Deliver workforce and carer focused training to build resilience and awareness of LD/ASD needs.
8. Transforming Care (cont.1)

<table>
<thead>
<tr>
<th>Reliance on inpatient care for people with LD or Autism</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of people from the CCG who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs</td>
<td>17</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>GP Registered Population of CCG (18+ only)</td>
<td></td>
<td></td>
<td>249,846</td>
<td></td>
</tr>
<tr>
<td>Learning Disability Inpatient Rate per Million GP Registered Population</td>
<td>68.04</td>
<td>64.04</td>
<td>64.04</td>
<td>64.04</td>
</tr>
</tbody>
</table>

The national ambition was that by March 2019 no area should need more inpatient capacity than is necessary at any one time to cater to: 10-15 inpatients in CCG commissioned beds (such as those in assessment and treatment units) per million population; 20-25 inpatients in NHS England-commissioned beds (such as those in low, medium or high-secure units or CAMHS Tier 4 units) per million population.

The trajectories above are on a Transforming Care Partnership (TCP) basis. The reduction in inpatient numbers is a proxy measure for a reduction in the number of inpatient beds. The above trajectory shows the TCP plan to maintain focus on this ambition.

<table>
<thead>
<tr>
<th>Improving access to health care for people with Learning Disabilities</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter (cumulative)</td>
<td>82</td>
<td>163</td>
<td>245</td>
<td>326</td>
</tr>
<tr>
<td>Population on the GPs Learning Disability Register (18+ only)</td>
<td></td>
<td></td>
<td>1087</td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>7.5%</td>
<td>15.0%</td>
<td>22.5%</td>
<td>30.0%</td>
</tr>
</tbody>
</table>
9. Prevention

Wider action on prevention will help people to stay healthy and also moderate demand on the NHS. Action by the NHS is a complement to – not a substitute for – the important role of individuals, communities, government and businesses in shaping the health of the nation. Nevertheless, every 24 hours the NHS comes into contact with more than a million people at moments in their lives that bring home the personal impact of ill health.

The Long Term Plan therefore focuses on specific new evidence-based NHS prevention programmes, including to cut smoking, to reduce obesity, to limit alcohol-related A&E admissions and to lower air pollution.

Southwark CCG will work with partners, including jointly working with the London Borough of Southwark Public Health Team, to achieve the following deliverables for Prevention across South East London:

• Enhanced, comprehensive core prevention offer – systematically rolled out and embedded within each and every level of our ICS.

• Focus on early identification of risk and targeted intervention to improve population health, reduce disease burden and health inequalities across the Southwark and wider SEL population.

• Ongoing work to develop a borough-wide prevention framework and strategy as part of the SEL STP Prevention Programme and our Long Term Plan response – this will focus on driving out inequalities, including the at scale roll out of targeted prevention, risk identification and management approaches.

• Rolling out a consistent approach to commissioning for prevention across SEL including rollout of the Ottawa Model (smoking cessation) and The ‘Vital 5’ (systematic monitoring and acting on key health indicators across all providers).
Further local priority deliverables for the CCG include:

**Smoking**  By 23/24 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services. The model will be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway. A new universal offer will be made available as part of specialist mental health services for long-term users of specialist mental health and in learning disability services.

As part of the on-going JSNA process of understanding health and wellbeing needs in the borough, the public health team have recently published the health needs assessment related to smoking.

- In 2017 it was estimated that 12.2% of adults in Southwark were smokers; below both the national and London average.
- Smoking remains the single biggest cause of premature death and disease nationally and locally.
- In Southwark the economic impact of smoking is estimated to be over £84 million per year.

**Obesity**
- Tier 2 & Tier 3 Weight Management programmes commissioned for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+
- NHS Diabetes prevention programme and Walking Away from Diabetes available to people who are diagnosed with pre-diabetes. Several digital options are being reviewed.
- Very low calorie diets are an option in the Tier 3 WMP. An additional small pilot will be commissioned shortly trialling very low calorie, low carb and intermittently fasting diets.

**Alcohol**  Introduction of Alcohol Care Teams for those hospitals with the highest rate of alcohol dependence-related admissions.

**Air pollution**  Continue to support the Southwark Air Quality Strategy & Action Plan, which includes: Cut business mileages and fleet air pollutant emissions by 20% by 2023/24.

**Antimicrobial resistance**  Support the implementation and delivery of the five year action plan on antimicrobial resistance.
10. Other Priorities: Personal Budgets

Personalised care means people have choice and control over the way their care is planned and delivered. One way to provide care in this way is by a personal health budget (PHB).

The deliverable for PHBs is that by March 2021, 50,000 to 100,000 people should have a PHB.

Southwark CCG will work with partners to achieve the following deliverables for across South East London:

• SEL CCGs will continue to increase the numbers of PHBs being offered by ensuring PHBs are the default delivery method of care for people in receipt of NHS continuing healthcare. In 2019/20, SEL CCGs will continue to maximise the proportion of patients currently eligible for PHBs and will explore extending the availability to other appropriate cohorts (particularly for people with mental health needs and for the provision of wheelchairs).

• We have established a SEL PHB leads group which will continue to meet monthly and provide a valuable forum to review and assure delivery, explore opportunities for further expansion of PHB provision and share best practice.

• The STP is working with NHS England to explore the potential for securing additional resource/support to enable CCGs to implement plans to expand the offer of PHBs to other cohorts. We are also working with other STPs to share learning and best practice.

• Expanding the offer of PHBs to wheelchair users will be a particular focus for most CCGs in SEL following successful implementation in Bexley.

• SEL CCGs will continue to work to identify any opportunity to count current PHBs where they already exist. This could apply where the NHS has contributed funding to a social care or education package where there is a health need identified and the six essential features of a PHB are in place.
10. Other Priorities: Personal Budgets (cont.)

**Personal Health Budgets**

<table>
<thead>
<tr>
<th>Cumulative number of PHBs in place</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>140</td>
<td>185</td>
<td>230</td>
<td>275</td>
</tr>
</tbody>
</table>

The above trajectories show the plan for there to be 275 personal health budgets across Southwark CCG by quarter 4 of 2019/20. By 2020/21, NHS England’s ambition is for there to be a total of 100 to 200 Personal Health Budgets over the course of a year for every 100,000 of population. For Southwark’s registered population (267,409), this is on target.
Southwark enabling workstreams including estates, digital and workforce form part of broader STP programmes overseen by a new / reset Enabler Board, ensuring that we are proactively pursuing all opportunities across our infrastructure, including estates, back office and procurement. We are also participating in the national LHCRE and prescribing programmes.

Our 2019/20 STP priorities are: to implement our pathology procurement programme; to continue to progress digital opportunities in support of our pathway transformation programmes; to maximise prescribing and medicines management opportunities; to implement our agreed estates programmes; and to review remaining back office opportunities across our whole system. We will further review opportunities across Rightcare, Getting It Right First Time (GIRFT) and Carter to ensure we have a comprehensive productivity and efficiency improvement programme.

### Pharmacy

A successful Wave 4 capital bid for “Patient-Centric Supply Chain” encompassing pharmacy is being mobilised, work on Aseptics will include developing a model for a central hub for chemotherapy that will serve SEL provider needs and, delivery of a plan to integrate Pharmacy and Medicines Optimisation (IPMO) across primary and secondary care sectors will start this year.

### Pathology

Four of our five providers and the six CCGs in SEL are working in collaboration to develop a network for delivering pathology services under a single shared specification to deliver the national programme of pathology networks. Contract award is expected during the second half of 2019/20.

### Procurement

A number of providers across south east London have joined GSTT’s procurement service adopting common best practice systems and processes, removing duplication, reducing back office overheads and delivering savings.

### Estates

The SEL Estates strategy has been refreshed. A comprehensive review of resource and delivery plans has been completed and governance arrangements refreshed to shift to a delivery focus in 2019/20. At a borough level the Dulwich Programme Board is overseeing delivery of the Dulwich Health Centre during 2019/20 and our Estates Programme Board is overseeing community hubs in earlier stages of development including Aylesbury, Canada Water and Elephant and Castle.

### Digital

Priorities for 2019/20 will be shaped by a Digital Strategy Review which has been procured. They will include working towards the implementation of the NHS App digital front door and implementation of the LHCRE programme to enable the linking of patient records. If NHSE funding is confirmed, a 3 year programme of work to deliver “core level digitisation” will roll out and lessons from the population health pilot in Lewisham will shape further work across the STP.

### Workforce

Key programmes of work for 19/20 across the STP include primary care support (recruitment, retention and skills development), provider collaboration including programmes focused on nursing and apprenticeships. Southwark level programmes include supporting the development of primary care networks (PCNs) and their associated new workforce, delivering the Nursing Ten Point Plan and linking our Community Education Provider Network (CEPN) to Partnership Southwark.
Financial and budget framework for 2019-20

The best possible health outcomes for Southwark people
The financial scenario facing the CCG for 2019-20 and future years is increasingly tough and has tightened further since last year. The CCG anticipates closing its accounts for 2018-19 having achieved a £989k surplus in line with plan.

Our funding settlement for 19-20, and later, represents a significant increase in resources. In 2019-20 our core services commissioning budget has increased by 5.98%. Our Delegated primary care budget has increased by 6.5%. Running costs remain static, but with a 12% saving from April 2020. We are aiming to achieve a 10% saving in this year, leading to making the full 12% from April 2020.

Overall this is higher than previously awarded, but has significantly increased commitments attached to it. National pay awards are now funded through this uplift. The PBR tariff has increased net by nearly 3% this year, compared to 1% the year before. Mental Health budgets are expected to be increased through investment in IAPT, CAMHS and other local schemes by 6.7%. Community services are also to be invested in by 6% extra this year. The primary care uplift is to take account of the new contract deal, and fund the new Clinical Negligence scheme that applies to Practices (CNSGP). There are many other commitments, as well as the need to pump-prime to achieve some of our savings initiatives.

The CCG is now seen as 1.75% above its target allocation, and will receive c. 4% uplift in 2020-21.
The CCG has determined that it will need a net QIPP saving programme of c. £16.5m in 2019-20. This is similar to 2018-19, but must be set against a recognition that there are limited contractual efficiencies to be achieved, therefore, there is an increasing need to be more innovative with respect to the development of transformational programmes.

As a result of known pressures and the QIPP requirement, the CCG is unable to maintain contingency and reserves at the same level as previous years. National business rules have been revised to require the CCG to hold only a minimum 0.5% contingency in reserves that can be used to meet in year pressures. We are no longer required to hold a separate 0.5% for non-recurrent spend in 2019/20. The CCG’s 0.5% general contingency is £2.5m and the CCG holds other reserves of £2.0m.

Financial balance and the delivery of the CCG’s planned financial position is a core priority and a statutory requirement for NHS Southwark CCG.

The financial position is reviewed regularly by the CCG’s Governing Body and the Integrated Governance & Performance Committee. The committee is accountable for: overseeing a robust organisation-wide system of financial management, including QIPP delivery; ensuring that budgets are set in an appropriate and timely manner and that the Governing Body is fully aware of any financial risks which may materialise throughout the year. The annual budget was approved by the CCG Council of Members in March 2019, and they receive updates throughout the year.
## Opening Budgets 2019-20

<table>
<thead>
<tr>
<th>Opening Resources 2017-20 (£’000)</th>
<th>2018-19</th>
<th>2019-20</th>
<th>2020-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent core Allocation</td>
<td>413,881</td>
<td>439,773</td>
<td>459,236</td>
</tr>
<tr>
<td>Delegated Primary Care</td>
<td>44,749</td>
<td>47,696</td>
<td>49,830</td>
</tr>
<tr>
<td>Adjustment for CNSGP</td>
<td></td>
<td>-1,373</td>
<td>-1,373</td>
</tr>
<tr>
<td>Non recurrent sums announced</td>
<td>1,355</td>
<td>841</td>
<td>0</td>
</tr>
<tr>
<td>Running Costs allocation</td>
<td>6,533</td>
<td>6,537</td>
<td>5,766</td>
</tr>
<tr>
<td>Total Resources</td>
<td>466,518</td>
<td>493,474</td>
<td>513,459</td>
</tr>
<tr>
<td>Target surplus for the year</td>
<td>989,000</td>
<td>Break even</td>
<td>TBA</td>
</tr>
</tbody>
</table>

In 2018-19, we were required to make a surplus of £989k, which will be carried forward on our balance sheet, for future investment, at such time as we are allowed to “drawdown” these funds by NHSE. For 2019-20, we are asked to achieve a break even position for the year (taken on its own).
Due to known/likely cost pressures we face, QIPP planning is based on a 3.6% net saving of £16,550k in 2018/19. Such a level of QIPP will inevitably be challenging and will need close monitoring of both planning and implementation to ensure it is successful.
Reserves 2019/20 (indicative)

<table>
<thead>
<tr>
<th></th>
<th>2018-19 opening reserves</th>
<th>2019-20 proposed opening reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>General contingency ½ %</td>
<td>2,350</td>
<td>2,475</td>
</tr>
<tr>
<td>Winter Resilience</td>
<td>700</td>
<td>700</td>
</tr>
<tr>
<td>Dulwich costs</td>
<td>0</td>
<td>250</td>
</tr>
<tr>
<td>QIPP risk reserve</td>
<td>0</td>
<td>250</td>
</tr>
<tr>
<td>NR drawdown of historic underspend</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CCG risk reserve</td>
<td>2,352</td>
<td>873</td>
</tr>
<tr>
<td><strong>Total Reserves available</strong></td>
<td><strong>5,402</strong></td>
<td><strong>4,548</strong></td>
</tr>
<tr>
<td>% of total Resources</td>
<td>1.20</td>
<td>0.90</td>
</tr>
</tbody>
</table>

The financial plan meets national business rules with regard to holding a 0.5% contingency. We are no longer required to hold a separate 0.5% for non-recurrent spend in 2019/20.
High level plan on a page for our NHS LTP response

Our challenges:
- Demand for health and care services is increasing
- There is unacceptable variation in care, quality and outcomes across SEL
- Our system is fragmented resulting in duplication and confusion
- The cost of delivering health and care services is increasing

Our goal:
To address inequalities in south east London and deliver a sustainable system for the future

How we will deliver:
- National, London and local priorities
- Our ICS Delivery Models
  - Acute Based Care
  - Community Based Care
  - Mental Health
  - Enablers: Digital, workforce
    - Estates, productivity

Our cross cutting transformation programmes:
- Delivery at neighbourhood, place and system level as part of the SEL System of Systems
- Underpinned by OD & transformation across clinical leadership, commissioning and provider systems

What we will achieve:
- Equality in health outcomes for our population
- Equality in service offer for our population
- A sustainable workforce
- Sustainable performance
- Financial sustainability
- Sustainable estates
ITEM FOR DECISION

<table>
<thead>
<tr>
<th>CCG Committee</th>
<th>Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item title:</th>
<th>Southwark CCG Operating Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Enclosure number:</th>
<th>C</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Any known conflict of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Author</th>
<th>Responsible Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Garrett Turbett</td>
<td>Ross Graves</td>
</tr>
<tr>
<td>Job title</td>
<td>Job title</td>
</tr>
<tr>
<td>Head of Programmes</td>
<td>Managing Director</td>
</tr>
<tr>
<td>Directorate</td>
<td>Directorate</td>
</tr>
<tr>
<td>Integrated Commissioning</td>
<td>N/A</td>
</tr>
<tr>
<td>Email</td>
<td>Email</td>
</tr>
<tr>
<td><a href="mailto:g.turbett1@nhs.net">g.turbett1@nhs.net</a></td>
<td><a href="mailto:r.graves@nhs.net">r.graves@nhs.net</a></td>
</tr>
</tbody>
</table>
Process followed for development of this paper:

<table>
<thead>
<tr>
<th>Process followed</th>
<th>Urgent paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Followed agreed CCG process in full</td>
<td>✓</td>
</tr>
</tbody>
</table>

For urgent papers only: explain the reason for urgency

Click here to enter text.

<table>
<thead>
<tr>
<th>Impact on patients / service users</th>
<th>Financial impact</th>
<th>Impact on providers</th>
<th>Estates impact</th>
<th>Workforce impact</th>
<th>Equalities legislation</th>
<th>OSC involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Does the recommendation align with the CCG's objectives and responsibilities?

<table>
<thead>
<tr>
<th>Deliver IAF improvement</th>
<th>Improve patient outcomes</th>
<th>Improve quality / safety</th>
<th>Secure financial sustainability</th>
<th>Support integration</th>
<th>Address health inequalities / parity of esteem</th>
<th>Enable the delivery of care coordination</th>
<th>Promote early action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

The best possible health outcomes for Southwark people
1. Purpose of the paper

This version of the Operating Plan takes account of comments received at the IG&P meeting in May 2019, as well as those received from locality meetings in May and June.

2. Describe the issue being presented to the committee

An updated version of the Operating Plan with a summary of feedback (see below) and where appropriate the changes made. The following is a summary document in which the queries and feedback received regarding the Operating Plan are captured with a description of the response. Where feedback has not resulted in significant changes to the Operating Plan the CCG will capture appropriate actions as part of the broader CCG work plan.

3. What is your recommendation to the committee (i.e. what course of action do you suggest is taken?).

To endorse the Operating Plan 2019/20.

4. What is the rationale for your recommendation?

This draft has heard and included where required the views and comments of the IG&P members and other key stakeholders and is therefore a robust version of how Southwark CCG plans to operate in 2019/20.

5. What equality and diversity considerations have been highlighted in the Equality Analysis and how have they been addressed?

All deliverable activities discussed within the Plan will have been considered with due regard to the Public Sector Equality Duty and Equality Impact Assessments conducted where necessary. The document has been shared and discussed with our local CCG engagement and equality lead.

6. What stakeholder engagement has taken place?

Chair: Dr Jonty Heaversedge       Accountable Officer: Andrew Bland       Managing Director: Ross Graves
This has previously been discussed at IG&P and has been shared with and discussed at north and south locality meetings.

7. Do stakeholders support the recommendation being made?

There have been comments and some feedback (see table below) and changes made where appropriate. But broadly speaking, there has been support for the draft version.

8. What other options were considered?

n/a

9. What are the risks in proceeding with the recommendation?

There are programme risks within the different areas described within the plan. These are captured in programme and board risk documents.

10. What are the risks in not proceeding with the recommendation?

Without an Operating Plan aligned with national and STP plans, there is a risk that services would be misaligned and not serving the needs of residents.
### Supporting information / documents

Please append any relevant documents including detailed reports; options appraisals; background documents; national guidance etc.

<table>
<thead>
<tr>
<th>Appendix #</th>
<th>Name of document</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>Southwark CCG Operating Plan 2019/20</td>
</tr>
</tbody>
</table>

**Date paper completed**

Friday, 21 June 2019
# 2019/20 Operating Plan, Feedback and Comments

The following is a summary document in which the queries and feedback received regarding the Operating Plan are captured with a description of the response. Where feedback has not resulted in significant changes to the Operating Plan the CCG will capture appropriate actions and follow up as part of its broader CCG work plan.

<table>
<thead>
<tr>
<th>Feedback received</th>
<th>Amendments made to draft</th>
<th>Other actions and next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Slide 18 - Key deliverables: there is no mention of outcomes</td>
<td>The opening sentence reads “We are in the process of detailed planning and mobilisation against each of our system priorities.” This section refers to PS and projects are in planning/mobilisation, the deliverables are what the programme is measured against. We have added two introductory slides to this section which link the content to the Southwark Five Year Forward View and make reference to outcomes.</td>
<td>Share updated version with IG&amp;P for final comments on 27-June.</td>
</tr>
<tr>
<td>ii. Slide 45 – Prevention: should state this as a joint programme with LB Southwark and this is the health offer (I think this just refers to Smoking); a huge amount of work has been done over a number of years – not really reflected on this slide (I think this just refers to Obesity); yes to the question about Alcohol Care Teams;</td>
<td>Included reference joint working with LB Southwark teams on opening Prevention slide. Updated alcohol care teams. Reference added to SEL priority deliverables for prevention: Ottawa Model and Vital 5 on slide 44.</td>
<td>Share updated version with IG&amp;P for final comments on 27-June.</td>
</tr>
<tr>
<td>iii. Difficult in places to distinguish Southwark from SEL e.g. slide 9</td>
<td>Slide 9 is within an SEL/ICS section, so it’s necessary for it to be more SEL focused - the section title: “Responding to the NHS Long Term Plan in the context of our development towards becoming an Integrated</td>
<td>Share updated version with IG&amp;P for final comments on 27-June.</td>
</tr>
<tr>
<td></td>
<td>Slide 17 – Transformation priorities: ‘supporting people to have greater control……’ This needs to be set in the context of the viewpoint of a Southwark resident – what differences will they see on their high street, at their GP surgery for example.</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>iv</td>
<td>Changed this part of the slide to read: “Supporting people to have greater control over their own health and wellbeing and connecting people and services so that care is delivered as close to home as possible, streamlining pathways, and clustering services where appropriate within neighbourhoods.” This is taken from a document entitled, ‘A high-level planning document for the neighbourhood care coordination and wellbeing workstream of the Partnership Southwark programme’. Being that it is high-level, the document lists key objectives, but not specifics regarding what a resident will see on their high street or at their GP surgery.</td>
<td>Share updated version with IG&amp;P for final comments on 27-June. Continue to develop narrative around the real and on the ground differences that the priority programmes within Partnership Southwark will make for local residents and for staff.</td>
</tr>
<tr>
<td>v</td>
<td>Slide 48, new slide developed by Ross Graves to describe broader enablers and how these are coordinated across the STP as well as in Southwark.</td>
<td>n/a</td>
</tr>
<tr>
<td>vi</td>
<td>My comments/observation ref page 21 of this document still stand about workforce etc that I raised</td>
<td>We recognise the significant risk that workforce poses to delivery of plans both at a borough level and across the NHS. The Operating Plan 2019-20 document has</td>
</tr>
<tr>
<td>at the last locality about what the actual plan is to enact these aspirations.</td>
<td>The 4 lines on Page 21 are the only place in the document that refer to Estates. As the manager of 2 surgeries that are very close to the Elephant &amp; Castle, is anything going to come to fruition at/around the E&amp;C?</td>
<td>Further detail on key estates deliverables added on pages 21 and 48 but also propose this is followed up with more detailed overview of CCG primary and community estate programme.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>been strengthened to make reference to the NHS People Plan (currently in interim draft, final Plan to follow later this year) and to include further detail on how workforce development is being delivered in the short term across the CCG and as a programme across the STP as a whole. Furthermore, detailed plans support these deliverables and we will create the opportunity to explore and shape these in more detail.</td>
<td>I appreciate that this isn’t the key purpose of this document but the realisation of Estates planning has always been glacial at best - understandable given the investment needed. The E&amp;C regen has been talked about for the best part of 20 years since I joined general practice in Southwark. Housing has appeared but nothing for general practice and yet the Estates Strategy (which hasn’t changed a great deal in the last few years) still references a Community Hub at the E&amp;C with c22k population increase expected in the Aylesbury area.</td>
<td></td>
</tr>
</tbody>
</table>
1. Summary of prime committee meetings since the last Governing Body

<table>
<thead>
<tr>
<th>Committee meetings included in this report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Governance &amp; Performance Committee</td>
</tr>
<tr>
<td>Meeting Date</td>
</tr>
</tbody>
</table>
2. **Summary of the principal role of CCG prime committees**

<table>
<thead>
<tr>
<th>Committee</th>
<th>Principal role of the committee</th>
<th>Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Governance &amp; Performance Committee</td>
<td>Overarching duty of the committee is to act to oversee governance in an integrated way, with all aspects of commissioning and provider activities are scrutinised using an approach that considers finance, quality, safety and performance together. Assurance of the effective functioning of the CCG and its main contracted providers. Provision of assurance to the CCG Governing Body for safeguarding; information governance; health and safety and equality and diversity management. Responsible for assuring the Governing Body on the monitoring of the CCG’s risk management and Board Assurance Framework.</td>
<td>Andrew Nebel, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td>Commissioning Strategy Committee</td>
<td>Oversees the development and implementation of the CCG’s strategic plans and commissioning intentions, taking into account information received from Localities and the Council of Members on commissioning strategy and priorities; scrutinises the on-going efficacy of commissioned services where service developments are identified; works with Member Practices to implement plans and undertake designated actions in the localities; receives reports from strategic programme boards charged with overseeing major commissioning programmes.</td>
<td>Dr. Jonty Heaversedge, Chair, NHS Southwark CCG</td>
</tr>
<tr>
<td>Joint Commissioning Strategy Committee</td>
<td>Sets direction and provides guidance on the development of strategic plans that are shared between NHS Southwark Clinical Commissioning Group and Southwark Council. Provides a joint forum for the senior leadership of the two organisations to discuss the local approach to strategic issues and oversee the key partnership strategies for children and young people, mental health, and older adults and complex needs, within the overarching Joint Southwark Five Year Forward View for Health and Social Care.</td>
<td>Dr. Jonty Heaversedge, Chair, NHS Southwark CCG &amp; David Quirke-Thornton, Strategic Director, Children’s and Adults Services, Southwark Council</td>
</tr>
<tr>
<td>Committee</td>
<td>Principal role of the committee</td>
<td>Chair</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Engagement and Patient Experience Committee</strong></td>
<td>Responsible for monitoring, advising and providing assurance on patient engagement ensuring statutory duties are met and building on local good practice and report to the Governing Body on progress in implementing the engagement strategy and advising of any major deviation from engagement plans.</td>
<td>Joy Ellery, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td><strong>Southwark CCG Primary Care Commissioning Committee</strong></td>
<td>The Primary Care Commissioning Committee makes collective decisions on the review, planning and procurement of primary care services in Southwark, under delegated authority from NHS England</td>
<td>Robert Park, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td><strong>Remuneration Committee</strong></td>
<td>Remuneration Committee is an advisory committee of the Governing Body, which makes recommendations about the remuneration, fees, payments and other allowances for employees and for people who provide services to the CCG</td>
<td>Richard Gibbs, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td><strong>Audit Committee</strong></td>
<td>Audit Committee provides the Governing Body with an independent and objective view of the CCG’s financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance, and assurance on risk and fraud issues;</td>
<td>Richard Gibbs, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td><strong>South East London Integrated Governance &amp; Performance Committee</strong></td>
<td>SEL CCGs agreed that a pan-SEL Committee should be established to monitor the delivery of provider organisations’ statutory and delivery responsibilities to ensure agreed actions / mitigations are followed through; to discuss and agree appropriate remediation; and to pro-actively identify and address declining performance indicators, ensuring deterioration is managed rapidly. The scope of the SEL Committee includes oversight of and coordination of the SEL CCGs’ response to:</td>
<td>Ray Warburton, Independent chair of SEL IG&amp;P</td>
</tr>
</tbody>
</table>
Committee | Principal role of the committee | Chair
--- | --- | ---

- The delivery of the SEL CCG control total and as such the individual annual CCG control totals and both individual and collective mitigations where this is off plan.
- The sustainable delivery of the NHS Constitution standard for RTT, cancer and diagnostics
- Matters of clinical quality and safety related to the areas of business within the SEL Committee’s scope.
- Identification and pro-active management of key strategic and operational risks relating to the areas deemed as in-scope.
## 3. Recommendations to the Governing Body for decision/approval

The Governing Body should review the papers referenced and formally approve the recommendation made by the stated committee. This decision will be recorded in the minutes of the Governing Body meeting.

<table>
<thead>
<tr>
<th>No.</th>
<th>Committee name</th>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Recommendation for decision</th>
<th>Associated documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 June 2019</td>
<td>CCG Operating Plan 2019/20</td>
<td>The Committee endorsed the CCG Operating Plan 2019/20 and agreed to recommend it to the Governing Body.</td>
<td>ENC F</td>
</tr>
<tr>
<td>2.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 June 2019</td>
<td>IGP Committee – revised approach to business</td>
<td>The Committee endorsed revised terms of reference which reflect the impact of the expanded scope of the SEL IGP Committee. They also allow for standing agenda items that are usually presented to the Commissioning Strategy Committee to be presented to the IGP instead. The Governing Body is requested to approve these terms of reference.</td>
<td>ENC D (iii)</td>
</tr>
</tbody>
</table>
4. Action taken under delegation: Governing Body to note for assurance

The Governing Body should note the below items, where a prime committee made a decision under the scheme of delegation as set out in the CCG Constitution.

<table>
<thead>
<tr>
<th>No.</th>
<th>Committee name</th>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Action taken under delegation by the committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Engagement and Patient Experience Committee</td>
<td>6 May 2019</td>
<td>Agreeing Membership, Engagement and Equalities workplan</td>
<td>The committee agreed the membership, engagement and equalities workplan.</td>
</tr>
<tr>
<td>2.</td>
<td>Engagement and Patient Experience Committee</td>
<td>6 May 2019</td>
<td>Reviewing EPEC terms of reference</td>
<td>The committee agreed the terms of reference until March 2020 with two minor changes.</td>
</tr>
</tbody>
</table>
| 3.  | Primary Care Commissioning Committee        | 28 May 2019  | Urgent planned Primary Care Commissioning Committee decisions for reporting public | The following urgent planned Primary Care Commissioning decision was reported in the public meeting:  
On 23 April 2019 the Committee agreed to issue Dr Misra with a formal action plan to provide assurance that the practice had addressed all of issues highlighted by the CQC following the inspection of Dr Misra’s practice Borough Medical Centre on 31 January 2019 which rated the practice as ‘requires improvement’ overall.  
The decision was taken in line with the London standard operating procedure for practices rated as ‘required improvement’ by the CQC.                                                                 |
<table>
<thead>
<tr>
<th>No.</th>
<th>Committee name</th>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Action taken under delegation by the committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>Primary Care Commissioning Committee</td>
<td>28 May 2019</td>
<td>Primary Care Network Update</td>
<td>The Committee endorsed the proposal for two primary care networks for Southwark.</td>
</tr>
<tr>
<td>5.</td>
<td>Remuneration Committee</td>
<td>29 May 2019</td>
<td>Registered Nurse Member – extension of contract</td>
<td>The Committee agreed to extend the contract of the current postholder to 31 March 2020.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The Annual Report and Accounts has been published on the CCG website as required by NHSE within the stipulated timescale; link <a href="#">here</a>.</td>
</tr>
<tr>
<td>7.</td>
<td>Audit Committee</td>
<td>24 May 2019</td>
<td>External Audit Reports - Year-end Report (ISA 260) - External Audit Opinion</td>
<td>The Committee accepted the Year End Audit Report as prepared and presented by external auditors KPMG.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>The Committee also noted the Audit Opinion issued by KPMG.</td>
</tr>
</tbody>
</table>
5. **Committee items for the Governing Body to discuss**

The Governing Body should note and discuss the below items. These are items where assurance has been received at a prime committee, but where the Governing Body may wish to seek additional assurance or discuss pertinent issues relating to the business of the CCG.

<table>
<thead>
<tr>
<th>No.</th>
<th>Committee name</th>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Recommendation for discussion / to note</th>
<th>Associated Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 June 2019</td>
<td>CCG/SEL Assurance reports (M2)</td>
<td>The committee recommended to the Governing Body for review and approval</td>
<td>G (i) &amp; G (ii)</td>
</tr>
<tr>
<td>2.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 June 2019</td>
<td>CCG Finance Report (M2) and SEL Finance Report (M12)</td>
<td>The committee noted and recommended to the Governing Body for review and approval</td>
<td>G (iii) &amp; G (vi)</td>
</tr>
<tr>
<td>3.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 June 2019</td>
<td>CCG Board Assurance Framework and risk report (M2), and SEL Board Assurance Framework</td>
<td>The committee recommended to the Governing Body for review and approval</td>
<td>G (v) &amp; G (vi)</td>
</tr>
<tr>
<td>4.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 June 2019</td>
<td>Other items for assurance.</td>
<td>The Committee noted updates on quality and GP IT, and received the results of the 360° stakeholder survey.</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Committee name</td>
<td>Meeting date</td>
<td>Agenda item</td>
<td>Recommendation for discussion / to note</td>
<td>Associated Documents</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>5.</td>
<td>Engagement and Patient Experience Committee</td>
<td>6 May 2019</td>
<td>Report on engagement in developing support for people living with and beyond cancer</td>
<td>The committee was assured by the engagement undertaken. <a href="#">You can read a copy of the engagement report here.</a></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Audit Committee</td>
<td>24 May 2019</td>
<td>Annual Internal Audit Report including Final Head of Internal Audit Opinion</td>
<td>The Committee noted the Annual Internal Audit Report and the Final Head of Internal Audit Opinion. The CCG was issued a Substantial Assurance &quot;green&quot; rating.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Audit Committee</td>
<td>24 May 2019</td>
<td>Counter Fraud Reports</td>
<td>The Committee accepted the Counter Fraud Progress Report, including the Final Self Review Tool, Counter Fraud Annual Report and Training Report.</td>
<td></td>
</tr>
</tbody>
</table>
| 8.  | Audit Committee                                     | 24 May 2019  | Service Auditor Reports                                                      | The Committee noted assurance from independent Service Auditor Reports for the following services provided to the CCG:  
- NEL CSU AAF Type 11 Finance and Payroll,  
- NHS Shared Business Services (NHS SBS) Finance and Accounting Services  
- NHS Digital GP Payments |                      |
<table>
<thead>
<tr>
<th>No.</th>
<th>Committee name</th>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Recommendation for discussion / to note</th>
<th>Associated Documents</th>
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<td>- Capita PCSE Report 18-19</td>
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<td>- NHS Business Service Authority (NHS BSA) Dental Payments Process</td>
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<td>- NHSBA – Prescription Payments Process</td>
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<td>- ESR Programme ISAE 3000 Type II Controls Report</td>
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Summary report from the latest meeting of the SEL Integrated Governance & Performance Committee

Date: 21 June 2019

<table>
<thead>
<tr>
<th>South East London Integrated Governance &amp; Performance Committee</th>
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<tbody>
<tr>
<td><strong>Principal role of the committee</strong></td>
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</tbody>
</table>

**Chair:** Ray Warburton, Independent chair of SEL IG&P

SEL CCGs agreed that a pan-SEL Committee should be established to monitor the delivery of provider organisations’ statutory and delivery responsibilities to ensure agreed actions / mitigations are followed through; to discuss and agree appropriate remediation; and to pro-actively identify and address declining performance indicators, ensuring deterioration is managed rapidly. The current scope of the SEL Committee includes oversight of and coordination of the SEL CCGs’ response to:

- The delivery of the SEL CCG control total and as such the individual annual CCG control totals and both individual and collective mitigations where this is off plan.
- The sustainable delivery of all acute NHS Constitution standards and Transforming Care performance.
- Matters of clinical quality and safety related to the areas of business within the SEL Committee’s scope.

The committee will additionally act to identify and pro-actively manage key strategic and operational risks relating to the areas deemed as in-scope. The committee approves the SEL BAF for all areas within its scope.

---

**Report Enclosures**

<table>
<thead>
<tr>
<th>Annex</th>
<th>Description</th>
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<tbody>
<tr>
<td>Annex 3</td>
<td>Final approved minutes – SEL IG&amp;P Committee – May 2019 – <strong>AGENDA ITEM 15, ENC H (viii)</strong></td>
</tr>
</tbody>
</table>
1. Recommendations to the Governing Body for decision / approval / action

The Governing Body should formally note the recommendation made by the committee and undertake the proposed action(s):

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda item</th>
<th>Recommendation for decision / approval / action</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.</td>
<td>South East London IG&amp;P Board Assurance Framework – June 2019</td>
<td>Members agreed that CCGs will use the SEL BAF for July Governing Body meetings and CCGs would ensure there was no duplication of acute or SEL-wide financial risks on local CCG BAFs.</td>
</tr>
</tbody>
</table>

2. Action taken under delegation: Governing Body to note for assurance

The Governing Body should note the below items, where a prime committee undertook an action under the authority delegated to it by the CCG Governing Body:

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda item</th>
<th>Action taken under delegation by the committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.</td>
<td>Deep dive: acute activity and finance</td>
<td>Sarah Cottingham, Director ICDT presented a paper that set-out 19/20 contracting objectives; planning assumptions and key risks for the year. The paper covered performance, activity and finance. The committee noted the paper and discussed the risks and plans for mitigation. CCGs contributions to mitigation plans were discussed and included approaches to demand management and roll-out of enhanced community pathways. The committee was advised of the governance arrangements in place to monitor contract delivery.</td>
</tr>
<tr>
<td>No.</td>
<td>Agenda item</td>
<td>Action taken under delegation by the committee</td>
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<tr>
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<tr>
<td>ii.</td>
<td>SEL CCG Performance Assurance Report</td>
<td>The committee received the monthly report and focused assurance discussions on the current position on Transforming Care; elective waits; cancer pathways and waiting times: A&amp;E and diagnostic waiting times – particularly at PRUH. The committee further discussed: endoscopy waiting times; MSK elective waits in Bexley; cancer 62-day recovery action plan; and prevention admissions for people with learning disabilities. The committee noted the current performance position and further noted the key issues associated with this. The committee registered its assurance that an adequate set of remedial actions had been identified and agreed with the provider; but further noted the significant risks relating to capacity for trusts and the wider system to deliver on these actions.</td>
</tr>
<tr>
<td>ii.</td>
<td>SEL CCGs Finance Update – M2 19/20</td>
<td>The committee noted that SEL CCGs are currently forecasting delivery of plans across the board based on an assumption that acute plans would be delivered within the start-year budget. Risks relating to continuing healthcare expenditure; and delegated primary care budgets were noted. The committee noted the current financial position and registered its assurance that an adequate approach to remediation is in place to mitigate identified risks. It was agreed that planned mitigations may reasonably be expected to deliver the necessary improvement to deliver year-end financial targets.</td>
</tr>
<tr>
<td>v.</td>
<td>South East London IG&amp;P Board Assurance Framework – June 2019</td>
<td>The committee endorsed the BAF for June 2019 and accepted the proposed risk scores for each risk included. It was agreed that for the July BAF, the full range of finance risks as included in the finance report would be incorporated into the SEL BAF.</td>
</tr>
</tbody>
</table>
3. Further items of business highlighted by the committee for the Governing Body to discuss

In addition to the above actions and items of business concluded under delegation, the Governing Body should note and discuss the following:

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda item</th>
<th>Item to note or discuss further</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No further items arising at the June 2019 committee meeting.</td>
<td></td>
</tr>
</tbody>
</table>
INTEGRATED GOVERNANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Introduction

1.1 The Integrated Governance and Performance Committee [the “Committee”] is established in accordance with the CCG’s constitution. These terms of reference set out the remit, membership, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG’s constitution.

1.2 The Committee is established to provide oversight of the activities of the CCG and of providers, particularly in respect of the following areas:

a. CCG Finance and QIPP in relation to CCG control total and QIPP delivery
b. Performance and quality in relation to matters that fall outside the scope of the South East London Integrated Governance and Performance Committee (SEL IGP)
c. Governance and Risk Management
d. Information Governance
e. Quality assurance including serious incidents, medicines management, continuing healthcare and safeguarding
f. Equality Delivery System-2 compliance
g. Human Resources, including policies
h. Emergency Planning and Business Continuity

1.3 The Committee will be enabled to maintain effective control in these areas in its operation and through the operation of its sub-Committees.

1.4 All members of staff and members of the CCG are directed to co-operate with any requests made by the Committee.

2. Committee Membership

2.1 The membership of the Committee is as below:

a. All clinical lead members of the Governing Body;
b. All lay members, one of whom is the Committee Chair; and
c. All executive directors including the Managing Director.

The Committee will be supported by appropriate members of Public Health and the CCG management team as required.
2.2 The Committee will meet at least ten times a year.

2.3 Members will be expected to attend all meetings. Executive director committee members will be required to nominate a deputy if they are unable to attend.

3. **Duties**

   **Integrated Governance**

3.1 The over-arching duty of the Committee is to act to oversee governance in a way that is truly integrated: where all aspects of commissioning and provider activities are scrutinised using an approach that considers finance, quality, safety and performance together.

3.2 To give assurance to the Governing Body that actions and plans put in place are appropriate, adequate and followed through as planned.

3.3 To act as an advisory forum to enable the CCG Governing Body to manage the performance, QIPP delivery, safety and quality of all its providers, with the exception of those matters of performance and quality, provider finance and shared south east London programmes that are within the scope of the SEL IGP.

3.4 To prepare for inclusion in the CCG’s constitution, the CCG’s over-arching Scheme of Reservation and Delegation, which sets out those decisions of the CCG reserved to the membership and those delegated to:
   a. the Governing Body
   b. the committees and sub-committees of the CCG
   c. Governing Body members or employees
   d. an individual who is member of the CCG but not the Governing Body, or a specified person.

3.5 Approve governance arrangements and supporting policies, including those to minimise risk related to the CCG’s responsibilities and remit to secure continuous improvement in quality and outcomes for the resident population.

3.6 Recommend proposals for action on litigation against or on behalf of the CCG to the Governing Body.

3.7 To oversee the procedures for identifying, investigating and learning from serious incidents and for safeguarding children and vulnerable adults.

3.8 Receive regular reports on the activities of the following groups or sub-committees:
   a. Quality and Safety Sub-committee
b. Safeguarding Executive
c. Information Governance Steering Group
d. Medicines Management Committee
e. Southwark IT Steering Group
f. Dulwich Programme Board
g. Estates Programme Board
h. Equalities Leadership Group, as applicable (in lieu of reporting to the Commissioning Strategy Committee)
i. Locality meetings (in lieu of reporting to the Commissioning Strategy Committee)

3.9 To receive the Board Assurance Framework and CCG risk reports on a regular basis for scrutiny of mitigation and to review their adequacy. The Committee will assure the Governing Body and the Audit Committee on adequacy of risk management arrangements for the CCG.

3.10 To consider changes to the CCG Constitution and governance structure and recommend them to the CCG Governing Body before final sign off by the Council of Members.

3.11 To receive assurance on the CCG’s compliance with information governance requirements via IG Steering Group reports

3.12 To receive and approve/provide formal comment on the following:
   a. Equality Delivery System-2 as required
   b. Emergency Planning and Business Continuity Plans
   c. Annual Governance Statement and Annual Report
   d. Policies for the CCG.

3.13 Assure the Governing Body that there are robust procedures in place to enable the CCG to deliver:
   a. Effective management of CCG finances and financial performance against contracts
   b. Assurance of safety and quality of local services
   c. Assurance that national performance targets are being met where these fall outside the scope of the SEL IGP
   d. Recovery plans when CCG finances, quality or performance is off track
   e. Effective discharge of duties in regard to safeguarding, equality delivery system and information governance.

3.14 Assure itself that the Quality and Safety Sub-committee is working effectively to support the Committee.

3.15 The Committee will act to recommend changes to the CCG Constitution and governance structure to the Council of Members via the CCG Governing Body.
**CCG Finance and Performance:**

3.16 Receive regular performance and delivery progress reports on Finance & QIPP Performance. The Committee will act to provide oversight of the extent to which projected benefits are being achieved and will assure themselves that the application of any proposed action or recovery plans are sufficient to address identified variance.

3.17 Receive appraisals of the current and forecast year-end financial position and position against the QIPP Plan from Finance Director. This will include plans for mitigating or remedial actions where variance is identified. The Committee should report this to the Governing Body.

3.18 To ensure that any issues relating to financial probity or emergent financial risks are brought to the attention of the CCG Governing Body and CCG Audit Committee.

3.19 The Committee will operate with delegated responsibility to take decisions in relation to the following areas.

   a. Agree CCG action plans to address areas of sub-optimal performance, financial variance or projected QIPP shortfall.
   b. Receive and approve tender ratification reports between the values of £250,000 and £1,000,000.
   c. Receive and make recommendations to the Governing Body on tender ratifications reports for values over £1,000,000.

3.20 Act with delegated authority from the Governing Body to take decisions on its behalf in relation to specific programmes as directed.

**Provider Assurance (Finance, Performance, Quality and Safety)**

3.21 To review providers’ performance against key quality and safety measures, with the exception of those matters of clinical quality and safety that are within the scope of the SEL IGP. To seek and gain assurance that risk and exceptions are being managed in an adequate way by the appropriate organisation.

3.22 To review the key quality issues identified by clinical leads within each provider and assure that action is taken. Escalate any concerns or issues to the CCG Governing Body if required.

3.23 To assure the Governing Body that there are robust procedures in place with providers for the effective management of clinical incidents, for managing infection control, for safeguarding children, young people and vulnerable adults and for the safe and effective prescribing and management of medicines.
3.24 To review the providers’ position against key performance metrics, with the exception of those matters of provider performance that are within the scope of the SEL IGP. To undertake enhanced scrutiny and remedial action planning for any consistently low performing areas.

4. Accountability and relationship with the CCG Governing Body

4.1 The Committee will operate with some delegated responsibility for decision making from the CCG Governing Body. The Committee will additionally act to undertake an advisory function where decisions must be taken by the CCG Governing Body.

5. Reporting arrangements

5.1 The committee will report on its activities to the CCG Governing Body via a report following each Committee meeting.

5.2 The minutes of the Committee meetings shall be formally recorded and submitted to the CCG Governing Body. Minutes will be made publicly available on the CCG website.

5.3 Recommendations and decisions arising from the work of the Committee will be reported to the CCG Governing Body as required.

5.4 The Committee will receive minutes from all its sub-committees for the period.

6. Conduct of the Committee

6.1 The Committee will operate within CCG local policies where these relate to the discharge of its functions.

6.2 The Committee will operate in accordance with NHS England guidance and national policy requirements.

6.3 The Committee will abide by the CCG standards of conduct. Compliance will be overseen by the Chair of the Committee.

6.4 Committee members will be required to declare any interests they may have in accordance with the CCG Conflict of Interest Policy.

6.5 The Committee agrees to enact its responsibilities as set out in these Terms of Reference in accordance with the Nolan Principles for Standards in Public Life.
7. **Quorum rules**

7.1 The quorum of the Committee is six members and must include at least:

a. two clinical members of the CCG Governing Body (GP clinical leads, practice nurse clinical lead, secondary care nurse, secondary care doctor),

b. one lay member

c. two executive directors.

8. **Committee support**

8.1 The Committee will be supported by the Corporate Secretary who will ensure that the minutes of the Committee are approved within one week after the meeting.

9. **Monitoring adherence to the Terms of Reference**

9.1 The Chair of the Committee will be responsible for ensuring the Committee abides by the Terms of Reference.

10. **Review**

1. The Terms of Reference will be reviewed following any significant changes in CCG’s governance structure, or in the governance arrangements for South East London CCGs as a whole.

Reviewed: June 2019
Southwark CCG Committee Report

ITEM FOR DISCUSSION / ASSURANCE

<table>
<thead>
<tr>
<th>CCG Committee</th>
<th>Governing Body</th>
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<tr>
<td>Month</td>
<td>June</td>
</tr>
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<td></td>
<td>Year 2019</td>
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</table>

Item title: Prime Committees’ Report

Enclosure number: D

Any known conflict of interest: N/A

The item is being presented to the committee for (select only one):

- [ ] Discussion
- [x] Assurance
1. Purpose of the paper (why does the Governing Body need to discuss / receive assurance?)

This report summarises the activities of the CCG’s main committees for the period stated. It provides the Governing Body with assurance that its prime committees are functioning effectively and are fully exercising their duties as described in the CCG Constitution and scheme of delegation.

The most recent minutes of CCG prime committees are also included in Governing Body papers. Minutes and agendas are also available at: http://www.southwarkccg.nhs.uk/news-and-publications/meeting-papers/Pages/default.aspx.

2. Describe the issue being presented to the Governing Body for discussion or assurance

The standard report records the following for each of the prime committee meetings:

1. Recommendations made by a committee to the Governing Body for decision. Accompanying documents are referenced as part of the report. The Governing Body will be asked to agree the recommendation received from the prime committee.

2. Actions taken under delegation by CCG prime committees. The Governing Body should note these actions, which are provided for information.

3. Other items of committee business may also be flagged to the Governing Body to note and to discuss further.

3. What stakeholder engagement has taken place?
All minutes have been circulated and signed off by the committees. Membership of these committees is noted at the start of each set of minutes.

4. What equality and diversity considerations have been highlighted in the Equality Analysis and how have they been addressed?

N/A

Supporting information / documents

Please append any relevant documents including detailed reports; options appraisals; background documents; national guidance etc.

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<thead>
<tr>
<th>Appendix #</th>
<th>Name of document</th>
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<tbody>
<tr>
<td>i</td>
<td>Prime Committees’ Report</td>
</tr>
<tr>
<td>ii</td>
<td>SEL IG&amp;P Report to CCG GB</td>
</tr>
<tr>
<td>iii</td>
<td>IGP revised terms of reference</td>
</tr>
</tbody>
</table>

Date paper completed: Thursday, 04 July 2019
“Everything to gain and nothing to lose”

Mental wellbeing and resilience in young people:

a Southwark priority

2018 Annual Public Health Report
February 2019
A very special thank you to the many children and young people who shared their experiences with mental health and wellbeing, through spoken word and art. You have afforded us a glimpse into the challenges and battles you face on a daily basis. You have also shown us the strength and resilience of Southwark young people and brought to light what more we could be doing to support you. Thank you.
Each year, Directors of Public Health in local authorities across England fulfil a statutory requirement to write an annual report on the health of their population. The Annual Public Health Report (APHR) is a vehicle for informing our partners and residents about the health of our community, as well as providing information and evidence on key health and wellbeing needs that should be prioritised in the forthcoming year. This year we have focused on the mental wellbeing of Southwark’s young people.

We have focused this report on 10 to 17 year olds, recognising that while measuring mental wellbeing across populations is underdeveloped and there is no definitive methodology that provides insights into trends of wellbeing, young people are increasingly saying that they feel their mental wellbeing could be improved.

This local focus on young people’s mental wellbeing comes at a time of increasing national attention and the release of a number of Governmental policies and initiatives. The December 2017 green paper, Transforming children and young people's mental health provision, set out three key proposals that the Government has committed to trialling in certain areas by the end of 2019:

1. To incentivise and support educational settings to identify and train a designated senior lead for mental health
2. To fund new mental health support teams supervised by NHS child and adolescent mental health professionals to work with and in schools
3. To increase child and adolescent mental health service access by piloting four-week waiting times

Locally, Southwark has built on and accelerated the national direction by ensuring 100% of children and young people requiring specialist child and adolescent mental health treatment are able to access it in a timely manner and pledging an additional £2 million for young people’s mental health.

The early identification and treatment of mental ill-health is necessary to improve children and young people’s mental health but it is not sufficient in itself. Good mental health requires a positive sense of mental wellbeing - the combination of feeling good and functioning well. Indeed, much like good physical health, mental wellbeing does not originate from health services. Rather, it is through supportive relationships, thriving schools and communities. There are a range of individual, community and social factors through which we can promote and support wellbeing. Southwark Council recognises the multifactorial nature of mental wellbeing and we have formally committed through the Council Plan 2018/19-2021/22 to delivering good quality and affordable homes; to ensuring regeneration delivers better schools, parks, and leisure centres for our young people; and to promoting a healthier, safer life for our residents, beginning in early childhood. All of these things contribute to feeling good and functioning well.

Our report is comprised of two sections. In the first, we explore what mental wellbeing means to young people, the factors that influence it across individuals, communities and wider determinants, and what we can do individually and collectively – as communities, schools and organisations – to promote this in our young people. This is followed by five recommendations (page 20) to help shape and direct priorities for action over the upcoming year. The second section – a separate document – is a full statistical appendix, providing further evidence around the risk factors for poor mental wellbeing.

This annual public health report reflects our continued commitment to supporting our young people to fulfil their potential and navigate the path to adulthood, setting an upstream focus to both national and local developments by examining the determinants of positive mental wellbeing. As we explore in the early sections of the report, concepts of mental wellbeing are complex. Therefore as part of the APHR development process we engaged with a number of young people in new, creative ways to understand what mental wellbeing means to them. We are very grateful for their time and insight and for sharing moving and personal accounts of how they conceptualise mental wellbeing in their own lives. May their experience and stories, coupled with the recommendations in this report, serve as a call to action for all of us to promote and protect the mental wellbeing of our next generation.

Professor Kevin Fenton
Strategic Director of Place & Wellbeing (including the statutory function of the Director of Public Health)
Southwark Council
Definitions

Mental wellbeing:
The combination of feeling good and functioning well. This encompasses good physical and mental health, as well as feelings of connectedness, purpose, and belonging.

Mental health:
Describes a spectrum of health from mental illness to positive mental health and wellbeing.

Mental illness/mental health disorder:
Encompasses a range of mental health conditions; from common conditions such as depression and anxiety, to severe mental illnesses such as schizophrenia and bipolar disorder.
What do we mean by mental wellbeing?

Mental wellbeing is more than the absence of a mental illness and is broader than just ‘being happy.’ It can be summed up as the combination of ‘feeling good and functioning well:’ a dynamic process in which the external circumstances of our lives interact with our personal characteristics to shape how we feel and how we function (Figure 1). More simply put, mental wellbeing is our ability to flourish, realise our potential, be productive, and contribute to our community. Mental wellbeing in children and young people builds psychological resources and cultivates resilience to bounce back from challenges.

The places in which we live and grow are also strong determinants of wellbeing. A thriving community is one which provides secure and safe environments and housing, supports accessible employment and education, and promotes equal opportunities for all. These wider determinants of mental wellbeing are important because they are modifiable.

Figure 1. ‘A dynamic model of wellbeing’ Adapted from NEF Consulting. Mental Wellbeing of Young People (aged 0-24 years) in Southwark. Southwark’s JSNA. Southwark Council: London. 2018.
Adolescence and mental wellbeing - why 10-17 year olds?

The importance of the early years in securing good mental and physical health is well documented. However, new research has shown that, after the early years, adolescence presents a second critical opportunity in which to build good mental wellbeing. The age range of what constitutes adolescence is complex as it starts with the biological process of puberty and ends at a culturally defined point during young adulthood. We have selected 10 to 17 year olds as the focus of this report as young people of this age still spend most of their time at school and at home, key opportunities at which to intervene and support.

Adolescence is a critical time in individual development: long-term conditions emerge, risk-taking behaviours begin, and health behaviours tend to be set for adulthood. The effects of poor health and wellbeing, both physical and mental, in adolescence can last into adulthood. Indeed half of all mental illnesses will also begin by age 14. A proportion of these illnesses will go undiagnosed and untreated but not all cases require exclusively clinical support.

Adolescence is also a distinctive period in that it is dominated by transitions: primary to secondary school, school to work, children services to adults, moving home, and even changes in family structures. Bodily changes in puberty and navigating new types of relationships can leave adolescents feeling out of step with their peers and isolated in managing their personal transitions.

Transitions can be difficult at any age. However, the loss of a support system - be it a physical space, routine, individual relationships or social networks – can leave adolescents vulnerable at an already sensitive time. Some may find it harder than others to embrace the new, re-establish support systems, or to seek help when they need it, while simultaneously fighting to establish independence and make decisions that will impact their future. The ability to trust others outside of the family home is also key to establishing support networks that will see them through to adulthood; social media, peer and school networks play an increasingly prominent role during this period.

In adolescence, young people are increasingly exposed to new interactions and experiences, such as embarking on relationships and experimentation with risk-taking, for example, drug and alcohol use. Developing independence, trying different ways of doing things, and balancing personal responsibility with risks are part of the adolescent journey, however, this period is vulnerable to the development of mental health disorders.

Adolescents in Southwark

Eight percent of our total population are aged 10-17 years, equating to approximately 24,200 young people. Our young people are much more diverse than our older populations and they are more deprived. The number of adolescents in Southwark identifying as black (40.7%) is almost double that of the general population (22.9%). There are also more 10-17 year olds living in our most deprived areas; over 45% 10-17 year olds compared to 38% of all residents. These demographics are important to consider when thinking about mental wellbeing and some of the challenges our young people may be facing.

<table>
<thead>
<tr>
<th>1/10</th>
<th>15/10</th>
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<tbody>
<tr>
<td>would be from a household without English as a first language</td>
<td>would have a diagnosed mental health disorder</td>
</tr>
<tr>
<td>4.5/10</td>
<td>4/10</td>
</tr>
<tr>
<td>would live in our most deprived quintile</td>
<td>would be black</td>
</tr>
<tr>
<td>2.5/10</td>
<td>1/10</td>
</tr>
<tr>
<td>would be obese</td>
<td>would be LGBTQI+</td>
</tr>
</tbody>
</table>

Figure 2. If all adolescents in Southwark were represented by 10 people
“TEEN ANGST”

ANYONE THERE?

I REJECT UNIFORMITY

ANYONE THERE?

HELLO?

Artwork by Gus, age 16
We know what mental wellbeing means to professionals, but what does it mean to young people? What constitutes mental wellbeing is complex and it is not a clinical concept with a defined threshold. As discussed in previous sections, mental wellbeing has both individual and social determinants and combines both how we feel and how we function. Improving mental wellbeing in young people requires us to understand what they feel impacts on it.

**How we engaged young people for this report**

As part of our Annual Public Health Report, we took the opportunity to engage young people in new ways to ask them directly about their mental wellbeing, what it means to them, what affects it, and how they cope. We commissioned the charity Poetic Unity to run two spoken word workshops with a cohort of around 30 young people. Through poetry and spoken word, participants were encouraged to write about their experiences with mental wellbeing. We then reached out across Southwark to ask all interested young people to tell us, through their art, what mental wellbeing means to them.

We hosted a borough-wide art competition, judged by a panel of staff from Public Health and Culture, and members of the Youth Council. Submissions will be displayed in a temporary gallery at the Council in spring 2019, and the winning piece is featured on the cover of this report. Excerpts from both activities are included within the report.

A number of shared themes emerged from the engagement exercises on the causes and consequences of poor mental wellbeing, and methods used to improve mental wellbeing; these are displayed in the word clouds below (Figures 3-4). The size of the word below corresponds to its prevalence.

**Figure 3.** Themes emerging from young people’s poetry and artwork on the causes and consequences of poor mental wellbeing

**Figure 4.** Themes emerging from young people’s poetry and artwork on how to improve mental wellbeing
## Young people at increased risk for poor mental wellbeing

Certain cohorts of young people are more likely to experience multiple vulnerabilities. Southwark has a greater number of children who are potentially at risk for poor mental wellbeing. Particular consideration should be given to targeted engagement and support for young people who are:

<table>
<thead>
<tr>
<th>Looked-after children (LAC)</th>
<th>Young carers</th>
<th>Black, Asian, and minority ethnic</th>
<th>Teenage parents</th>
<th>Special educational needs and disabilities (SEND)</th>
<th>LGBTQI+</th>
<th>Not in education, employment, or training (NEET)</th>
<th>Engaged with the youth offending service</th>
<th>Insecure housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- There are approximately 500 LAC in Southwark; they are among the most vulnerable in our society</td>
<td>- Nearly 800 students in Southwark are estimated to be caring for someone at home; this is a risk factor for poor mental health that often goes unrecognised</td>
<td>- Forty percent of Southwark adolescents of Black ethnicity</td>
<td>- The number of teenage mothers in Southwark has reduced significantly but they remain a vulnerable cohort</td>
<td>- Over 8000 children in Southwark have been identified as having SEND</td>
<td>- Ten percent of secondary students in Southwark report identifying as LGBTQI+</td>
<td>- The number of young people NEET in Southwark is similar to the England average</td>
<td>- Southwark has a higher than average rate of first-time entrants to the youth justice system</td>
<td>- Southwark has the sixth highest rate of family homelessness in London</td>
</tr>
<tr>
<td>- Almost 50% of child protection plans in Southwark were due to neglect and most LAC entered care during adolescence</td>
<td>- Caring is stressful and carries stigma</td>
<td>- BAME young people are more likely to be exposed to other risk factors for poor mental wellbeing</td>
<td>- Teenage pregnancy exposes parent and child to risk factors for poor mental wellbeing</td>
<td>- Children and young people with SEND are more likely to have a mental health disorder than those without an intellectual disability</td>
<td>- Young LGBTQI+ are coming out an earlier age, which frequently coincides with adolescence – an intense developmental period</td>
<td>- Young people NEET are more likely to suffer from depression and to engage in unhealthy behaviours such as substance misuse</td>
<td>- Young people exposed to violence live with heightened fear and anxiety, and may be suffering from PTSD</td>
<td>- Young people in care, of BAME ethnicity, and who identify as LGBTQI+ are more likely to be homeless</td>
</tr>
<tr>
<td>- LAC account for about a third of young people</td>
<td>- Young carers are more likely to have a SEND and are more likely to be BAME</td>
<td>- BAME are less likely to engage with mainstream services</td>
<td>- Teenage mothers have higher rates of postpartum depression, affecting their ability to form secure attachments</td>
<td>- They are also more likely to be Black Caribbean and more deprived</td>
<td>- These young people are more likely to be bullied but few ever report their experience</td>
<td>- One-in-five 16-18 year olds who are NEET is a teenage mother</td>
<td>- Young people involved in violence are at increased risk of exploitation and abuse</td>
<td>- Poor mental health is one of the top three support needs reported by young people accessing homelessness services</td>
</tr>
</tbody>
</table>
Early childhood experiences

Adolescent health outcomes and behaviours are heavily influenced by experiences in childhood. The wellbeing of children in early years is critical to providing the best start to life and is an important determinant of future and current health. Early adverse experiences may affect a child’s ability to form secure attachments and are strongly associated with an increased risk of poor physical and mental health later in life. Adverse childhood experiences (ACEs, Figure 5) are common: about half of all adults in England have experienced at least one. However, it is the multiplicity of ACEs that is most concerning and most strongly associated with poor outcomes and risk behaviour. In Southwark, about 9% of infants are affected by four or more ACEs. These children are more likely to use illicit drugs, have unhealthy diets, experience an unplanned teenage pregnancy, become involved in violence, and have poor mental wellbeing. This has considerable implications for the risk factors they may experience and the support they may need later in life.

Southwark recognises the importance of ACEs and Public Health have begun to quantify exposure locally. We undertook a review of health visiting case notes to estimate the number of ACEs in Southwark children, which has helped us to develop a picture of the vulnerabilities with which our children grow up and are impacted by.

Families, trusted adults, and peers

There is a plethora of good quality evidence which demonstrates how our very early experiences of relationships impact our social and emotional development. Children who have experienced positive and secure attachment to a primary care giver are better able to cope with stress, have a higher perception of self-worth, and are able to adjust better to adversity and change. Parenting styles have an impact on the behaviour and mental wellbeing of children as they enter adolescence. Parental warmth improves adolescent coping and is associated with less anxiety and better clinical and school adjustment.

The presence of a trusted, present adult (family or other) in childhood can reduce poor health behaviours in adulthood including unhealthy diet, daily smoking, and heavy alcohol consumption.

Individual risk and protective factors

![Figure 5. Adverse childhood experiences](image-url)
Trusted adult support can also mitigate the impact of adverse early childhood experiences, particularly on low mental wellbeing. Young people themselves consistently tell us how much trusted adult and family relationships are important to them. In a Princes Trust survey of over 2,000 young people, 77% said that spending time with their family made them happy. Supporting parents of adolescents will have positive benefits for both parent and child alike.

Peer relationships are important to young people and good quality friendships can enhance mental wellbeing. However, a significant minority of children are reporting feelings of loneliness, particularly those who are more deprived and living in larger cities. Loneliness is strongly correlated to low levels of mental wellbeing. Transitions such as the move to secondary school can fracture social support networks and are therefore key points of vulnerability for young people.

**Sexual relationships and identity**

Relationships are an important determinant of health and wellbeing across the life course and, as we grow older, the scope of our relationships begins to widen. Sexual relationships are a chief component of our interpersonal experiences. Similar to good mental health, good sexual health is more than just the absence of disease. Sexual health requires a positive and respectful approach to sexuality and sexual responses, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Southwark, along with Lambeth and Lewisham, have produced a new sexual and reproductive health strategy (2019-24) with a strong focus on the protective role of healthy relationships. Development of positive sexual identity is linked to self-esteem and body image. Adolescents may be exposed to peer-pressure, bullying or coercion around sexual behaviour, with phenomena such as ‘sexting’. For LGBTQI+ students, adolescence can be a particularly challenging time. Nearly half of LGBTQI+ students report being bullied at school while 53% felt there was no responsible adult at school to speak to about their sexuality. Of particular concern is that research suggests LGBTQI+ young people self-harm more than their peers and are more likely to take their own life.

&mdash; Young person aged 14-15 at Southwark secondary school

*Almost a quarter of secondary pupils surveyed in Southwark in 2016 experienced at least one of these negative behaviours, with either a current or previous partner.*

<table>
<thead>
<tr>
<th>Negative Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used hurtful or threatening language to me</td>
</tr>
<tr>
<td>Was angry or jealous when I wanted to spend time with friends</td>
</tr>
<tr>
<td>Kept checking my phone</td>
</tr>
<tr>
<td>Asked me to send them photos or videos of a sexual nature</td>
</tr>
<tr>
<td>Put pressure on me to have sex or do sexual things</td>
</tr>
<tr>
<td>Threatened to tell people things about me</td>
</tr>
<tr>
<td>Threatened to hit me</td>
</tr>
<tr>
<td>Hit me</td>
</tr>
</tbody>
</table>

&mdash; Young person aged 14-15 at Southwark secondary school

*Almost a quarter of secondary pupils surveyed in Southwark in 2016 experienced at least one of these negative behaviours, with either a current or previous partner.*
Comprehensive relationships and sex education (RSE) is a crucial tool in improving knowledge and understanding, and reducing stigma around sexual health and sexuality in young people. RSE contributes to a young person’s safety by supporting them to navigate through their own developmental changes and helping to prevent exploitation or abuse. Good RSE should focus on cultivating positive sexual health and exploring links with self-esteem, body image, and positive interpersonal relationships alongside risk-based education. Our 2019-24 Sexual and Reproductive Health Strategy prioritises working with schools to develop evidence-based RSE, including the continued provision of programmes targeted at increasing self-esteem and identifying unhealthy relationships.

Interpersonal violence

Violence can be physical, sexual or emotional. Adolescents may be exposed to violence in various different ways: through the family in the form of parental or domestic violence, through bullying at school, or through the community. Knife crime and gang violence are particularly poignant issues in Southwark. Culturally specific forms of violence, such as female genital mutilation, also have significant impacts on mental wellbeing.

Southwark Public Health has been contributing to work around youth violence ongoing at the local and London level. We have begun a comprehensive joint strategic needs assessment (JSNA) of serious youth violence, in collaboration with Southwark Community Safety. This report will clarify and seek to understand the determinants and causal pathway towards violence and identify opportunities for prevention, using a public health approach and a strong focus on what the epidemiology and the community are telling us. This JSNA feeds into Southwark’s knife crime action plan, which brings together Education, Community Safety, police, social care, youth offending services, and others to tackle this important issue.

“Sometimes I think how I got all this pent up aggression
Then I remembered I got bullied for the way I look
Didn’t tell no one, just started banging off faces”
- Young person aged 14-18 at Southwark YOS

“It started off good, it started as love.
Or maybe even ‘tough love’
That’s what he told her, that’s what he told me.
I ignored it, I trusted every word he was saying.
- Young person aged 14-15 at Southwark secondary school

“It started off good, it started as love.
Or maybe even ‘tough love’
That’s what he told her, that’s what he told me.
I ignored it, I trusted every word he was saying.”
- Young person aged 14-15 at Southwark secondary school
We know that, while the physical effects of violence are often more obvious, the mental and emotional pain brought about by violence cannot be overlooked. Violence can impact on mental health and wellbeing through trauma and learned violent or risk-taking behaviours. Adolescents growing up in deprived areas are more likely to be exposed to violence. Children who are exposed to violence are at higher risk of exhibiting behavioural problems, dropping out of education, experiencing reduced lifetime earnings and be at higher risk of unemployment and financial difficulties later in life. Violence itself tends to be cyclical. Those exposed to violence may in turn direct violence towards themselves. Research indicates that those exposed to physical or sexual abuse are at higher risk of suicidal thoughts or behaviours.

Exposure to violence has serious and long-lasting effects on mental wellbeing at the individual and community level. Victims and perpetrators of violence often experience post-traumatic stress disorder and live in a state of heightened anxiety. Communities affected by violence lose their sense of safety and inclusion.

Lifestyles and behaviours

Adolescents take more risks and engage in more impulsive behaviour than other age groups. Experimentation is natural but unhealthy behaviours may impact a lifetime. Impulsivity appears to have the greatest impact on likelihood of engaging in risky behaviours and poor mental wellbeing.

Adolescence is often the time when people may try alcohol or drugs for the first time. Experimentation is natural but the adolescent brain is still developing and is susceptible to damage. Risk-taking and experimentation may further coincide with other risky behaviours such as unsafe sexual practices. A recognition and understanding of this interrelationship is at the centre of Southwark’s new integrated wellbeing service for young people, ‘Healthy Young People’ (HYP). The HYP model brings together traditional young people’s sexual health and substance misuse services to provide a holistic offer that additionally supports self-care and resilience building.

Both alcohol and drug use are risk factors for mental illness and young people who misuse drugs are at higher risk of feeling depressed or anxious. Alcohol use in adolescence may be a result of poor mental wellbeing, but it may also be a risk factor for developing depression. Substance use can trigger changes in young people’s behaviour, attitude or mood. As well as having a negative effect on their physical health, it impairs cognitive development and comprehension. Addictions may be difficult to overcome and cannabis use may trigger psychoses. Substance misuse can leave young people feeling distant or disconnected from their peers and others who form their support networks. Adolescents are more likely to abuse alcohol or drugs if they have experienced an adverse childhood event, especially if their parents abuse substances.

“I am trying I am not the best or the worst But I am trying and that’s the only thing that matters.”
- Young person aged 14-15 at Southwark secondary school

"I am trying I am not the best or the worst But I am trying and that’s the only thing that matters.”
- Young person aged 14-18 at Southwark YOS

"Seen couple man that ain’t rated thought my side was better cause of the difference in our payslips. But in the corner of my eye I see a bad b looking finger licking so now I’m distracted I’ve stopped thinking I’m gonna hit him So I turned my back, felt a slap, had to throw the tee cause now there’s blood on that. Went back to them flats, seen a onsite nurse to get patched. Ain’t left the house for two weeks cause I’m scared again I’ll get stabbed. TRAUMA!"
- Young person aged 14-18 at Southwark YOS
Physical health

Mental wellbeing is both a determinant and consequence of good physical health. Many of the risk factors for poor physical and mental health are the same and thus young people from at-risk groups are likely to be vulnerable to both poor physical and mental health. While adolescence is generally a period of good overall health, the physical health of adolescents has not increased in line with other age groups. Adolescents in England have higher mortality rates for preventable causes of death, including common infections and chronic respiratory conditions. However, in Southwark, a slightly lower proportion of young people have a long term condition or disability than the London and national average.

Attendance at A&E amongst adolescents has increased significantly over the past five years while admissions have remained broadly stable. This suggests that reasons for A&E attendance were inappropriate for secondary care and highlights missed opportunities to engage with young people in primary care services. This supports research showing that, while adolescents are comfortable talking to GPs, they find it difficult to access appointments. Increasing access to GPs amongst adolescents will support both their physical and mental health.

Physical activity

Physical activity is positively associated with wellbeing; studies have shown a significant relationship between psychological symptoms and illness frequency, suggesting higher emotional distress in less healthy adolescents. To encourage physical activity in the borough, Southwark offers a Free Swim and Gym Programme to residents on weekends at any of our seven leisure centres. However, a national survey of 15 year olds revealed that only 11.4% of Southwark young people reported at least one hour of moderate or vigorous exercise per day in the past week; less than the England average of 14%. Physical inactivity was more prevalent among girls than in boys. Young people from more deprived areas nationally were also more likely to report ten hours or more of sedentary activities per day.

Southwark has high levels of overweight and obesity, particularly among children and those from the most deprived parts of the borough. We recognise the impact of the obesogenic environment and are committed to facilitating healthy choices by our young people. Major strategic policies have been implemented promoting active design, protecting and investing in green spaces and encouraging food growing. There are also specific policies that will contribute towards making our street less unhealthy including a restriction on new hot food takeaways within 400m of secondary schools, promoting the Healthier Catering Commitment to existing food businesses, and incorporating healthy urban design into regeneration activities.
Unhealthy diet

Unbalanced and unhealthy diet in young people is of ongoing concern. Consumption of fruit and vegetables is reportedly below the recommended 5-a-day in children aged 11-18 years and is less in those from lower-income households. Over the past eight years, a downward trend has been observed in the intake of most vitamins and minerals, particularly folate and vitamin A. Undernutrition is associated with behavioural deficits and a balanced diet is crucial for ensuring young people reach their developmental potential. Nutrient deficiency is also linked to weakened immune system and susceptibility to communicable diseases.

Eating disorders tend to emerge in adolescence and predominantly affect girls more than boys. Harmful eating behaviours are one of many ways in which emotional distress is expressed and can have severe impacts on physical and mental health. Feelings of guilt, anxiety, and depression are common comorbidities.

Long-term conditions

Adolescence is also the time in which young people take a more independent role in managing long-term conditions such as asthma and diabetes. Twelve percent of young people live with a long-term condition and those suffering from chronic illness are two to six times more likely to suffer from a mental illness. Feelings of social isolation may ensue and disengagement from health services may lead to poor outcomes. Young people with both a physical and mental illness are more likely to suffer from complications, increasing the cost of care by an average of 45%.

Asthma is the most common long-term condition in adolescence and is the primary cause of emergency admission locally. Among young people frequently (more than three times) having an emergency hospital admission, the most common cause was a sickle cell disorder. Enabling young people to actively managing their physical health and wellbeing is an important skill and should be encouraged during this critical stage to establish lifelong healthy habits.

Mental health

As with physical health, poor mental health impacts on our ability to flourish and thrive, therefore affecting mental wellbeing. Across the United Kingdom and internationally studies have revealed rising rates of diagnosed mental health disorders in young people, particularly young girls. Nationally, this increase is driven by a rise in emotional disorders. Based on national prevalence, we estimate that 2,500 young people in Southwark are affected by a mental health disorder. Gender patterns vary widely between conditions: girls are more likely to experience an emotional disorder whereas boys are more likely to be affected by a behavioural or hyperactive disorder. It is important to note that it is possible to have a mental health disorder and experience mental wellbeing. For young people managing a long-term mental health need, resilience training and coping mechanisms remain important tools in managing their mental wellbeing. Notably, risk factors for the development of a mental health disorder share similarities with those impacting on mental wellbeing. Preventing ACEs, supporting families through difficult times, and challenging social inequalities and adversity may help to prevent poor mental health and wellbeing.

Figure 7: Percentage 15 year olds with a long-term illness, disability or medical condition, in 2014-15
I Like Dancing

Balance your feelings
Balance and relax

Artwork by Tukudzwa, age 14
Community risk and protective factors

Built environment

The places in which young people live can have a significant impact on their mental and physical health and wellbeing. A safe, warm, and secure home is fundamental to a person’s wellbeing. Children living in poor housing conditions are more likely to have poor mental and physical health. For example, children living in cold homes may seek respite in other venues, which may further increase their exposure to health risks. The street environment can influence decisions to walk, cycle, or use public transport, contributing to daily physical activity. Walking and cycling have been shown to positively impact on mood and may reduce stress and anxiety. However, the reality for many of our young people is much different. Walking to school along a high-street saturated with fast-food takeaways, off-licences and betting shops does not set the tone for the healthy lifestyle being advocated for. Planning, designing, and developing higher quality places through regeneration of the borough is increasingly recognised as one of the ways we can help to influence patterns of behaviour for this generation of young people improve feelings of belong. Investing in health-promoting community assets and infrastructure also helps foster resilience at the community level.

Southwark are piloting a model of environmental interventions to improve health outcomes within a 50m ‘superzone’ radius around a school. This includes providing safe routes for walking and cycling, reducing traffic and air pollution risks, maximising use of green and recreation spaces, working with food businesses to ensure healthy affordable options are available and promoted, and ensuring there are places to go for young people to be social and safe.

Community centres, cafes, green spaces, and safe play facilities are important for community wellbeing and cohesion. Planning and regeneration policies are in place to support improvements to housing, parks and playgrounds, and to further develop the boroughs excellent leisure centre and cultural offer, and to extend which form an important part and connected communities.

Schools

Children and young people spend about one-third of their time in school, emphasising the importance of the school environment in supporting and shaping the mental wellbeing of our young people. Academic performance is interlinked with mental wellbeing: exam stress and pressures to attain impact negatively on mental wellbeing; equally, emotional wellbeing is associated with higher levels of engagement and achievement. The ‘whole school’ approach to prevention and promotion has been shown to be effective at building resilience in young people. This comprises of systematic changes (e.g. changes to ethos, anti-bullying policies and programmes to support teacher wellbeing), universal interventions for all pupils (e.g. curriculum-based school education), and outreach programmes for parents and the wider community. Whole school approaches are best combined with targeted support, providing timely school-based input for those with risk factors for poor mental wellbeing such as behavioural problems.

Community risk and protective factors

“I only realised now that from young I had mental health. I stress too much people say don’t stress yourself. Young days I used to get in trouble, so stress my thoughts in my head is muddled. Still stressed but I got better life now. I had to change my lifestyle, had to change my mental state and wellbeing.”

- Young person aged 14-18 at Southwark YOS
Artwork by Jabari, age 13
Technology

Social media has both positive and negative impacts on mental wellbeing. Social media can help young people build friendships and networks, be a platform for healthy lifestyle messaging, and allow for creativity and self-expression. Specific benefits of social media use on mental wellbeing include increased emotional support, self-disclosure, reduced social anxiety and belongingness. Online friendships provide means for social integration, opportunities for identity experimentation, and extended ‘bridging’ social capital. However these positive benefits appear to tend to be maximised for those who already have high quality relationships and consequently higher levels of mental wellbeing.39

Young people tell us how social media can harm their mental wellbeing by making them feel anxious or inadequate. Indeed, surveys of young people’s experiences of social media have consistent themes around feelings of inadequacy, anxiety and social pressure.38,40 Social media-induced anxiety and screen time before bed have been found to be associated with depressive symptoms41,42 and this association is stronger in girls than in boys.43 Idealised images of bodies online and cyberbullying affect self-perception and can lead to poor mental wellbeing. Emerging issues around sexting, peer-pressure, and exploitation are also becoming increasingly important to address. Social media may also have an influence in inciting violence and other crime. Young people need new skills to navigate social media and understand how it can impact on their mental wellbeing. New guidelines on screen time are expected from the Chief Medical Officer.

To embrace and address the increasing effect of digital technologies on health, Southwark Public Health are developing a new digital health strategy. This strategy will drive work around the role of technologies such as social media on health behaviours.

As part of the 2019-24 Sexual and Reproductive Health Strategy, we have committed to working with schools to ensure relationships and sex education is sufficiently inclusive of modern challenges such as sexting, cyberbullying, and revenge porn.

Inequalities

Poor mental wellbeing is both a cause and a consequence of material, social, and health inequalities.43,44 Experiencing inequalities and socio-economic disadvantage increases the risk of mental illness and poor physical health. Equally, people with mental illness are more likely to be isolated and experience poor health outcomes. Reducing inequalities is a key component of increasing mental wellbeing. Supporting communities to achieve wellbeing, including investing in the built environment, can contribute to the resilience and mental wellbeing of their individuals.

Wider determinants

"The stares already make it worse The words you say, yes they hurt Let me tell you a secret Those whispers you think I can’t hear I hear them, I believe them*

- Young person aged 14-15 Southwark secondary school

*I believe that mental health matters It copes with your struggles It’s good to talk about mental health cuz you don’t Know your own bro could be dying by himself It’s hard for us grown men to open up sometimes We feel as if we lose our masculinity It makes us feel weak This is how society has made men feel when talking about mental health It’s good to have someone to talk to Throughout the negativity Because mental health affects us all today*

- Young person aged 14-15 at Southwark secondary school
For Southwark’s young and diverse adolescents, a range of challenges and opportunities exist to create mental wellbeing. It is important to think outside of the clinical sphere and consider the homes and communities in which we live and the relationships which support us through difficult times. Southwark’s approach to supporting young people’s mental wellbeing must be four-fold:

Proportionate universalism

Poor mental wellbeing, like many public health issues, does not affect everyone equally. We have seen there are a number of vulnerable groups in Southwark who are more likely to have poor mental wellbeing. Nonetheless, many challenges to mental wellbeing are ubiquitous and the importance of resilience and coping mechanisms are important to all. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient of health, actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage. In Southwark, we promote an approach whereby services are available to all adolescents, but that groups with higher needs receive approaches tailored to meet them.

Engaging young people and communities

Literature and evidence can only tell us so much. Engaging with young people on their mental wellbeing – how they define it, the factors that influence it, and how it can be nurtured – has been an integral part of this report. We need to listen to young people and engage them in a range of creative ways, to help direct our strategies and services.

Taking a life course approach

Early experiences in life shape our health and development. Equally, we know that our adolescent years can lay the blueprint for health behaviours in adulthood, further reinforcing the need to promote good mental wellbeing at this age. In looking to mitigate risky behaviours and the development of poor mental wellbeing, we need to understand the accumulation of risk factors from early on in life, all the way through childhood, and provide appropriate family and individual support.

Multi-disciplinary and inter-sectorial

As well as spanning a life course, the determinants of mental wellbeing span numerous specialisations, including early care, schools, health, public health, social care, and others. We cannot work in isolation to address such a multifactorial issue.

Our calls to action

Creating an environment that promotes and protects young people’s mental wellbeing is entirely achievable, but it won’t happen overnight. While we continue to work on implementing this approach, we recommend the following quick wins for the year ahead:

1. Improve the physical health of adolescents by increasing their uptake of health promoting opportunities and their use of primary care services
2. Continue to support whole school approaches to improving mental wellbeing, including the implementation of evidence-based bullying prevention programmes
3. Support leisure and youth services to have whole setting-based approaches to improving mental wellbeing
4. Include young people aged 10-17 years as a targeted group in the Southwark Loneliness Strategy
5. Increase access to parenting support during adolescence
OUR EVIDENCE-BASED ‘BEST BUYS’ FOR INVESTMENT

ONE
Support whole settings-based approaches to mental wellbeing in schools and other youth services.
While individual child and young people-focussed mental health and wellbeing support is important for at-risk young people, settings-based approaches are very effective at improving mental wellbeing and resilience. There is also good quality evidence that they support learning and educational attainment. Evidence-based mental wellbeing and resilience frameworks can support schools in this approach, and support the commissioning and delivery of interventions to improve mental wellbeing and resilience.

TWO
Using an Attachment, Regulation and Competency (ARC) framework, offer a trauma-informed practice programme for schools and other youth settings.
The Attachment, Regulation and Competency (ARC) framework is a components-based intervention developed for children who have experienced trauma. It is both an individual intervention and an organisational framework to be used in educational and youth settings to support trauma-informed care. Trauma-informed practices in schools using the ARC approach have successfully been implemented in other inner-London boroughs.

THREE
Provide evidence-based parenting support for parents of adolescents.
There is good quality evidence that positive trusted adult relationships are supportive of good mental wellbeing and parenting programmes can be effective in improving child/care-giver relationships. Young people have also feedback that they value and want support in their relationships with care-givers and trusted adults.

FOUR
Improve the physical health of adolescents through the roll-out of the ‘teen health check’ in primary care and school health services.
Adolescent health has not improved at the same rate as other age groups and attendances at A&E are increasing year on year. There is a strong correlation between good physical health and mental wellbeing with many of the interventions used to promote one also improving the other.

FIVE
Support and improve the speech, language, and communication skills of children and young people.
There is very high quality evidence that good speech, language and communication skills support mental wellbeing.
References

30. The Mental Health Taskforce (2016) The Five Year Forward View for Mental Health A report from the independent Mental Health Taskforce to the NHS in England
33. BMJ 2018;361:k2608
34. The Marmot Review Team (2011) The Health Impacts of Cold Homes and Fuel Poverty
44. Mental Health Foundation (2018) Health inequalities manifesto 2018
Mental wellbeing and resilience in young people: a Southwark priority

"Everything to gain and nothing to lose"
1. OVERVIEW

The statistical appendix to this year’s Annual Public Health Report focuses on the demography and mental wellbeing of young people in the London Borough of Southwark. It seeks to provide an analysis of our population, along with the risk factors for, and inequalities in mental wellbeing in the borough. These quantitative data are intended to complement the narrative of the APHR, as well as qualitative findings from engagement with young people, completed as part of the APHR development.

The statistical appendix includes the following sections:

- The demography of children and young people in Southwark aged 10 to 17
- Mental wellbeing
- Factors influencing mental wellbeing
2. DEMOGRAPHICS

Southwark is a densely populated and diverse inner London borough situated on the south bank of the River Thames, with Lambeth to the west and Lewisham to the east. Home to some 314,200 residents, Southwark is a patchwork of communities: from leafy Dulwich in the south, to bustling Peckham and Camberwell, and the rapidly changing Rotherhithe peninsula. Towards the north, Borough and Bankside are thriving with high levels of private investment and development. Yet there remain areas affected by high levels of deprivation, where health outcomes fall short of what any resident should expect.

2.1 Current adolescent population

Approximately 24,200 young people aged between 10 and 17 are estimated to live in Southwark, representing almost 8% of our population.

<table>
<thead>
<tr>
<th>Age</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 yrs</td>
<td>1,770</td>
<td>1,750</td>
<td>3,520</td>
</tr>
<tr>
<td>11 yrs</td>
<td>1,610</td>
<td>1,560</td>
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</tr>
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<td>1,440</td>
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<td>2,800</td>
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<tr>
<td>17 yrs</td>
<td>1,490</td>
<td>1,430</td>
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<tr>
<td>All adolescents</td>
<td>12,350</td>
<td>11,840</td>
<td>24,190</td>
</tr>
</tbody>
</table>

Table 1: Mid-year resident population estimates by single year of age, 2017

2.2 Trends and projections of adolescents

While the number of people living in Southwark has increased significantly in recent years, there has been a much smaller increase in the number of adolescents. Since 2001 the number of people aged 10 to 17 living in the borough has increased by 6.7%, compared to an overall increase of 22% in the population as a whole.

Although the number of adolescents living in Southwark is projected to continue to increase in the medium-term, the pace of growth will remain lower than other age groups. By 2030, projections suggest the number of people aged 10 to 17 will increase by almost 17%, compared to an increase of 21% in the overall population.

2.3 Diversity of adolescents

Southwark is a diverse borough with residents from a wide range of ethnicities and backgrounds. Over 120 languages are spoken here, with just over 1 in 10 households having no members who speak English as a first language.

We know that the diversity of the borough varies markedly across age groups, and that our young people are much more diverse than our older population.

The number of adolescents in Southwark from a Black ethnic background is estimated to be almost double that of the general population, standing at over 40%. This is driven by a large Black African population, with almost a quarter of adolescents coming from this background.
2.4 Deprivation affecting children and young people

Deprivation has a significant impact not only on the health of our young people, but also their future life chances. Our most deprived communities are found in central and northern parts of the borough, including Elephant and Castle and Bermondsey in the north, through to Nunhead and Peckham in the east, and Camberwell in the west. Over 45% of our adolescents live in areas that fall within the most deprived quintile nationally, compared to 38% of our general population.

The latest child poverty statistics show that Southwark has the 5th highest proportion of children in low income families (25%) compared to other London boroughs. This accounts for over 13,000 children aged under 16 across the borough.

Figure 1: Ethnic diversity among adolescents in Southwark, 2017

Figure 2: Income deprivation affecting children in Southwark, 2015. © OS Crown copyright and database rights 2018. Ordnance Survey (0)100019252.
3. MENTAL WELLBEING

3.1 Mental Wellbeing

Findings from the 2016 Schools Health Education Unit (SHEU) survey in Southwark reveal that levels of positive wellbeing locally are lower compared to other areas, with 37% of pupils in Year 8 and Year 10 reporting high self-esteem compared to 42% in the wider sample across England.

Results from the survey also highlight substantial inequalities in positive wellbeing between the sexes, with boys far more likely to have high levels of self-esteem when compared to girls (41% v 30%).

As part of the survey, pupils were asked how much they worry about a list of issues, ranging from exams, through to health, family, and financial problems. Out of the list of issues 84% of adolescents responded that they worry about at least one of the issues either “quite a lot” or “a lot”, increasing to 90% of girls in Year 10.

The top three worries among those who said they worry about problems “quite a lot” or “a lot” are shown in the table below.

<table>
<thead>
<tr>
<th>Concern</th>
<th>Boys</th>
<th>Girls</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams and tests</td>
<td>47%</td>
<td>67%</td>
<td>57%</td>
</tr>
<tr>
<td>Family</td>
<td>38%</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>School-work</td>
<td>27%</td>
<td>46%</td>
<td>37%</td>
</tr>
<tr>
<td>The future</td>
<td>32%</td>
<td>41%</td>
<td>36%</td>
</tr>
<tr>
<td>Friends</td>
<td>25%</td>
<td>34%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Table 2: Top five concerns among adolescents in Southwark in 2016.

Almost 1 in 10 adolescents in Southwark (9%) stated that they did not have an adult they could trust to talk to if they had something that worried them.
4. FACTORS INFLUENCING MENTAL WELLBEING

4.1 Physical Health

While adolescence is generally a period of good overall health, young people can experience a range of physical health problems which can have a negative impact on their wellbeing.

It is estimated that just over 1 in 10 young people in Southwark have a long-term illness, disability or medical condition that has been diagnosed by a doctor, slightly below the London and national average.

Asthma is the most common long-term condition among young people, and one of the most common reasons for emergency admission locally. In Southwark there are over 1,700 (5.5%) young people aged 10 to 19 with a diagnosis of asthma, though more may be living with the condition.

The number of attendances at emergency departments by adolescents in Southwark has increased by almost a quarter since 2013-14, with just over 9,200 attendances in the last financial year. Rates of ED attendance in Southwark among adolescents are significantly above national levels.

The reason for attendance was recorded in just over half of cases, with the top five diagnoses (in order) being:

- Sprain / ligament injury
- Dislocation / fracture / joint injury
- Gastro-intestinal conditions
- Contusion / abrasion
- Respiratory conditions

Figure 4: Percentage of 15 year olds with a long-term illness, disability or medical condition in 2014-15.

Figure 5: Number of emergency department attendances among those aged 10 to 17 in Southwark.
While there has been a substantial increase in emergency department attendances among adolescents over the last five years, the number of emergency admissions to hospital has remained broadly stable. In 2017-18 there were 879 emergency admissions among those aged 10-17 in Southwark.

Over the past five years, sickle cell disorders, abdominal and pelvic pain and asthma have been the main primary diagnosis on emergency admission in this age group.

Table 3: Number of repeat emergency admissions among those aged 10 to 17 in Southwark in 2017-18.

<table>
<thead>
<tr>
<th>Number of emergency admissions</th>
<th>Number of patients</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 admission</td>
<td>576</td>
<td>84.6%</td>
</tr>
<tr>
<td>2 admissions</td>
<td>72</td>
<td>10.6%</td>
</tr>
<tr>
<td>3 or more admissions</td>
<td>33</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Sickle cell disorders accounted for the largest number of cases (30%) among those having an emergency admission more than three times within the year, followed by abdominal pain (7%).
4.2 Mental Health

As with physical health, poor mental health can negatively impact on an individual’s wellbeing, particularly during periods of acute illness.

Results from the 2017 survey of the mental health of children and young people show that 14.4% of children and young people in England aged 11 to 16 had a mental health disorder, with emotional disorders being the most prevalent. Table 4 illustrates the prevalence of the various categories of disorders along with estimates of how many children this would equate to in Southwark.

<table>
<thead>
<tr>
<th>Mental Disorder</th>
<th>National Prevalence</th>
<th>Southwark Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any disorder</td>
<td>14.4%</td>
<td>2,550</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>9.0%</td>
<td>1,590</td>
</tr>
<tr>
<td>Behavioural disorders</td>
<td>6.2%</td>
<td>1,110</td>
</tr>
<tr>
<td>Hyperactivity disorders</td>
<td>2.0%</td>
<td>350</td>
</tr>
<tr>
<td>Other less common disorders</td>
<td>2.2%</td>
<td>390</td>
</tr>
</tbody>
</table>

Table 4: Prevalence of mental health disorders among those aged 11 to 16 in 2017. Note: An individual may have more than one disorder.

Assuming a similar prevalence of mental health disorders in Southwark, findings from the national survey would indicate that approximately 2,550 adolescents in the borough have a mental health disorder.

While boys are equally as likely to have any mental disorder as girls the pattern varies between conditions. Girls are more likely to experience emotional disorders (10.9% compared to 7.1%), with boys more likely to experience behavioural (7.4% compared to 5.0%) or hyperactivity disorders (3.2% compared to 0.7%).

Data regarding the ethnic and social background of young people with a mental disorder is only available for those aged 5 to 19, rather than for the specific adolescent cohort. The results from the survey indicate that the prevalence of disorders is higher among those from a White British background, and lower among those from Black / Black British or Asian / Asian British backgrounds. This pattern is evident for “any disorder”, as well as for different types of disorder.
Figure 8: Prevalence of any mental disorder by ethnicity and sex, 2017

When comparing across income groups it is apparent that the proportion of children with a mental disorder in low income households is more than double the level of their counterparts in high income households (9% compared to 4.1%). However, the survey found no association with neighbourhood deprivation and the prevalence of mental disorders.
4.3 Lifestyles and Behaviours

The national survey of mental health of children and young people in England shows that alcohol and illegal drug use are much more common among adolescents with a mental disorder.

Findings from our local school survey in 2016 show that 8% of secondary school pupils in Southwark had at least one alcoholic drink in the week prior to the survey; broadly comparable with national drinking patterns among young people.

The local survey also showed that 4% of secondary school pupils got drunk on at least one occasion in the week prior to the survey, with levels slightly higher among girls than boys.

Hospital admissions among adolescents in Southwark for alcohol-specific conditions are amongst the lowest in London, and less than half the rate in England as a whole. As with drinking patterns, rates of admissions are slightly higher among girls than boys, though not significantly so.

The use of illicit drugs among adolescents in Southwark is much lower than the use of alcohol. In 2016, 3% of secondary pupils surveyed reported that they had taken an illegal drug in the last month, with cannabis being the drug most frequently used. However, there is a significant increase in use between year groups, with 12% of girls in Year 10 used illegal drugs in the last month, compared to 1% of girls in Year 8. The reported use of cannabis among boys is comparatively lower, increasing from 1% in Year 8 to 4% in Year 10.

Figure 9: Admission episodes for alcohol specific conditions (u18’s) in 2014-15 to 2016-17.
Maintaining a healthy weight is important for overall health and for wellbeing. Not only is being overweight or obese a risk factor for the development of long-terms conditions such as diabetes and heart disease, but it can also contribute towards low self-esteem and mental ill-health.

Levels of obesity among children entering adolescence in Southwark are significantly above the national average, with no significant change since measuring began in 2007-08. Latest figures show that approximately **1 in 4** children in Southwark in Year 6 are obese.

![Figure 10: Percentage of children in Year 6 (aged 10-11) who are obese](image)

Levels of obesity in the borough are particularly high in the north, from Elephant & Castle, through to Camberwell in the west and Peckham in the east.
Physical activity is positively associated with wellbeing, and our local data shows that the overwhelming majority of adolescents in Southwark enjoy being physically active. However, we also know that too few of our young people meet the recommended amount of physical activity for healthy development and to maintain a healthy weight.

The Active Lives Survey in 2017-18 shows that 15.8% of children and young people in Southwark are active for 60 minutes or more every day, slightly below the national average of 17.5%, with almost a third being active for less than 30 mins a day.

National results from the Active Lives Survey also show that levels of physical activity decline significantly as children move into adolescence. By Years 9-11, 13.6% of young people in England meet the recommended guidelines, compared to 17.4% in Years 1-2.

The survey also highlights the significant inequalities that exist in adolescents in Years 9-11 meeting the recommended physical activity guidelines, particularly among girls from ethnic minority groups.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>16.2%</td>
<td>10.7%</td>
</tr>
<tr>
<td>White Other</td>
<td>20.3%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Black</td>
<td>17.7%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>16.3%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Mixed</td>
<td>14.0%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Other</td>
<td>18.8%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Table 5: Percentage of pupils in Years 9-11 in England who are active for 60 minutes or more per day.
4.4 Relationships
Positive relationships are a key component of mental wellbeing in all age groups. The 2016 school survey asked pupils about negative behaviours they may have experienced in their relationships. The list of behaviours covered within the survey are shown in Table 6.

<table>
<thead>
<tr>
<th>Negative Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used hurtful or threatening language to me</td>
</tr>
<tr>
<td>Was angry or jealous when I wanted to spend time with friends</td>
</tr>
<tr>
<td>Kept checking my phone</td>
</tr>
<tr>
<td>Asked me to send them photos or videos of a sexual nature</td>
</tr>
<tr>
<td>Put pressure on me to have sex or do sexual things</td>
</tr>
<tr>
<td>Threatened to tell people things about me</td>
</tr>
<tr>
<td>Threatened to hit me</td>
</tr>
<tr>
<td>Hit me</td>
</tr>
</tbody>
</table>

Table 6: Negative behaviours experienced in relationships with boyfriend / girlfriends

Findings showed that almost a quarter (23%) of secondary pupils surveyed had experienced at-least one of the negative behaviours listed, with either a current or previous partner.

Pupils were most likely to have experienced their partner becoming angry or jealous when they wanted to spend time with friends (15%), followed by their partner checking their phone (11%). Approximately 1 in 20 pupils had experienced pressure to have sex, or to do sexual things, with similar numbers being threatened, or experiencing physical violence.
5. REFERENCES


Health & Wellbeing Related Behaviour Survey 2016.
# Southwark CCG Committee Report

## ITEM FOR DISCUSSION / ASSURANCE

<table>
<thead>
<tr>
<th>CCG Committee</th>
<th>Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>July</td>
</tr>
<tr>
<td>Year</td>
<td>2019</td>
</tr>
</tbody>
</table>

**Item title:** Annual Public Health Report  
**Enclosure number:** ENC E  
**Any known conflict of interest:** No

The item is being presented to the committee for (select only one):

- **Discussion** [✓]
- **Assurance** [ ]
1. Purpose of the paper (why does the committee need to discuss / receive assurance?)

Each year, Directors of Public Health in local authorities across England fulfil a statutory requirement to write an annual report on the health of their population. This year’s report has focused on the mental wellbeing and resilience of young people in Southwark.

2. Describe the issue being presented to the committee for discussion or assurance

The report is comprised of two sections. In the first, we explore what mental wellbeing means to young people, the factors that influence it across individuals, communities and wider determinants, and what we can do individually and collectively to promote this in our young people. This is followed by five recommendations:

1. Continue to support whole school approaches to improving mental wellbeing, including the implementation of evidence-based bullying prevention programmes.
2. Increase access to parenting support during adolescence.
3. Support leisure and youth services to have whole setting based approaches to improving mental wellbeing.
4. Include young people aged 10-17 years as a targeted group in the Southwark Loneliness Strategy.
5. Increase access to parenting support during adolescence.

The second section – a separate document – is a full statistical appendix, providing further evidence around the risk factors for poor mental wellbeing.

6. What stakeholder engagement has taken place?

Public Health commissioned a series of co-creation poetry workshops with secondary schools and the youth offending service.

Public Health also held an art competition for 10-17 year olds in the borough on the theme of mental wellbeing.
7. What equality and diversity considerations have been highlighted in the Equality Analysis and how have they been addressed?

10-17 year olds are more diverse and more deprived than the general Southwark population and have not experienced the health gains of other age groups.

Supporting information / documents

Please append any relevant documents including detailed reports; options appraisals; background documents; national guidance etc.

<table>
<thead>
<tr>
<th>Appendix #</th>
<th>Name of document</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>‘Everything to gain and nothing to lose’. Mental wellbeing and resilience in young people – a Southwark priority. Annual Public Health Report 2018</td>
</tr>
<tr>
<td>iii</td>
<td></td>
</tr>
<tr>
<td>iv</td>
<td>Title of appended document.</td>
</tr>
<tr>
<td>v</td>
<td>Title of appended document.</td>
</tr>
</tbody>
</table>
Date paper completed: Friday, 01 February 2019
Governing Body Paper

Commissioning System Reform in south east London

Update report - July 2019

1. Introduction

1.1. In order to achieve our ambition to secure more integrated, high quality and sustainable services for south east London’s residents and in response to the NHS Long Term Plan (January 2019), the six CCGs in south east London (SEL) have agreed to undertake a programme of commissioning system reform that will result in:

- the merger of our six organisations to establish a single south east London CCG from 1 April 2020; and

- the formation of local system boards (prime committees of the governing body – see section 4.5) within each borough that will oversee the planning and commissioning of local services across health and social care

1.2. Through these arrangements, we will be seeking to create a commissioning system for SEL that:

- locates decision making for populations and services we serve at the scale at which they are best planned and delivered (at SEL, borough or neighbourhood level)

- brings about a greater integration of health and social care commissioning around the wider needs and well being of our populations and the whole person

- fundamentally shifts the interaction between providers and between commissioners and providers towards collaboration and collective responsibility for patient outcomes and living within available resources

1.3. We will be changing our commissioning arrangements alongside the establishment of provider and commissioner alliances in each borough (Local Care Partnerships) and at SEL level as the platform for our emergent Integrated Care System (ICS), now formally recognised as the first London ICS to join the national roll out of ICS arrangements from June 2019.

2. Purpose

2.1. The purpose of this paper is to:

- confirm the process by which we will pursue our CCG system reform programme

- update the governing body on our progress to date, including noting proposals that are now considered established (as a result of our engagement to date) and will therefore form the basis of our CCG merger application and single CCG

- outline the work planned and next steps to complete this programme of work
Recommendations

2.2. Governing bodies are asked to note the content of this paper and confirm their continued support for the actions being pursued through the system reform programme.

3. Process

3.1. In January 2019, the NHS Long Term Plan provided a clear direction on the expected future role and function of CCGs in England:

‘… [ICSs will grow from] … the current network of Sustainability and Transformation Partnerships (STPs). ICSs will have a key role in working with Local Authorities at ‘place’ level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, for example in relation to procurement and contract award).

Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.’

(Pg. 29, Long Term Plan, January 2019)

3.2. The footprint of our ICS as the six SEL boroughs has been established for some time and our reform programme seeks to secure the NHS Long Term Plan expectation whilst also developing an approach and operating model for the single CCG that makes sense locally.

3.3. In order to establish a new SEL CCG from the 1 April 2020 the following national guidance will be adhered to: https://www.england.nhs.uk/wp-content/uploads/2019/04/procedures-ccgs-constitution-change-merger-dissolution.pdf.

This requires a formal application to be submitted to NHS England and NHS Improvement (NHSE&I) on either 30 September or 31 October 2019 (by exception).

3.4. In April 2019, following a process of engagement, our six CCGs confirmed their intention to consider an application to NHSE&I’s Regional Director and over May 2019 each governing body received and confirmed support for an outline case for change for a single CCG and the process each CCG would undertake in support of that application. Our agreed case for change said that CCG merger would secure:

- responsive population-based commissioning at very local (neighbourhood), borough and system (SEL) place levels that our diverse communities require - simultaneously through the planning and co-ordination of a single commissioning authority
- a different approach to commissioning - that gives greater focus to system strategy, planning and oversight, greater integration of health and social care commissioning and frees up alliances of providers to take ‘traditional commissioning roles’ in service design, responding to populations of similar geography or need
the ability to derive solutions at the required scale and pace to attend to the quality, performance and financial challenges that cannot be resolved by our current organisations

the requisite capacity and different capability required to commission services for our populations going forward within a reduced management cost envelope

the ability to take control and design our structures locally, in south east London, by acting now

(Case for Change Extract, CCG Governing Body Seminar, May 2019)

3.5. The timeline for our process is provided in Appendix A.

3.6. Over the first phase of that process, ending 30 May 2019, a series of engagement discussions were undertaken with governing bodies, member practices, staff, providers and local government in order to confirm and accept a case for change.

3.7. The second phase, beginning in June and running over a three-month period, involves an intensive period of design, engagement and testing of the proposed governance, decision-making, functions and operating model of the new CCG. This has included further discussions in governing body seminars with members from all six governing bodies (per CCG and then collectively) and also through ‘all staff’ briefings in each borough.

3.8. During this second phase and building in the results of the above engagement, we will be completing a draft application covering the full arrangements for the new CCG in late July / early August 2019. These arrangements will be further tested with governing bodies, members and our stakeholders during August 2019. In September 2019, a final application proposal and approval to submit will be considered by each governing body, alongside a new constitution for the single CCG that will be recommended to our members.

3.9. Our current understanding is that approval of that application will be provided in late October / November this year and an implementation phase would then be enacted ahead of dissolution of the six current CCGs and the formal establishment of a single SEL CCG from 1 April 2020. That implementation phase will establish the key features of our CCG in organisation and governance and related terms. Importantly, it will also involve some significant restructuring of the team and staffing structures across each part of our CCG system.

Programme Governance and Principles

3.10. The reform programme is led by a System Oversight Group (SOG), comprising the Chairs and Accountable Officers of our six current CCGs and that group makes common recommendations to governing bodies.

3.11. The SOG is supported by a delivery board - the System Reform and Delivery Group (SRDG) that brings together subject matter experts and senior responsible owners for the key workstreams of the programme. The SRDG has an independent Chair and is supported by a small but dedicated Programme Management Office (PMO) and Executive Director.

3.12. Each part of London is pursuing a similar programme of work and so our programme is also linked to the London CCG Merger Support Group that brings together regulators and CCG leaders to develop and co-ordinate this process.
3.13. As part of the programme’s initiation, the SOG agreed a set of principles by which the programme would be shaped and delivered, and these are included at Appendix B.

Engagement

3.14. We are committed to ensuring comprehensive engagement throughout the programme with staff and our full range of stakeholders, noting this is a requirement of the national process but also a commitment we have made to our staff, members and other partners.

3.15. To date there have been more than 60 engagement meetings or activities as part of the programme, with a further 40 (plus) planned over the summer. These have included regular cycles of engagement meetings with governing bodies, staff, providers, member practices and local authorities – supported by written materials and a ‘live’ Frequently Asked Questions (FAQs) document. We have endeavoured to demonstrate rapid consideration and response to feedback through these discussions and that has shaped our emerging proposals.

3.16. In June, we commenced a programme of engagement with our residents that will occur in each borough and we are also involved in discussions with Healthwatch in each borough. We will also have further opportunities to engage residents in our NHS Long Term plan events over the next few months.

3.17. These engagement and testing events / activities will further inform and shape our proposals ahead of any recommendation to the governing bodies.

Management Costs

3.18. In November 2018, each CCG in England was required to plan for and deliver a management cost reduction of 20%, from 2017/18 management costs resource limits / allocations, by 1 April 2020. The SEL CCGs are already spending below the current allocations and the required saving of circa £8m for the six CCGs is reduced to circa £4.5m as a result.

3.19. The achievement of this management cost reduction will not be secured through the merger programme alone and represents a corporate objective of the CCGs within their business as usual efficiency or QIPP programmes during 2019/20. We have also committed to minimise redundancies and ensure that we are maximising savings elsewhere whenever possible. However, it is clear that the merger of CCGs will contribute to this requirement as any resultant organisation must not have management costs that exceed the new limit.

3.20. Any released costs associated with this national requirement are reinvested into core commissioned services; as they have been in previous years by current our CCGs.

4. Established features of the system reform programme

Ways of Working and Organisational Development

4.1. The most significant and prevalent feature of our engagement to date has been the requirement to look beyond governance and organisational structures and to give focus to ways of working. This recognises that staff and organisations will operate in different partnerships (of commissioners and providers, NHS and local authority
teams) and with different relationships between them - teams operating with different geographies or scope of population in mind.

4.2. As we bring forward details of our application and implementation plans it will be important that governing bodies consider the organisational development requirements of this change; and consider ‘structural’ change in the context of those new ways of working.

Governance

4.3. A single CCG will require a single governing body and associated prime committees. Proposals for these arrangements will be presented to the governing body according to the timetable at Appendix A.

4.4. As part of this governance it is now established that in addition to the SEL-wide committees that will support the CCG, there will be six ‘Place’ or borough-based boards. These boards will operate as prime committees of the south east London CCG, and, with a formality to be agreed by each borough commissioning partnership, will bring together health and local authority commissioners to focus on local service planning and delivery of local or SEL commissioning intentions in each area.

4.5. The formality and population of these joint arrangements within each board is to be determined, although there is consensus around the three potential models for establishing this from 1 April 2020 as outlined below.

Our case for change has emphasised the importance of joint Health and Social Care commissioning and we have suggested three models:

1. Greater Involvement
   - Local Authorities and CCGs discuss priorities and map collaborative but do not make aligned decisions
   - E.g. limited membership/participation on place based boards (nothing they would be members of the Local Care Partnership).
   - The Place Based Director is an NHS employee e.g. Managing Director.

2. Aligned Commissioning
   - “Align roles, separate budgets”
   - Local Authorities and place based health leaders agree priorities and take respective organisational decisions on achieving these
   - E.g. members of the place based boards, with agreement, shared decisions are actioned; there is an agreed link into Local Authority governance.
   - Place Based Director dual accountability to the LA and CCG

3. Collaborative Commissioning
   - “Aligned plans, aligned budget”
   - Local Authorities and place based health leaders would jointly make decisions on health and Local Authority functions with delegated budget from both organisations e.g. through pooled budgets & SSMS
   - E.g. the place based board is a committee in common or similar to the Local Authority.
   - The Place Based Director has dual accountability to the LA and CCG

4.6. Importantly, provided a local board is established in support of the SEL CCG’s operating model, with the appropriate governance required by the CCG, the level of formality in each borough need not be uniform, but agreed with each partnership locally. However, a core expectation is that this arrangement enables a delegation of responsibility to borough level for the commissioning of primary and community based care (see below).

Decision-Making and Influence

4.7. The final proposals brought forward later this year will now be established based on an agreed position around decision-making and influence across our diverse and complex system. Our arrangements will follow our ‘System of Systems’ ICS approach such that from 1 April 2020:
• the commissioning strategy and planning functions and responsibilities of the new CCG will be undertaken once for SEL. The development process will however be reflective of the need for commissioning activities to occur throughout our system (at a borough and SEL level). As such the planning of health services will involve an interaction between place and system partnerships at each level but will be agreed once for SEL, noting this model meets the national NHS Long Term Plan expectations with regards to decision making.

• the commissioning of acute services with responsibility for associated budgets will be held at SEL level and undertaken once. Again, borough boards will have influence over these areas through the process of planning (as set out above) and the governance of the CCG (with equal representation of all boroughs on the governing body and associated committees).

• the commissioning of community-based services, including primary care and client group commissioning will be formally delegated to the borough board with responsibility for associated budgets; and the potential to bring those together with local authority budgets under the joint arrangements that that board is agreed to have.

• the governing body, in agreeing its strategy and commissioning intentions, will require at all levels, pursuit of an ambition or goal of ‘minimum standards, delivered everywhere’ alongside relevant local priorities.

4.8. It is important to note that the arrangements above represent the basis for the initial establishment of the new CCG. It is expected that progress towards a full ICS for SEL will require a further change to system responsibilities and where they sit. It is also anticipated that some borough partnerships will wish to take further delegated responsibility at a borough board level. The principles by which that would be considered by the SEL CCG, either in shadow or final form, depending on when proposals are made, will be proposed to the governing bodies in September 2019.

Capacity and Capability Approach

4.9. The operating model and governance of the CCG will require the right skills and capacity to ensure its success and our proposals will need to outline how this will be secured and also the management of change process, in Human Resources policy terms, that will be required to achieve it.

4.10. At this stage, the programme and its CCGs are undertaking an engagement process on this specifically. We are clear that each CCG’s policies will be adhered to. We will involve representative bodies and are committed to minimising any redundancies as a result of this process. We will support our staff, as our most important asset, through this process.

4.11. Beyond these clear commitments the following principles will also shape our programme of work in this regard:

• That testing of structures for teams, delivering the CCG’s functions, may require differential levels of time depending on the complexity of the area in question. To that end we will make proposals for phased changes to functions:
  o Some in advance of April 2020 as they will be critical to the business of the new CCG either in terms of its safe functioning or because of its near-term objectives.
Some post April 2020 to provide a longer period for their consideration, design and testing (noting that current and future CCGs will always be pursuing ways to optimise their arrangements).

- That, in broad terms CCG teams will work in one of three ways:
  - single teams undertaking their responsibilities once for SEL
  - teams with single leadership and point of coordination, but with resources working on behalf of or embedded in each borough
  - borough based teams

4.12. Irrespective of the timing and method of deployment, we are clear that all functions need to be designed in a way that optimises their delivery, are affordable and have the future ICS in mind.

4.13. The programme and the SOG has, through engagement to date, heard a clear concern from general practices about ensuring their continued access to local primary care advice and support, medicines management support and GP IT support. Notwithstanding the process outlined above, the SOG has felt able to communicate an assurance to member practices that these features of our current CCG will continue to be available locally post April 2020.

5. Integrated Care System Development

5.1. The development of the SEL ICS as London’s only wave three partnership will take place over the next two years and CCGs / partners have made clear their commitment to ensuring this current system reform is aligned to our ICS development.

5.2. As governing bodies consider the new CCG arrangements generally, this alignment will need to be kept in mind. At this point in time, there appears to be two early and important points of consensus in this regard:

- that in the design of CCG functions and team structures there must be a focus on transformation ‘delivery’ and that associated resources and teams should not be CCG ‘owned’ but should in future represent ‘system teams’ either at SEL or borough level - resourced and directed by provider led alliances, working with health and care commissioners.

- that ‘Place’ or borough based boards will be commissioning entities, however they will sit alongside Local Care Partnerships in each borough and corresponding arrangements at SEL (e.g. South London Partnership or any emergent Acute Based Care partnerships). There should be a clear interaction between those groups if we are to adopt an ICS way of working, whilst ensuring clear governance for management of conflicts of interest is established.

6. Next Steps

6.1. As outlined above and included in Appendix A, the current work of the programme is focused upon engagement, design and testing of our proposed operating model and governance.

6.2. Ultimately this will result in the production of draft proposals and the content of an ‘application’ (with associated documentation), as required nationally, in late July / early
August for governing body review and further engagement with our stakeholders (internal and external).

6.3. Each governing body will then consider a single application for merger of the CCGs at their September meeting in public (4-18 September 2019). Subject to that approval, the application will be submitted to NHSE&I and the constitution of that new body will be considered by memberships, according to their current requirements.

6.4. A successful application will allow an implementation phase in advance of April 2020.
Appendix A

Since the initiation of our System Reform programme in March 2019, we have been developing our proposed approach to a South East London CCG merger. The phasing of the full programme is shown below:

We have undertaken significant engagement work around principles and a case for change. Our engagement focus now shifts to the design of our commissioning system, its functions, governance and ways of working

• This conversation can often feel transactional or ‘structure heavy’ – we mustn’t lose sight of our culture, Organisational Development and ways of working.

• In June, July & August we will be identifying and utilising engagement opportunities that build from our May discussions with Governing Bodies and stakeholders
Appendix B

Set of Principles agreed through the System Oversight Group

1. **Evidence enhanced effectiveness** and enable our ICS development in response to the Long Term Plan

2. Seek to **drive best value out of all corporate investment**; we will aim to **minimise impact on staff by maximising efficiencies** from estates, corporate costs and other non-pay costs

3. **Ensure capacity and capability at each scale**; the necessary cost savings will need to be delivered but there must be assurance that the CCG and place based systems are able to undertake the CCG’s required functions effectively

4. **Encourage integration with other partners**; particularly at the borough level it is expected that there could be **increased blended teams with Local Authorities and other partners**, and that some place based functions could be delivered with or by these partners

5. **Initially include all functions**; however some may be moved out of scope by the System Reform Delivery Group or System Oversight Group

6. Speak to **immediate and future operating environments**; this programme should **actively move us towards our ‘system of system’ ICS vision** and therefore consider our resource requirements for the future as well as the immediate term

7. **Support our staff through this change**; we will aim to communicate regularly, engage as much as possible, and offer options for our staff to **minimise the concerns and impact** related to these changes
**ITEM FOR DISCUSSION / ASSURANCE**

<table>
<thead>
<tr>
<th>CCG Committee</th>
<th>Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>July</td>
</tr>
<tr>
<td>Year</td>
<td>2019</td>
</tr>
</tbody>
</table>

**Item title:** Commissioning system reform in south east London - update

**Enclosure number:** F

**Any known conflict of interest:** No

**The item is being presented to the committee for (select only one):**
- **Discussion:** ✓
- **Assurance:** ☐
1. Purpose of the paper (why does the committee need to discuss / receive assurance?)

The Governing Body is asked to note the content of this paper and confirm its continued support for the actions being pursued through the system reform programme.

2. Describe the issue being presented to the committee for discussion or assurance

The purpose of this paper is to:

- Confirm the process by which we will pursue our CCG system reform programme
- Update the Governing Body on our progress to date, including noting proposals that are now considered established (as a result of our engagement to date) and will therefore form the basis of our CCG merger application and single CCG
- Outline the work planned and next steps to complete this programme of work.

3. What stakeholder engagement has taken place?

Extensive engagement throughout the whole reform programme to date – see 3.6 and 3.7 of the main report.

4. What equality and diversity considerations have been highlighted in the Equality Analysis and how have they been addressed?
### Supporting information / documents

Please append any relevant documents including detailed reports; options appraisals; background documents; national guidance etc.

<table>
<thead>
<tr>
<th>Appendix #</th>
<th>Name of document</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>Commissioning system reform in south east London - update</td>
</tr>
</tbody>
</table>

**Date paper completed**

Monday, 01 July 2019
Non-Acute Performance Assurance Report

19 June 2019

FINAL - Version 2.0.
Contents

Introduction and summary

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• Year-end positions – 2018/19 PAGE 8

Non-acute challenged performance

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Introduction and summary
Introduction

This pack summarises the south east London performance position for key areas of non-acute performance identified as on target, improving or challenging for south east London (SEL) CCGs.

The South East London Integrated Governance & Performance Committee (SEL IG&P) has a remit for undertaking assurance activities for the delivery of a number of key acute performance and financial standards across SEL CCGs. The committee does not currently include non-acute areas of performance within its scope. However it has been agreed that the SEL Executive will review non-acute performance on a regular basis to confirm if further action is required.

There are a number of national standards relating to non-acute care that CCGs are expected to achieve consistently and/or address as a priority should performance against the standard deviate from target. This pack focuses on indicators being specifically monitored at a regional level.

Whilst SEL CCGs do consistently meet a number of non-acute standards and targets, there are several others where this is not the case. A number CCGs in south east London are currently engaged in regulatory assurance activities in areas that demonstrate variance from the national standard / agreed local trajectory. SEL performance is also now compared against other STPs in London, and this is included here for reference.

The purpose of this pack is to:

• Set-out the SEL CCG and collective position against a number of national non-acute performance standards
• For those areas of performance not delivering to standard: set out the key drivers of performance and high impact actions underway to improve performance.
• Identify areas of best practice to enable sharing
• Capture SEL level actions and agreed priorities
• Support an executive discussion regarding next steps and priorities
• Support a more efficient responses to regulatory questions and assurance.
Mental health

• **SEL achieved both the 2018/19 IAPT access and recovery targets.** All CCGs except Greenwich have confirmed that sufficient capacity has been commissioned to deliver the 2019/20 targets.

• **IAPT waiting times remain good for SEL** for both 6 and 18 week targets, however regulators have highlighted that waiting times between 1st and 2nd appointments are well above the national mean and four SEL CCGs are significant outliers. The SEL IAPT Task and Finish Group is prioritising the development and implementation of improvement plans to bring the SEL performance position closer to the national mean and will report progress to the SEL Mental Health Strategic Commissioning Group.

• Following a data validation exercise and retrospective review of 2018/19 data, Bromley CCG’s CYP access performance improved significantly which helped improve the SEL position at the end of 2018/19. **Despite the improvement, the STP’s year-end position is 31.5%, which is narrowly under the target of 32%.** A national year-end data collection is currently taking place which is likely to confirm that the STP has narrowly missed the 2018/19 target. Plans are now being finalised for 2019/20 and these will be reviewed and monitored during monthly CYP access calls with providers.

• Both SLaM and Oxleas are implementing a range of improvement plans to reduce **Out of Area Placements (OAP)**, however increasing demand, delayed discharges and a lack of female PICU beds at Oxleas remain significant challenges. Both SLaM and Oxleas have revised their trajectories which aim to significantly reduce OAPs in 2019/20 and the STP will be submitting an OAPs recovery plan to regulators on 24 June.

• Dementia service user groups across London have **raised concerns about waiting times for diagnosis** including waiting times once referred to a memory service. In response, the NHSE regional team has set an ambition that **by 2020 services should work towards ensuring 85% of patients receive a diagnosis and start treatment within 6 weeks of a referral** to a memory service. Although there is currently no national memory service waiting time data, the regional team has asked CCGs to submit monthly local data starting from April 2019. The data shows there is considerable variation in waiting times across SEL and significant improvement will be required to achieve the 85% standard by 2020.
Key messages for 2018/19 and 2019/20

Personal Health Budgets

- SEL is making consistent progress in increasing the numbers of PHBs being made available to patients. SEL CCGs have each continued to increase the numbers of PHBs over 2018/19 and in March 2019 SEL exceeded its revised year-end target. The SELCA Assurance Team and the NHSE regional team are working with CCG leads to develop a plan to significantly expand the PHB offer to new client groups in 2019/20. The STP has secured £100k funding to recruit a SEL PHB lead to support CCGs to deliver their plans. Interviews have been completed and a successful candidate has been offered the position with a start date to be confirmed.

Diabetes

- CCGs are working with their practices to improve delivery against the diabetes standards, however there is a significant lag in the availability of national data and insufficient local data which limits our ability to monitor progress in year. A governance gap has been identified so a SEL diabetes group is being established to monitor performance and coordinate the implementation of operational and transformational improvement plans. The SEL Assurance Team is working with the ICDT to draft ToRs and consider membership of the group which is expected to be in place in Q2 2019/20. The group is likely to focus on standardising performance reporting and implementing at scale improvement plans to improve performance against National Diabetes Audit and Improvement and Assessment Framework targets.

Cancer Screening

- Although the SEL performance position has improved across most of the screening programmes, none of the CCGs in SEL are currently meeting the screening targets for bowel, breast and cervical screening. CCGs are supporting the implementation of both national and local programmes to increase uptake rates, however securing sufficient practice and patient engagement continues to be a challenge.

Primary Care Workforce

- The planned trajectory for GP recruitment will be approximately 70WTE below the national target by September 2020. This has been communicated to NHSE and it has been made clear that the SEL strategy to increase clinical capacity in primary care does not solely focus on recruitment but also on developing new roles and improved ways of working. No updates were provided for this report.
Current escalations and recommendations for action

Escalation processes in place

- PHB – monthly regional escalation process in place with response led by SELCA Assurance Team and supported by monthly SEL PHB lead teleconferences. Regulator has responded positively on progress and is working with SEL to explore potential for collaboration.

- Mental health high risk return covering CYP, IAPT and OAPs submitted 30 May 2019 and unknown if further escalation meetings are required.

Recommendations for action

- The SEL Executive should note the current performance and forecast year end position for each of the non-acute standards.

- It should be noted that the STP is responding to regulator exploratory KLOEs on IAPT 2nd appointment waiting times and the delivery of IAPT long term conditions services. The SEL IAPT Task and Finish Group is adopting a proactive approach to developing and implementing improvement plans and the SEL Executive is asked to ensure local mental health teams prioritise these performance areas.

- The SEL Executive is asked to note that CCGs are being asked to provide regulators with monthly dementia diagnosis waiting times data. There is significant variation in performance across SEL and improvement is required to meet the regional ambition.

- An offer has been made to a successful candidate for the fixed term SEL PHB Lead role. Once in post, the individual will work with CCG PHB leads and experts from the NHSE regional team to expand the PHB offer to new cohorts of mental health patients and wheelchair users across SEL.

- The SELCA and OHSEL team are working with providers and CCGs to ensure that all CYP activity is being reported locally and captured in the year-end national collection. For 2019/20, the SEL Executive is requested to ask their mental health teams to work with providers to ensure all activity is reported on the national MHSDS system.

- The SEL Executive should note that the STP is developing an OAPs recovery plan. The recovery plan will respond to a set of NHSE/I criteria and is due for submission on 24 June 2019. The lack of female PICU beds at Oxleas remains a particular challenge.

- CCGs should consider local actions to be taken so they are each appraised of their current position on the delivery of diabetes standards. The SELCA Assurance Team has commenced discussions with the ICDT to establish a SEL governance structure and the terms of reference for a SEL diabetes group.

- CCGs should consider further actions that could be taken to improve local rates of cancer screening.
This table summarises the year-end positions for all indicators covered in this pack based on the latest available data:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT Access</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end performance below</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
</tr>
<tr>
<td>(4.75% target)</td>
<td></td>
<td></td>
<td>target</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IAPT Recovery</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
</tr>
<tr>
<td>(50% target)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYP Access</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end target delivered</td>
<td>Year-end performance below</td>
<td>Year-end performance below</td>
<td>Year-end performance below</td>
<td>Year-end target narrowly missed</td>
</tr>
<tr>
<td>(32% target)</td>
<td></td>
<td></td>
<td></td>
<td>target</td>
<td>target</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Personal Health</td>
<td>Year-end target achieved</td>
<td>Year-end performance below</td>
<td>Year-end target achieved</td>
<td>Year-end performance below</td>
<td>Year-end target achieved</td>
<td>Year-end target achieved</td>
<td>Year-end target achieved</td>
</tr>
<tr>
<td>Budgets</td>
<td></td>
<td>target</td>
<td></td>
<td>target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Area Placements</td>
<td>Both SLaM and Oxleas did not deliver the trajectory for 2018/19 – trajectories for 2019/20 have now been revised based on the latest position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Due to the lack of up-to-date local data it is not possible to predict a year end position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Screening*</td>
<td>All CCGs are failing these targets and based on current performance there is a high risk that CCGs will not meet most of the cancer screening targets by year-end</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Workforce*</td>
<td>South east London is not expecting to achieve the trajectory to meet the target for GP FTEs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Year end data not yet available. Reflects latest reporting position
Non-acute challenged performance

Detailed performance position and recovery plans
Improved Access to Psychological Therapies
**IAPT access: performance position**

**Context**

- The SEL aggregate performance position finished the year above the Q4 standard of 4.75% at 4.85%.
- All CCGs except Greenwich have confirmed that sufficient capacity has been commissioned to deliver the access target in 2019/20.
- Achievement of IAPT targets in 2019/20 will be monitored by the IAPT Task and Finish Group

<table>
<thead>
<tr>
<th>CCG</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently off-track against Q4 standard</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Tab 15 ENC G (i) - Non-acute assurance report June 2019**
South East London CCGs are meeting the IAPT waiting time and the recovery rate standards but are not currently delivering the access rate standard.

### IAPT Access Rate Rolling 3 months (March 2019) - Standard 4.75% Q4 18-19

<table>
<thead>
<tr>
<th>CCG</th>
<th>Current month</th>
<th>Trend since last month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>4.89%</td>
<td>↑</td>
</tr>
<tr>
<td>Bromley</td>
<td>5.18%</td>
<td>↑</td>
</tr>
<tr>
<td>Greenwich</td>
<td>3.83%</td>
<td>↑</td>
</tr>
<tr>
<td>Lambeth</td>
<td>4.86%</td>
<td>↑</td>
</tr>
<tr>
<td>Lewisham</td>
<td>4.86%</td>
<td>↑</td>
</tr>
<tr>
<td>Southwark</td>
<td>5.28%</td>
<td>↑</td>
</tr>
<tr>
<td>South East London CCGs (SEL)</td>
<td>4.85%</td>
<td>↑</td>
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</table>

### IAPT Recovery Rate Rolling 3 Months (March 2019) – Standard 50%

<table>
<thead>
<tr>
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<th>Trend since last month</th>
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</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>48.2%</td>
<td>↓</td>
</tr>
<tr>
<td>Bromley</td>
<td>55.5%</td>
<td>↑</td>
</tr>
<tr>
<td>Greenwich</td>
<td>54.2%</td>
<td>↑</td>
</tr>
<tr>
<td>Lambeth</td>
<td>53.0%</td>
<td>↑</td>
</tr>
<tr>
<td>Lewisham</td>
<td>53.2%</td>
<td>↑</td>
</tr>
<tr>
<td>Southwark</td>
<td>50.0%</td>
<td>↑</td>
</tr>
<tr>
<td>South East London CCGs (SEL)</td>
<td>52.7%</td>
<td>↑</td>
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</table>

### IAPT Waiting Times 6 Weeks (March 2019) – Standard 75%

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<th>Trend since last month</th>
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</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>100%</td>
<td>⇬</td>
</tr>
<tr>
<td>Bromley</td>
<td>94.2%</td>
<td>↓</td>
</tr>
<tr>
<td>Greenwich</td>
<td>100%</td>
<td>↑</td>
</tr>
<tr>
<td>Lambeth</td>
<td>94.3%</td>
<td>↑</td>
</tr>
<tr>
<td>Lewisham</td>
<td>90.5%</td>
<td>↑</td>
</tr>
<tr>
<td>Southwark</td>
<td>91.1%</td>
<td>↑</td>
</tr>
<tr>
<td>South East London CCGs (SEL)</td>
<td>94.3%</td>
<td>↑</td>
</tr>
</tbody>
</table>

### IAPT Waiting Times 18 Weeks (March 2019) – Standard 95%

<table>
<thead>
<tr>
<th>CCG</th>
<th>Current month</th>
<th>Trend since last month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>100%</td>
<td>⇬</td>
</tr>
<tr>
<td>Bromley</td>
<td>100%</td>
<td>↑</td>
</tr>
<tr>
<td>Greenwich</td>
<td>100%</td>
<td>↑</td>
</tr>
<tr>
<td>Lambeth</td>
<td>100%</td>
<td>↑</td>
</tr>
<tr>
<td>Lewisham</td>
<td>97.6%</td>
<td>↑</td>
</tr>
<tr>
<td>Southwark</td>
<td>100%</td>
<td>↑</td>
</tr>
<tr>
<td>South East London CCGs (SEL)</td>
<td>99.7%</td>
<td>↑</td>
</tr>
</tbody>
</table>

**Key**
- Not achieving national standard: ✖
- Worsening position: ↓
- Achieving national standard: ↑
- Improving position: ↑
- Top Performer
- Worst performer

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[12 of 366]
### IAPT access: summary of high-impact actions

<table>
<thead>
<tr>
<th>CCG</th>
<th>High Impact Actions</th>
<th>Responsible Officer / Group</th>
</tr>
</thead>
</table>
| Bexley| • Bexley CCG has commissioned sufficient additional capacity to support achievement of the 5.5% access target. Capacity enhancements have been agreed collaboratively with the provider but achievement is dependant on maintaining and increasing the volume of referrals / self-referrals to the service. Bexley will be in a better position to assess the likelihood of achieving the increased access target by the end of Q2.  
• 2019/20 investment includes additional PWP and HIT staff, enhanced admin resource and an enhanced licence agreement with Silver Cloud enabling unlimited use of the platform as part of a more integrated online therapy offer.  
• The provider and commissioner continue to support the development of pathways for LTCs and other collaborative opportunities e.g. perinatal mental health.  
• A trajectory has been agreed to achieve the 5.5% target by Q4 19/20 and progress will be kept under regular review through established contract monitoring and review meetings.                                                                 | Graham Tanner               |
| Bromley| • Bromley CCG has confirmed sufficient activity has been commissioned  
• Additional capacity commissioned by using local step 3 provider and additional CBT provision  
• Strategies in place to recruit and retain staff in step 2 and step 3 service  
• CCG/BHC monthly contract performance meetings to review targets and weekly performance reporting  
• Service capacity increases in Q4 2019/20 due to new trainees recruited in September/October 2019 (anticipated to be 12 trainees) completing training and taking on caseloads by January 2020.  
• Improved communication with primary care with linked therapists, monthly referral report by practice with individual practices targeted | Paulette Robin              |
| Greenwich| • On-going discussions are taking place with Oxleas to agree a plan to meet the target in 2019/20, but so far a plan has not been signed-off by all parties.  
• The risk rating will be reviewed and potentially downgraded if a plan is agreed.  | Collete Meehan              |
# IAPT access: summary of high-impact actions

<table>
<thead>
<tr>
<th>CCG</th>
<th>High Impact Actions</th>
<th>Responsible Officer / Group</th>
</tr>
</thead>
</table>
| Lambeth   | • Lambeth CCG have agreed expansion funding of approximately £200k and will work with the service to increase the number of groups provided in the Living Well Centres within the Alliance.  
• Lambeth CCG will also be part of the London-wide business case to develop a single point of access (digital accelerator) which will support better coordination of access of the service for mental health patients, and will lead to an increase in service users. | Denis O’Rourke                   |
| Lewisham  | • Some assurance provided that sufficient activity has been commissioned  
• The CCG has funded this level within the MHIS and the service has planned for sufficient trainees to meet the capacity required by Q4.  
• The Provider Alliance formed by SLaM with primary care providers should enable sufficient referrals to be managed. Performance in Q4 2018-19 is 4.83% which will meet the Q1-Q3 level for 2019-20. | Kenneth Gregory                  |
| Southwark | • Some assurance provided that sufficient activity has been commissioned  
• Southwark CCG expects the access target to be achieved by Q4 following the level of investment into the service at the start of 2019/20.  
• An action plan will be instituted as soon as concerns about access rates become apparent, the CCG will require the provider to take urgent action to address poor achievement in this area. | Sam Hepplewhite                  |
**IAPT recovery: performance position**

### CCGs not currently delivering the performance standard

<table>
<thead>
<tr>
<th>CCG</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently off-track</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>

### Context

- The STP has delivered the IAPT recovery rate target in 2018/19 and performance is currently at 52.7% in March 2019.
- CCGs have confirmed that they expect performance to be compliant throughout 2019/20.
## IAPT recovery: summary of high-impact recovery actions

<table>
<thead>
<tr>
<th>CCG</th>
<th>High Impact Action</th>
<th>Responsible Officer/ Group</th>
</tr>
</thead>
</table>
| Bexley    | • The 50% recovery target continues to present challenges to providers in terms of the extent to which access to services require gate-keeping in view of their complexity and potential for recovery.  
  • Bexley are confident that existing protocols within the service are sufficient to deliver recovery rates at 50% throughout 2019/20.                                                           | Graham Tanner              |
| Bromley   | • Bromley CCG expects to meet the recovery target in 2019/20. In Q4 2018/19 the service achieved the rolling quarter 50% target.  
  • The IAPT service has improved data quality and focused on recovery.  
  • Recovery-focused supervision has been implemented and completed for step 3 counsellors and sub-contracted counselling service | Paulette Robin             |
| Greenwich | • The CCG has consistently met the 50% target  
  • Additional mitigation plans are not currently required.                                                                                                                                                           | Collete Meehan             |
| Lambeth   | • Lambeth CCG expects to meet the recovery target over the year.  
  • SLaM has identified that dips in performance coincide with intake of new trainees and is looking at approaches to address this including work with other services to determine how this can be avoided going forward.  
  • Q4 2018/19 performance of 53.4% exceeds the 50% standard, and the extra funding will provide additional capacity to increase throughput and treatment numbers.  
  • SLaM are looking to improve staff retention and development which will have a direct impact on the quality and consistency of care. Longer term, Lambeth will be exploring alternatives, for instance how the Living Well Centres can provide group-based support and follow-up intervention thereby reducing the demand on the talking therapies service. | Denis O'Rourke             |
| Lewisham  | • The CCG IAPT service has delivered the recovery rate for 2018-19 at 51.3% with Q4 18-19 at 53% and anticipates continued delivery on a quarterly basis in 2019-20                                                                 | Kenneth Gregory           |
| Southwark | • Southwark CCG expects the recovery target to be achieved over the year following the level of investment into the service at the start of 2019/20. The service has made improvements to recovery over 2018/19.  
  • Recovery is a standing agenda item in monthly contract monitoring meetings. An action plan will be instituted as soon as concerns about the recovery rate become apparent, the CCG will require the provider to take urgent action to address poor achievement in this area | Sam Hepplewhite           |
**Context**

- The current IAPT waiting time standards measure waiting times from diagnosis to starting treatment (i.e. first treatment) and mandate that 75% of patients start treatment within 6 weeks and 95% within 18 weeks.

- SEL is performing well against these standards, however the NHSE regional team have highlighted that some CCGs in SEL have long waits between 1st and 2nd appointments with a significant proportion of patients waiting over 90 days.

- Currently four CCGs (Bexley, Bromley, Greenwich and Lewisham) are significant outliers against the national average of 15.2% and SEL is being asked to implement improvement plans to move closer to the national position.

- It should be noted that this position was taken from December 2018 data.

- SEL CCGs are developing improvement plans and at the next IAPT task and finish group meeting on 20 June. CCG teams will report on progress. The focus will be on increasing productivity through reduction in DNAs and better utilisation of appointment slots, e.g. working with GPs to promote group therapy and online options as alternatives to one-to-one sessions. In addition, Bexley CCG has increased capacity of online provision having procured an enhanced licence with online provider Silvercloud.
**Context**

As set out in the Five Year Forward View for Mental Health, the expansion of IAPT services will focus on people with long term conditions (LTC) or medically unexplained symptoms (MUS). To achieve this expansion, new psychological therapy provision will aim to co-locate physical and mental health care and therapy will be integrated into existing medical pathways and services – either primary care, or secondary care services (e.g. diabetes, cardiac, respiratory).

There are some specific requirements around the expansion of IAPT LTC provision:

- All CCGs are required to commission an IAPT-LTC service and to recruit the necessary additional staff using the additional funding which has been included in CCG baselines from April 2018.

- From 2020/21, two thirds of the expansion of IAPT services will include people with LTCs and medically unexplained symptoms.

All CCG IAPT teams have established models for the delivery of IAPT LTC, mainly across diabetes, COPD, cardiac, pain and MUS pathways to varying levels of integration due to challenges with reaching into secondary care services and maintaining momentum to embed LTC IAPT once implemented.

The IAPT Task and Finish group has agreed that a strategic approach is needed to reduce variation in models of delivery and to align team resource to LTCs where there is scope to maximise opportunity as identified by RightCare data. Successful approaches to increase LTC access is being shared, e.g. the Southwark joint work in diabetes teams model is being tested and so far showing success. Further planning and feedback is due at the next meeting on 20 June with a view to services replicating this approach from Q2.
Children & Young Peoples Mental Health
CYP mental health: performance position and trend

CCGs not currently delivering the performance standard

<table>
<thead>
<tr>
<th>CCG</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently off-track</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Context

- The 2018-19 planning requirement was that 32% of Children and Young People estimated to have mental health needs are assessed.
- There is a five year ambition to achieve 35% annually by 2020/21, with the target for 2019/20 set at 34% by Q4.
- In order to count against this target children and young people must have completed at least two sessions in the year. Once each person has had these two sessions, they are not counted again for the year.
- The year-end position for south east London CCGs in 2018/19 is **31.5% against a target of 32%**. In December at the NHSE escalation meeting we forecast a year end position of 27.7% and in February we forecast 28.7%.
- NHS England made the decision to move back to local activity data rather than using MHSDS data to record CYP access performance. Local activity data is being used as the basis of reporting until 2019/20 and NHS England is currently conducting a full-year activity submission for 2018/19 which is likely to confirm the local position as stated above plus-or-minus a small % for duplications in data recording, which is applied by provider.
**CYP mental health: performance position**

### SEL current position by CCG by month 18/19

#### Notes / assumptions:
- April 18 to March 19 using local data as shared with NHS England.
- Total trajectory for SEL was calculated by NHSE and shows what we were expected to achieve each month across SEL.
CYP mental health: performance position

<table>
<thead>
<tr>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP Access Rate – Year-end position (based on local data) – target 32%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Current month</td>
<td>33.5%</td>
<td>44.6%</td>
<td>35.5%</td>
<td>22.6%</td>
<td>28.3%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Trend since last month</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
</tr>
</tbody>
</table>

Context and data

- The above data on CYP reflects the 2018/19 year-end position of each CCG based on locally reported data to March 2019.
- NHS England confirmed CCGs could submit local data from April 2018 and this would be used for regional assurance purposes instead of MHSDS data given the known data flow issues with the latter.
- The SEL Assurance Team and STP CYP Lead worked with Bromley CCG to review data reported by Bromley Y and SLaM. The data validation exercise with Bromley Y has been completed and has resulted in a significant increase in reported activity.
- Bromley activity carried out by SLaM has not historically been included in local data submissions but this activity is now being collected and has been incorporated into the annual position.
- The improvement in Bromley’s position has resulted in a significant uptick in south east London performance.

Key drivers of under performance and mitigations

- Not all services have referral routes consistently supported from other CYP services, especially schools. Oxleas have developed a method to capture this data and SLaM are reviewing their current methods following discussion with Oxleas.
- There are workforce challenges, especially diversion of planned resource to the CYP crisis pathway and recruitment to deliver the waiting list initiatives. Oxleas has developed an innovative approach to improving retention of Band 6/7 by supporting staff to train in a range of therapies.
- There is potential to have a consistent offer for South East London e.g. online and telephone access. Roll-out of the online offer Kooth across SEL launched 4th Feb which should increase access across each CCG by 30-60 a month. A business case has been developed by Oxleas for tele-triage across Greenwich and Bexley.
## CYP mental health: summary of high-impact actions

<table>
<thead>
<tr>
<th>Owner</th>
<th>High Impact Action</th>
<th>Expected completion date and status</th>
<th>Key risks to delivery of the action</th>
<th>Responsible Officer / Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxleas Bexley &amp; Greenwich CCGs</td>
<td>Business case has been developed for mainstreaming the tele-triage service offer in Bexley and Greenwich CCGs. Previously the tele-triage was being delivered as a pilot run by volunteers.</td>
<td>Implemented November 18</td>
<td>Outcome of MHIS and ability to recruit</td>
<td>CCGs / Oxleas</td>
</tr>
<tr>
<td>Bromley CCG</td>
<td>Bromley CCG was awarded funding by NHSE to be a Mental Health in Schools Trailblazer site which includes 2 dedicated teams who will work with a cohort of 8,000 pupils and will provide universal mental health support over 2yrs.</td>
<td>Completion by December 2020. Impact on access expected July 2019</td>
<td>In mobilisation phase with risks around staffing to capacity.</td>
<td>Bromley CCG / Bromley Y</td>
</tr>
<tr>
<td>SEL CCGs</td>
<td>Kooth Xenzone launched across SEL 4th Feb. Previously delivering solely in Lewisham. Expectation is that Kooth widens access by 30-60 CYP each month per borough. Wide promotion of the new service offer needed to achieve this target – SEL wide communication plans is under development</td>
<td>Full impact on access rate expected by November 2019</td>
<td>Dependent on effective promotion of the service via social media channels</td>
<td>SEL CCGs</td>
</tr>
</tbody>
</table>
| SLaM Oxleas | Further actions included in stretch plan:  
• Ongoing improvements to data quality including identification of other services where performance is not currently recorded (e.g. local authority commissioned psychologist support for adopted children) | In place at SLaM since August 18; in place at Oxleas since November 18 and on-going | Challenge in determining precise opportunity remaining from data quality exercises at SLaM and Oxleas. It is likely that the benefit of this work is already reflected in Q4 activity levels and so does not offer a further stretch. | SLaM /Oxleas / CCGs |
| SLaM & Lambeth, Southwark and Lewisham CCGs | Awarded NHSE funding to deliver waiting list initiative which includes offering a mixture of group therapies, schools based treatments and 1-2-1 interventions for 133 CYP that are either waiting over 52 weeks for treatment or are waiting between 39-52 weeks for treatment. | Funding to be spent by March 31st 2019. Target achieved by May 2019 and will impact on access rate in 19/20 | Managing increased treatment demands | SLaM / LSL CCGs |
| Lewisham CCG | Awarded NHSE funding to deliver waiting list initiative which support Core Assets (non-NHS provider) and a SLaM clinician to identify suitable cases and agreeing an assessment framework for CYP on the CAMHS waiting list. The funding will support CYP with behavioural challenges, low mood and anxiety. Core Assets to undertake 106 sessions, with 8 sessions per child and to support 13 CYP in total | Funding to be spent as requested by March 31st 2019. Target achieved by May 2019 | Late allocation of funds reduced time to mobilise | Lewisham CCG / Core Assets |
CYP mental health: summary of high-impact actions

Further SEL Local initiatives and plans to improve CYP access

CAMHS plans for 2019/20 have been developed as part of the 2019/20 planning round with a firm focus on achieving the access standard and all refreshed CAMHS transformation plans will set out key actions to deliver the standard.

- SLaM and Oxleas have undertaken a CAMHS demand and capacity exercise to help inform 2019/20 planning. An indicative monthly target for CYP having second appointments is being provided to support planning and transparency with local commissioners.

- There will be a full year effect in 2019/20 of the roll out of Kooth online counselling service for all CCGs in SEL

- A SEL half day workshop was held in May on the neurodevelopmental pathway bringing together multi-disciplinary system leaders to drive the transformational changes required across the STP in alignment with our priorities and to help us in preparing to respond to the NHS LTP

- Impact of the implementation of Bromley trailblazer mental health in schools project and 4 week waiting times pilot will be seen from July 2019

- A business case for the Oxleas CAMHS telephone triage has been presented to BBG CCGs for consideration following a successful pilot

- A business case for the Oxleas Dialectical Behaviour Therapy as part of the crisis care pathway has been presented to the South London Partnership for consideration for further roll out across boroughs following a successful pilot

- Bids put forward from Lewisham, Lambeth and Greenwich to become mental health in schools trailblazer sites – outcome likely in Q2-3

- A 7 borough CAMHS meeting managed by the STP now takes place every 2 months enabling a learning collaborative approach with commissioners and providers to share best practice within SEL and elsewhere

- Implementation of recommendations from the NHSE Mental Health Intensive Support Team review (delivered in Lewisham in Jan 2019) has provided a range of recommendations for Lewisham to action which will likely improve performance and provide learning for other boroughs

- Implementation of recommendations from Lewisham, Southwark, Greenwich and Lambeth reviews of CYP Early Help likely to impact on improved performance but not quantifiable at this stage e.g. Southwark has implemented ‘CYP pathway navigators’ to support families to access appropriate services

- Some ongoing improvements to data quality will be delivered including identification of other services where performance is not currently recorded

- The Healthy London Partnership published a CYP mental health workforce strategy in May 2019. SEL will use this as a template for developing our own strategy with support from HEE and HLP. There will be a focus in SEL on what the South London partnership (SLP) can offer to support recruitment and retention
CYP mental health: forward-look on performance

SEL position: year end position by CCG based on local data reported between April 2018 and March 2019

Notes / assumptions:

- SEL position for 18/19 is 31.5%: year-end performance based on local data from April 2018 to March 2019. Due to technical issues, Kooth were unable to provide local data for February and March so the actual forecast will be slightly higher than 31.5%.
The table below presents CYP waiting times performance (contact in under 18 weeks from referral) for first and second contacts.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>1st</td>
<td>2nd</td>
<td>1st</td>
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<td>1st</td>
<td>2nd</td>
<td>1st</td>
<td>2nd</td>
<td>1st</td>
<td>2nd</td>
</tr>
<tr>
<td>Bexley</td>
<td>88%</td>
<td>60%</td>
<td>93%</td>
<td>64%</td>
<td>90%</td>
<td>67%</td>
<td>96%</td>
<td>69%</td>
<td>93%</td>
<td>79%</td>
<td>80%</td>
<td>63%</td>
</tr>
<tr>
<td>Bromley</td>
<td>90%</td>
<td>80%</td>
<td>82%</td>
<td>87%</td>
<td>83%</td>
<td>82%</td>
<td>73%</td>
<td>96%</td>
<td>79%</td>
<td>93%</td>
<td>80%</td>
<td>91%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>92%</td>
<td>71%</td>
<td>92%</td>
<td>83%</td>
<td>93%</td>
<td>65%</td>
<td>92%</td>
<td>84%</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>85%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>52%</td>
<td>47%</td>
<td>30%</td>
<td>38%</td>
<td>42%</td>
<td>23%</td>
<td>60%</td>
<td>54%</td>
<td>40%</td>
<td>32%</td>
<td>38%</td>
<td>44%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>56%</td>
<td>45%</td>
<td>61%</td>
<td>45%</td>
<td>69%</td>
<td>49%</td>
<td>60%</td>
<td>42%</td>
<td>63%</td>
<td>48%</td>
<td>71%</td>
<td>50%</td>
</tr>
<tr>
<td>Southwark</td>
<td>97%</td>
<td>86%</td>
<td>84%</td>
<td>80%</td>
<td>90%</td>
<td>71%</td>
<td>89%</td>
<td>90%</td>
<td>92%</td>
<td>84%</td>
<td>85%</td>
<td>72%</td>
</tr>
</tbody>
</table>

- Waiting times performance at Lambeth and Lewisham CCGs are significantly below performance of the other SEL CCGs.
- Lambeth, Lewisham and Southwark (SLaM) and Bexley and Greenwich (Oxleas) have been awarded NHSE funding to deliver waiting list initiatives and performance is expected to improve by May 2019
Out of Area Placements
Context

- An out of area placement (OAP) occurs when a patient is being admitted to an inpatient unit in any provider other than their home provider and this includes other NHS and independent sector providers. The OAP is inappropriate if the reason for placement out of area is non-availability of a local bed.
- The *Five Year Forward View for Mental Health* states that by 2020/21 OAPs will essentially be eliminated for acute mental health care for adults.
- SEL has committed to eliminating the practice of sending patients requiring non specialist acute care out of their local area. SLaM are now working to a revised trajectory to halve OAPs by March 2020. Oxleas have committed to significantly reducing OAPs, however a position of zero would require local access to female PICU beds which they presently do not have.
- OAPs lead to poor patient experience and can impact on the patient’s ability to recover. OAPs are also adding to the financial pressure on SEL because over 90% of inappropriate OAPs are provided by the private sector.
- Performance across SEL has started to improve and OAPs have reduced from their peak of 5,095 in December 2018 to 4,155 in March 2019. The majority of the reduction has occurred at Oxleas as their improvement plans to reduce non female PICU related OAPs are beginning to have an impact.

Key drivers of performance position

- The high numbers of OAPs is driven by high demand for acute inpatient beds because increasing numbers of complex patients are presenting later in the pathway - capacity is also stretched due to delays in discharging patients.
- Recovery plans are in place and have been implemented as part of the winter plans and multi-agency discharge events (MADE) which highlighted the key issues and provides a focus on resolving discharge for complex cases.
- Recovery actions have been detailed in the 9th January NHSE assurance submission, (e.g. increased investment in community mental health team (CMHT) resource – Oxleas; and procurement of 15 additional beds - SLaM), and the impact of these actions on the OAPs position are being robustly monitored.
- The STP is developing an OAPs recovery plan to accompany its bid for CMHT and crisis care funding. The recovery plan will respond to a set of NHSE/I criteria and is due for submission on 24 June 2019.
SLAM and Oxleas have implemented flow plans as part of their winter planning, which will impact on their OAPs performance.

### Number of inappropriate OAP days in three month period ending

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>295</td>
<td>375</td>
<td>530</td>
<td>325</td>
<td>410</td>
<td>380</td>
<td>420</td>
<td>360</td>
<td>315</td>
<td>195</td>
<td>110</td>
<td>90</td>
</tr>
<tr>
<td>Bromley</td>
<td>290</td>
<td>445</td>
<td>525</td>
<td>275</td>
<td>220</td>
<td>345</td>
<td>590</td>
<td>705</td>
<td>600</td>
<td>510</td>
<td>445</td>
<td>505</td>
</tr>
<tr>
<td>Greenwich</td>
<td>1,405</td>
<td>1,720</td>
<td>1,720</td>
<td>975</td>
<td>820</td>
<td>785</td>
<td>1,095</td>
<td>1,245</td>
<td>1,330</td>
<td>1,175</td>
<td>1,030</td>
<td>995</td>
</tr>
<tr>
<td>BBG total</td>
<td>1,990</td>
<td>2,540</td>
<td>2,775</td>
<td>1,575</td>
<td>1,450</td>
<td>1,510</td>
<td>2,105</td>
<td>2,310</td>
<td>2,245</td>
<td>1,880</td>
<td>1,585</td>
<td>1,590</td>
</tr>
<tr>
<td>BBG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,547</td>
<td>2,547</td>
<td>2,547</td>
<td>2,245</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lambeth</td>
<td>405</td>
<td>560</td>
<td>810</td>
<td>775</td>
<td>740</td>
<td>695</td>
<td>755</td>
<td>830</td>
<td>920</td>
<td>830</td>
<td>735</td>
<td>740</td>
</tr>
<tr>
<td>Lewisham</td>
<td>365</td>
<td>365</td>
<td>415</td>
<td>415</td>
<td>620</td>
<td>805</td>
<td>855</td>
<td>1,005</td>
<td>995</td>
<td>855</td>
<td>735</td>
<td>555</td>
</tr>
<tr>
<td>Southwark</td>
<td>405</td>
<td>355</td>
<td>405</td>
<td>490</td>
<td>585</td>
<td>580</td>
<td>350</td>
<td>510</td>
<td>935</td>
<td>1,255</td>
<td>1,305</td>
<td>1,270</td>
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<tr>
<td>LLS total</td>
<td>1,175</td>
<td>1,280</td>
<td>1,630</td>
<td>1,680</td>
<td>1,945</td>
<td>2,080</td>
<td>1,960</td>
<td>2,345</td>
<td>2,850</td>
<td>2,940</td>
<td>2,775</td>
<td>2,565</td>
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<td>LLS</td>
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<td></td>
<td></td>
<td>676</td>
<td>455</td>
<td>230</td>
<td>2,850</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* The trajectory for BBG has now been revised and reduces OAPs to 1,000 by Q4 2019/20 (zero for any activity outside of female PICU beds). Previously the trajectory reduced OAPs to zero by September 2019.

** The trajectory for LLS has now been revised and reduces OAPs to 1,425 by Q4 2019/20 (half the current position). Previously the trajectory reduced OAPs to zero by April 2019.

*** Greenwich is our borough with the highest demand / demographically most challenged, and the acute and PICU bed need is greater, as it stands, than the beds available. There will be a higher need for female PICU than the other boroughs for this reason.
### Out of Area Placements: summary of high-impact actions

<table>
<thead>
<tr>
<th>Local challenges to delivery</th>
<th>Local initiatives and plans to reduce OAPs</th>
<th>Does the local system have any reflections on what the biggest local challenges are in tackling OAPs?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SLAM / Lambeth, Lewisham, Southwark</strong>&lt;br&gt;1. Increasing demand in A&amp;E, Anecdotal evidence from ED staff (Lewisham) is that more people are coming to A&amp;E with higher levels of acuity 50% known 50% not known.&lt;br&gt;2. Delays in discharge where decisions required from multiple internal &amp; external stakeholders (highlighted in the MADE events) are not timely resulting in beds being blocked and stagnant flow.&lt;br&gt;&lt;br&gt;As a result of the limited bed capacity we have seen increased breaches in A&amp;E which has led to a need to place individuals in Private beds which negatively impacts our ability to reduce OAPs.</td>
<td>SEL CCGs committed additional winter monies - £1.2m.&lt;br&gt;SLaM Patient flow plan puts into action several initiatives to improve flow in general and create capacity to meet demand.&lt;br&gt;Initiatives to improve flow:&lt;br&gt;• Multi agency discharge events – MADE events have started and where patient cases are reviewed and discharge action plans are produced.&lt;br&gt;• Social care discharge team in each borough to manage patients with complex social and welfare needs to reduce delays in discharge.&lt;br&gt;• Ring fencing borough beds incentivise borough teams to discharge and not expect a OAP&lt;br&gt;• Red to green days&lt;br&gt;• Enhanced HTT and liaison to support ED assessment&lt;br&gt;Initiatives for admission avoidance:&lt;br&gt;• Predictive care planning for patient known to be frequently admitted therefore providing more intense support to avoid crisis.</td>
<td>Increasing demand; patients presenting at a higher acuity, with an increasing numbers of patients not previously known to MH services.</td>
</tr>
<tr>
<td><strong>Oxleas / Bexley, Bromley &amp; Greenwich</strong>&lt;br&gt;High bed occupancy levels, limited crisis support between the hours of 10pm – 8am (liaison support in A&amp;E only) resulting in no real alternative to admission.&lt;br&gt;&lt;br&gt;Do not have a female PICU which is a barrier to delivering Zero OAPs.</td>
<td>Bexley, Bromley &amp; Greenwich boroughs have provided additional investment to increase capacity of:&lt;br&gt;• CMHT to concentrate on care planning, risk assessment to anticipate and mitigate, and rapid review response for patients diverted from A&amp;E.&lt;br&gt;• HTT team to assess and treat patients at home and provide 24/7 cover.&lt;br&gt;Oxleas have now recruited all additional staff required for 24/7 HTT, and will be able to start once that are all in post. The trust will be able to start in some form or other during February, being fully up to speed by the beginning of April.&lt;br&gt;Crisis café (in Bexley) and crisis operational from Spring 2018.&lt;br&gt;Purposeful admission policy ensure that admission to a ward has a specific purpose to that admission and plan for discharge to reduce inappropriate admission.</td>
<td>Increasing demand; patients presenting at a higher acuity, with an increasing numbers of patients not previously known to MH services.&lt;br&gt;Oxleas do not have a female PICU which is a barrier to delivering zero OAPs.</td>
</tr>
</tbody>
</table>
Further SEL Local initiatives and plans to reduce OAPs

• The SLAM inpatient flow plans showed a positive impact in the first 3 months of being implemented but this is now tailing off and flow has become fairly stagnant.

• Further mitigations is being put in place such as known patients programme being rolled out immediately. Lewisham has very low private usage and the trust is looking at what lessons can adopted for Lambeth and Southwark.

• Reasons for delayed discharge continue to be identified via MADEs (multidisciplinary admission & discharge events) with a focus on stuck patients (e.g. issues with housing and recourse to funds).

• SLAM will also map their current crisis referral home treatment model to the ULC fidelity model to assess whether changes are required to better fit with fidelity for 24/7 access to treatment in the community.

• Oxleas continue to see an improvement since the launch of the 24/7 community model in April 19. The trust has also implemented an acute adult centralised bed management system which provides real time bed utilisation and availability data and help to address waits in A&E.

• Workforce issues was discussed at the STP workforce event on 9th May with both trusts citing risk with recruitment of skilled staff and medics leaving resulting in increased agency usage. Retention was highlighted by members in this meeting as one of the focus areas for the STP 1920 workforce plan as well as further opportunities to engage with non NHS provider colleagues to address risk as a system.

• Next steps – linked to the implementation of COMPACT, both Trusts will need to map current ED & admission processes with respect to the compact to begin to highlight and understand the pressure points in the system and risk to OAPs to support development of compact implementation plans by Q2 1920.

• The STP is developing an OAPs recovery plan to accompany its bid for CMHT and crisis care funding. The recovery plan will respond to a set of NHSE/I criteria and is due for submission on 20 June 2019.
Dementia Diagnosis Waits: performance position

<table>
<thead>
<tr>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people diagnosed within 6 weeks of referral</td>
<td>8%</td>
<td>12%</td>
<td>13%</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Average waiting time for diagnosis (days)</td>
<td>141</td>
<td>107</td>
<td>136</td>
<td>27</td>
<td>27</td>
</tr>
</tbody>
</table>

**Context**

- For people with dementia and their families, an additional wait of several weeks or months before they have an initial assessment from a Memory Service can be particularly stressful and service user groups across London have raised concerns about waiting times for diagnosis including waiting times once referred to a memory service.

- To address this disparity and improve outcomes, the NHSE Regional team has set an ambition for services to work towards ensuring 85% of patients receive a diagnosis and start treatment within 6 weeks of a referral to a memory service. This has been discussed and agreed at the London Mental Health Transformation Board and Parity of Esteem Board. It is hoped that the ambition will support memory services to streamline their pathways and support CCGs to address any obstacles leading to delays in patients being seen.

- There is currently no national memory service waiting time data, however the regional team asked CCGs to submit monthly local data starting from April 2019.

- The SEL Assurance team will work with CCGs in June to provide an update on action plans to improve performance. This will be included in the July non-acute report.
Personal Health Budgets
Personal health budgets: context

Context

- Delivery of Personal Health Budget (PHB) trajectories have been made a national priority and in-year the NHS England regional team has established a process of oversight in order to track STP area progress on delivery of local targets. NHS England London Region have requested PHB expansion plans for 2019/20, monthly data (rather than quarterly) and monthly trajectories along with monthly assurance/workshop meetings to ensure performance is on track.

- SEL CCGs are making consistent progress in terms of increasing the numbers of PHBs being made available to patients. SEL CCGs have each continued to increase the numbers of PHBs over the course of the year.

- It is important to note that CCGs are set an individual target range set by NHS England, which is set as a function of the potential eligible cohort. CCGs each returned a set of trajectories as part of the planning rounds in 2017 and 2018. This means there is some variation in the absolute number of PHBs that each CCG is set for the year.

- Full delivery of PHB targets has not previously been a high-priority performance area and as such we are at a relatively early stage of development on the action plans. Our work to date can be split into two areas of focus: work with CCGs to identify and implement 'quick-win' actions to increase update of PHBs; and work with CCGs to stock-take current and future provision of PHBs across the full range of client groups in order to then develop the offer across all groups at all CCGs in the medium term. The status of both is provided on the following pages.

- The SEL aggregate plan for the end of 2018-19 was revised down from 1,332 to 1,066 in February 2019 with delivery of this target now achieved.

Next steps / follow-on actions

- CCGs should continue to ensure all PHBs currently in place are being counted and reported. This should include any budgets that CCGs contribute resources too (even if it’s just a penny) and which may be held by local authority social services or education departments.

- NHSE has committed £100k to support the expansion of the PHB offer in SEL. The majority of funds are being used to recruit a SEL PHB lead who will work with CCG PHB leads to put in place the infrastructure to significantly increase the PHB offer in SEL. Interviews have taken place and a successful candidate has been offered the role.
## Performance in 2018/19

SEL CCGs delivered the revised 2018/19 target as per the below.

<table>
<thead>
<tr>
<th>CCG performance 18/19</th>
<th>Q1 planned</th>
<th>Q1 actual</th>
<th>Q1 % distance from plan</th>
<th>Q2 planned</th>
<th>Q2 actual</th>
<th>Q2 % distance from plan</th>
<th>Q3 planned</th>
<th>Q3 actual</th>
<th>Q3 % distance from plan</th>
<th>Q4 Plan</th>
<th>Revised Q4 Planned</th>
<th>Q4 actual</th>
<th>Q4 % distance from plan</th>
<th>Q4 % distance from revised plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley CCG</td>
<td>119</td>
<td>24</td>
<td>-80%</td>
<td>143</td>
<td>83</td>
<td>-42%</td>
<td>158</td>
<td>163</td>
<td>3%</td>
<td>190</td>
<td>190</td>
<td>281</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>Bromley CCG</td>
<td>150</td>
<td>136</td>
<td>-9%</td>
<td>200</td>
<td>144</td>
<td>-28%</td>
<td>250</td>
<td>196</td>
<td>-22%</td>
<td>347</td>
<td>347</td>
<td>323</td>
<td>-7%</td>
<td>-7%</td>
</tr>
<tr>
<td>Greenwich CCG</td>
<td>211</td>
<td>140</td>
<td>-34%</td>
<td>236</td>
<td>158</td>
<td>-33%</td>
<td>166</td>
<td>189</td>
<td>14%</td>
<td>296</td>
<td>175</td>
<td>191</td>
<td>-35%</td>
<td>9%</td>
</tr>
<tr>
<td>Lambeth CCG</td>
<td>93</td>
<td>51</td>
<td>-45%</td>
<td>118</td>
<td>59</td>
<td>-50%</td>
<td>152</td>
<td>71</td>
<td>-53%</td>
<td>170</td>
<td>95</td>
<td>91</td>
<td>-46%</td>
<td>-4%</td>
</tr>
<tr>
<td>Lewisham CCG</td>
<td>67</td>
<td>47</td>
<td>-30%</td>
<td>74</td>
<td>54</td>
<td>-27%</td>
<td>109</td>
<td>64</td>
<td>-41%</td>
<td>150</td>
<td>80</td>
<td>73</td>
<td>-51%</td>
<td>-9%</td>
</tr>
<tr>
<td>Southwark CCG</td>
<td>82</td>
<td>87</td>
<td>6%</td>
<td>113</td>
<td>120</td>
<td>6%</td>
<td>157</td>
<td>152</td>
<td>-3%</td>
<td>179</td>
<td>179</td>
<td>213</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>SEL</td>
<td>722</td>
<td>485</td>
<td>-33%</td>
<td>884</td>
<td>618</td>
<td>-30%</td>
<td>992</td>
<td>835</td>
<td>-16%</td>
<td>1,332</td>
<td>1,066</td>
<td>1,172</td>
<td>-12%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Delivery of transformation by client group / pathway

Whilst CCGs have all largely implemented PHB for CHC as a default, progress in rolling out this work in other client group areas is limited and will need to be addressed if CCGs are to meet performance expectations.

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing healthcare (adults)</td>
<td>In place</td>
<td>In place</td>
<td>In place</td>
<td>In place</td>
<td>In place</td>
<td>In place</td>
</tr>
<tr>
<td>End-of-life care / fast-track</td>
<td>Not planned</td>
<td>Not planned</td>
<td>Planned for 2019/20</td>
<td>Planned for 2019/20</td>
<td>In place – working to extend in 2019/20</td>
<td>In place</td>
</tr>
<tr>
<td>Learning disability and autism</td>
<td>In place</td>
<td>Not planned</td>
<td>In place</td>
<td>Not planned</td>
<td>In place – working to extend in 2019/20</td>
<td>In place</td>
</tr>
<tr>
<td>Mental health / section 117</td>
<td>Initiated work</td>
<td>Initiated work</td>
<td>In place – working to extend in 2019/20</td>
<td>In place</td>
<td>In place – working to extend in 2019/20</td>
<td>In place – working to extend in 2019/20</td>
</tr>
<tr>
<td>Wheelchair users</td>
<td>In place</td>
<td>Initiated early exploratory work</td>
<td>Significant opportunity for 2019/20</td>
<td>Initiated early exploratory work</td>
<td>Significant opportunity for 2019/20</td>
<td>Significant opportunity for 2019/20</td>
</tr>
<tr>
<td>Children’s continuing care</td>
<td>Initiated work</td>
<td>In place – working to extend in 2019/20</td>
<td>In place – working to extend in 2019/20</td>
<td>In place – limited cohort</td>
<td>In place – limited cohort</td>
<td>In place – limited cohort</td>
</tr>
<tr>
<td>LTCs</td>
<td>Not planned</td>
<td>Not planned</td>
<td>Not planned</td>
<td>Not planned</td>
<td>Not planned</td>
<td>Not planned</td>
</tr>
</tbody>
</table>
CCGs have delivered increases in the number of personal health budgets over the course of 2018/19 which have mainly been in continuing healthcare. CCGs will continue to deliver PHB growth in CHC in 19/20, though will need extend provision to new client groups in order to deliver the target level for the new year and into 20/21.

### CCG performance

<table>
<thead>
<tr>
<th>CCG performance</th>
<th>Q1 18/19 actual</th>
<th>Q2 18/19 actual</th>
<th>Q3 18/19 actual</th>
<th>Q4 2018/19 actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Bexley CCG</td>
<td>24</td>
<td>83</td>
<td>163</td>
<td>281</td>
</tr>
<tr>
<td>NHS Bromley CCG</td>
<td>136</td>
<td>144</td>
<td>196</td>
<td>323</td>
</tr>
<tr>
<td>NHS Greenwich CCG</td>
<td>140</td>
<td>158</td>
<td>189</td>
<td>191</td>
</tr>
<tr>
<td>NHS Lambeth CCG</td>
<td>51</td>
<td>59</td>
<td>71</td>
<td>91</td>
</tr>
<tr>
<td>NHS Lewisham CCG</td>
<td>47</td>
<td>54</td>
<td>64</td>
<td>73</td>
</tr>
<tr>
<td>NHS Southwark CCG</td>
<td>87</td>
<td>120</td>
<td>152</td>
<td>213</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4 19/20 lower bound target</th>
<th>Q4 19/20 higher bound target</th>
</tr>
</thead>
<tbody>
<tr>
<td>210</td>
<td>290</td>
</tr>
<tr>
<td>300</td>
<td>430</td>
</tr>
<tr>
<td>260</td>
<td>400</td>
</tr>
<tr>
<td>290</td>
<td>410</td>
</tr>
<tr>
<td>240</td>
<td>340</td>
</tr>
<tr>
<td>230</td>
<td>320</td>
</tr>
</tbody>
</table>

### Risk of achieving lower bound

- NHS Bexley CCG: Moderate
- NHS Bromley CCG: High
- NHS Greenwich CCG: Very high
- NHS Lambeth CCG: Very high
- NHS Lewisham CCG: Very high
- NHS Southwark CCG: High

### CCGs have proposed a differential level of ambition for delivery in 2019/20 against the NHS lower/upper bounds

<table>
<thead>
<tr>
<th>CCG plan</th>
<th>Q1 19/20 plan</th>
<th>Q2 19/20 plan</th>
<th>Q3 19/20 plan</th>
<th>Q4 19/20 plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Bexley CCG</td>
<td>210</td>
<td>230</td>
<td>250</td>
<td>290</td>
</tr>
<tr>
<td>NHS Bromley CCG</td>
<td>150</td>
<td>200</td>
<td>250</td>
<td>347</td>
</tr>
<tr>
<td>NHS Greenwich CCG</td>
<td>185</td>
<td>210</td>
<td>235</td>
<td>260</td>
</tr>
<tr>
<td>NHS Lambeth CCG</td>
<td>130</td>
<td>170</td>
<td>230</td>
<td>290</td>
</tr>
<tr>
<td>NHS Lewisham CCG</td>
<td>100</td>
<td>120</td>
<td>140</td>
<td>240</td>
</tr>
<tr>
<td>NHS Southwark CCG</td>
<td>140</td>
<td>185</td>
<td>230</td>
<td>275</td>
</tr>
</tbody>
</table>

### Year end target relative to NHSE bounds

- Upper bound
- Within inter-bound range
- Lower bound
- Lower bound
- Lower bound
- Within inter-bound range
Opportunities for expansion in 2019/20

- SEL CCGs delivered 1,172 PHBs in 2018/19 which exceeded the revised year end target of 1,066. The majority of 2018/19 PHBs were default CHC and most of the SEL CCGs have maximised the opportunity to deliver CHC PHBs.

- The ambition for 2019/20 marks a significant increase from the current position, so CCGs will be required to expand their PHB offer to other client groups. Particular priorities for 2019/20 will be expanding the PHB offer to wheelchairs and mental health 117 because the Department of Health and Social Care announced in February 2019 that the legal right to a PHB will be extended to eligible individuals within these cohorts.

- **Personal wheelchairs** – in the second half of 2018/19, Bexley CCG expanded the PHB offer to wheelchair users and were able to deliver 160 personal wheelchair budgets. Bexley is the only SEL CCG to offer personal wheelchair budgets so there may be a significant opportunity to expand this offer more widely across SEL. Although a couple of CCGs have initiated exploratory work to offer personal wheelchair budgets there are some challenges that need to be resolved particularly for CCGs that have block contracts in place with their wheelchair providers.

- **Mental Health 117** – this cohort represents a significant opportunity for SEL because fewer than 20 MH 117 PHBs were delivered in 2018/19 and yet it represents the largest estimated cohort. For example, Greenwich CCG estimates 100 MH 117 clients could be eligible for a PHB in 2019/20.

- SELCA secured £100k funding to recruit a SEL PHB lead to support CCGs to deliver their plans. Interviews have been completed and a successful candidate has been offered the position.
Diabetes
Diabetes: context – the 3 targets

The National Diabetes Audit (NDA) measures diabetes performance using the three indicators below and performance is also monitored in the IAF for the treatment targets and structured education. There are, however, no formal expectations for diabetes performance.

Care Processes

- Care processes for all people aged 12 and over. There are nine annual measures and the first 8 are the responsibility of Diabetes Care providers. The 9th Care Process is the responsibility of NHS Diabetes Eye Screening (NHS Public Health England).

1. HbA1c (blood test for glucose control)
2. Blood Pressure (measurement for cardiovascular risk)
3. Serum Cholesterol (blood test for cardiovascular risk)
4. Serum creatinine (blood test for kidney function)
5. Urine Albumin/Creatinine ratio (urine test for risk of kidney disease)
6. Foot Risk Surveillance (examination for foot ulcer risk)
7. Body Mass Index (measurement for cardiovascular risk)
8. Smoking History (question for cardiovascular risk)

Treatment Targets

NICE recommends treatment targets for HbA1c (glucose control), blood pressure and statins:

- Target HbA1c reduces the risk of all diabetic complications
- Target blood pressure reduces the risk of cardiovascular complications and reduces the progression of eye and kidney disease
- Target statins prescriptions reduces the risk of cardiovascular complications

Structured education

The percentage of people with diabetes diagnosed for less than one year who have a record of attendance at a structured education course. This is measured using the number of people who have attended a structured education course within 12 months of diagnosis, as recorded by the NDA. Attendance at diabetes structured education, by those newly diagnosed with diabetes and those with established diabetes, will improve patient outcomes by:

- Reducing patients' HbA1c levels and subsequently increasing their likelihood of achieving the three NICE-recommended treatment targets.
- Improving patients' knowledge and capability for managing their diabetes.

The data source for these diabetes targets, is the National Diabetes Audit. The latest results of which are shown further in this pack. However, because the data is only produced annually, there is a significant lag in availability so monitoring improvement can be difficult. It is possible however for CCGs to use local data and systems to monitor in year at a practice level. This is something that has been adopted by Southwark and Lewisham CCGs for example.
Diabetes: drivers of performance and availability of data

Drivers of Performance

The majority of CCGs across south east London have reported similar challenges in delivering the diabetes targets.

• **Primary care engagement** - Consistent engagement with primary care to implement the changes in pathways has been a challenge particularly as GP practices come under increasing pressure. Many practices do not have sufficient systems and processes in place to run regular contact patients through call and re-call. Under and incorrect reporting of activity has also been an issue particularly for structured education, however the recently launched book and learn service across SEL will improve data reporting by automatically uploading data on behalf of practices.

• **Capacity of workforce** - Practices are struggling to provide sufficient workforce capacity to deliver the activity required to significantly improve on diabetes performance. Releasing practice staff to receive training and securing sufficient specialist input into primary care to oversee MDTs and run virtual clinics has also been challenging. Not all practices have a dedicated GP diabetes lead which is generally recognised as best practice.

• **Capability in primary care** - Repatriation of care to primary care needs to be supported by updating skills and competencies in general practice, however practices are struggling to free up the capacity to release practice staff to receive training. An online education programme has been commissioned for Lambeth, Lewisham, Greenwich and Southwark which will make it easier for practice staff to access training. Some practices are also not equipped with sufficient IT to enable them to participate in virtual clinics.

Availability of data

• **NHS Digital** have established and operate a system for the collection and analysis of the NDA. The main national diabetes audit collects information from GP practices.

• Data is published annually and the latest published data is for 2017/18, while 2018/19 data will be published in late 2019. The data is extracted from general practices on a quarterly basis via the General Practice Extraction Service.

• **Comparable local data across south east London is a gap** and currently only Southwark, Lewisham and Greenwich CCGs have provided local data. CCGs have been unable to replicate the nationally published data because the NDA uses a complex data extraction methodology. CCGs have asked the NDA to share their search, however due to technical issues this has not been possible.

• SEL CCGs are keen to collect and monitor local data, however there isn’t a consistent agreement across SEL on inclusion/exclusion criteria so even if local data was available it would not be possible to directly compare performance across the CCGs.

Governance

• A governance gap has been identified so a SEL diabetes group is being established to monitor performance and coordinate the implementation of operational and transformational improvement plans. The SEL Assurance Team is working with the ICDT to draft ToRs and consider membership of the group which is expected to be in place in Q2 2019/20.
# Diabetes: performance position

The following tables present the latest available published data from the National Diabetes Audit.

<table>
<thead>
<tr>
<th>CCG</th>
<th>NDA participation</th>
<th>Registered Patients</th>
<th>8 Care Processes</th>
<th>Treatment Targets</th>
<th>DSE (Attended)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 1 Diabetes</td>
<td>221,620</td>
<td>242,910</td>
<td>34.4%</td>
<td>42.9%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Bexley CCG</td>
<td>96.3%</td>
<td>92.3%</td>
<td>33.7%</td>
<td>39.0%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Bromley CCG</td>
<td>100.0%</td>
<td>100.0%</td>
<td>26.2%</td>
<td>30.1%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Greenwich CCG</td>
<td>80.0%</td>
<td>94.3%</td>
<td>27.0%</td>
<td>35.1%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Lambeth CCG</td>
<td>100.0%</td>
<td>100.0%</td>
<td>41.1%</td>
<td>54.3%</td>
<td>22.4%</td>
</tr>
<tr>
<td>Lewisham CCG</td>
<td>100.0%</td>
<td>100.0%</td>
<td>27.7%</td>
<td>33.0%</td>
<td>23.9%</td>
</tr>
<tr>
<td>Southwark CCG</td>
<td>100.0%</td>
<td>100.0%</td>
<td>42.0%</td>
<td>52.7%</td>
<td>22.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCG</th>
<th>Registered Patients</th>
<th>8 Care Processes</th>
<th>Treatment Targets</th>
<th>DSE (Attended)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-17</td>
<td>2017-18</td>
<td>2016-17</td>
<td>2017-18</td>
</tr>
<tr>
<td>England</td>
<td>2,721,580</td>
<td>2,914,670</td>
<td>47.4%</td>
<td>58.8%</td>
</tr>
<tr>
<td>Bexley CCG</td>
<td>11,750</td>
<td>11,510</td>
<td>49.4%</td>
<td>52.8%</td>
</tr>
<tr>
<td>Bromley CCG</td>
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<td>13,640</td>
<td>39.7%</td>
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</tr>
<tr>
<td>Greenwich CCG</td>
<td>10,215</td>
<td>13,590</td>
<td>39.8%</td>
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</tr>
<tr>
<td>Lambeth CCG</td>
<td>16,535</td>
<td>17,280</td>
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<tr>
<td>Lewisham CCG</td>
<td>15,225</td>
<td>15,400</td>
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<tr>
<td>Southwark CCG</td>
<td>14,585</td>
<td>15,510</td>
<td>41.7%</td>
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</table>
# Diabetes: summary of high-impact actions

<table>
<thead>
<tr>
<th>CCG</th>
<th>High Impact Action</th>
<th>Expected completion date</th>
<th>Key risks to delivery of the action</th>
<th>Responsible Officer / Group</th>
</tr>
</thead>
</table>
| Bexley                 | • New integrated diabetes model is currently being designed across BGL CCGs to streamline the diabetes pathway  
                         • Engagement with primary care to increase uptake in diabetes education                                                                                                                                  | • 19/20 rollout  
                         • On-going                                                                                                             | • Lack of structured education in languages other than English language remains a risk  
                         • Workforce - delivery of courses remains a concern and challenge due to number of structured education courses being made available  
                         • Changes to the contract may affect uptake                                                                                   | • Bexley, Greenwich & Lewisham CCG  
                         • Joanne Hare                                                                                                            |
| Bromley                | • DSE takes place across Bromley operated by BHC.  
                         • NDPP and Walking away from diabetes education courses to prevent pre-diabetics from becoming diabetic.  
                         • Monitoring key performance indicators including the 8 care processes under the diabetes contract.  
                         • Advertising the NDA completion details to the Bromley practices.  
                         • Additional funding has been made available to increase uptake of structured education and the NDPP courses. | • Q1 2019/20  
                         • Q1 2019-20  
                         • Q1 2019-20  
                         • Completed Q1 2019/20  
                         • Completed March 2019                                                                                                           | • Slow uptake of the new book and learn portal. Bookings are slowly increasing.  
                         • Low referrals into NDPP - PH have taken action to target the practices not referring. Some improvement.  
                         • Risk that some practices do not register and submit data.                                                                        | CCG Contracts team/ Planned Care and Primary Care teams                                                                                     |
| Greenwich              | • New integrated diabetes model currently being designed across BGL CCGs to streamline diabetes pathway.  
                         • Engagement with primary care and providers to increase uptake in diabetes education.  
                         • Existing project in place to promote achievement of treatment target for patients with HbA1c of 75mmol and above with regular performance monitoring  
                         • Collaboration with PH to effectively implement NDPP | • 2019/20  
                         • On-going  
                         • Ongoing                                                                                          | • Lack of structured education in languages other than English remains a gap.  
                         • Workforce related challenges around delivery of structured education  
                         | Planned Care  
                         Commissioning and Performance Manager                                                                                       |
|                        |                                                                                                                                                                                                                     |                                | 3TT Project  
                         • Ongoing risk around levels of DNA in the service  
                         • Practice engagement is still not as high as expected although it is increasing.  
                         • Increase in Federation involvement in Primary Care Networks could impact on capacity to deliver and manage                   |                                |
## Diabetes: summary of high-impact actions

<table>
<thead>
<tr>
<th>CCG</th>
<th>High Impact Action</th>
<th>Expected completion date</th>
<th>Key risks to delivery of the action</th>
<th>Responsible Officer / Group</th>
</tr>
</thead>
</table>
| Lambeth  | • Provision of one virtual clinic per practice from the Lambeth Diabetes Intermediate Care Team.  
• Lambeth Premium Scheme (PMS) includes prevention indicators which encourage practices to identify patients at risk of diabetes, add them to the Non-diabetic hyperglycaemia register and, if consent provided, refer them to the NDPP. The PMS also includes indicators which encourage practices to improve their offer, measurement and coding of all 8 care processes.  
• The eligibility criteria for Diabetes prevention programmes in Lambeth, NDPP and STEPs to prevent diabetes has been reverted back to the original HbA1c criteria 42–47 mmol/mol to ensure access for all patients at high risk of diabetes.  
• Structured Education - Engagement with primary care to refer patients to Diabetes Book & Learn to increase uptake of Diabetes structured education. Lambeth structured education provider exploring DESMOND courses in a different language. Early engagement site for HELP diabetes.  
• Diabetes Intermediate Care Team in partnership with AT Medics to provide ongoing support to practices following the successful QI programme from 2018/19. Focus on further improvements to call & re-call systems and processes and other areas including coding and use of dashboards to drive improvements.  
• Market testing and re-procurement of our Lambeth Diabetes Intermediate Care Team, new contract to commence in 2020. | Q4 2019-20                                          | • Procurement process for the community diabetes service may lead to capacity issues in commissioning and providers to focus on the improvement targets. | Assistant Director Medicines and Long Term Conditions |
|         |                                                                                     | Q1 2019/20                |                                                                                                     |                                                   |
|         |                                                                                     | Q4 2019/20                |                                                                                                     |                                                   |
|         |                                                                                     | Q4 2019/20                |                                                                                                     |                                                   |
|         |                                                                                     | Q4 2019/20                |                                                                                                     |                                                   |
| Lewisham| • New integrated diabetes model currently being designed across BGL CCGs to streamline diabetes pathway  
• DSE - Extra Capacity to Targeted Population Groups - Deliver 84 extra group education sessions (including weekend sessions)  
• Population Health - Whole systems - Developing a local Diabetes Register and a benefits analysis of diabetes indicators. Also testing data sharing between primary and secondary care acute  
• Diabetes Transformation Programme - Working with practices to improve 3 Treatment Target performance, improving admin & IT support, rolling out a mentorship and training programme (CDEP) and holding monthly MDT meetings at hub level  
• CQUIN - Build knowledge and skills in primary care to manage type 2 diabetes patients | 2019/2020 & 2020/2021 | • Allocated resources/engagement & co-production to support planning and design of redesign programme  
• DSE - NHSE funding to support expansion of DSE interventions including online courses  
• Population Health – increased complexity of a wide range of partners working collaboratively and sharing information  
• Diabetes Transformation programme funding | Director of Comm and Primary Care. |
| Southwark| • Southwark is implementing the similar high impact actions as Lambeth.  
• Transformation funding provided by Diabetes Treatment & Care programme enables incentivisation of primary care to increase achievement of the 3 treatment targets. 2018-19 outcomes – Treatment Targets improved by 4.4% and 8 Care Processes by 18.1% year on year. RAG rated Green by NHSE  
• Additional funding has been provided to improve the uptake of diabetes structured education.  
• NDPP on track to meet national targets, WAFD exceeded annual target referral numbers, attendance 54.6% | 31 March 2019 | • 3 Treatment Targets funding for 2019-20 reduced by 60%  
• Commissioner capacity  
• Failure to increase attendance at structured education | Sarah Cottingham, SEL Director ICDT |
Cancer Screening
Cancer Screening: context

CCGs not currently delivering the performance standards

<table>
<thead>
<tr>
<th>CCG</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently off-track</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Context

The aim of the NHS cancer screening programme is to reduce mortality from cancer, by identifying the eligible population and ensuring efficient delivery with optimal coverage. The national data collection monitors uptake and coverage of screening programmes by eligible populations against nationally set standards.

Transforming Cancer Services Team (Healthy London Partnership) and NHS England work in partnership with key stakeholders including CCGs, cancer alliances, the voluntary sector and local government to review uptake improvement initiatives across London and develop a joint pan-London work-plan. This regional plan will identify key evidence-based priorities for implementation through partnership working and will be overseen by a joint working group.

CCGs have multiple requirements in each of the 3 screening programmes:

**NHS Bowel Screening**
- Bowel Cancer Coverage (60-74) 60%
- Bowel Cancer Uptake (60-74) 60%

**NHS Cervical Screening**
- Cervical Cancer Coverage (25-49) 80%
- Cervical Cancer Coverage (50-64) 80%

**NHS Breast Screening**
- Breast Cancer Coverage (50-70) 80%
- Breast Cancer Uptake (50-70) 80%
# Cancer Screening: performance position and trend (1 of 2)

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bowel Cancer Coverage (60-74) October 2018 – Target 60%</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current month</td>
<td>56.0%</td>
<td>60.5%</td>
<td>50.1%</td>
<td>45.1%</td>
<td>47.6%</td>
<td>45.1%</td>
<td>52.1%</td>
</tr>
<tr>
<td>Trend since last reported period</td>
<td>↓</td>
<td>↑</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
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</tr>
</tbody>
</table>

| **Bowel Cancer Uptake (60-74) October 2018 – Target 60%** |        |         |           |         |          |           |     |
| Current month | 56.4%  | 57.8%   | 47.6%     | 43.6%   | 46.1%    | 43.2%     | 50.1%|
| Trend since last reported period | ↑      | ↓       | ↑          | ↑       | ↑        | ↓         | ↑   |

| **Breast Cancer Coverage (50-70) October 2018 – Target 80%** |        |         |           |         |          |           |     |
| Current month | 76.1%  | 75.9%   | 67.1%     | 62.3%   | 66.6%    | 63.9%     | 68.9%|
| Trend since last reported period | ↓      | ↑       | ↓          | ↑       | ↑        | ↓         | ↓   |

| **Breast Cancer Uptake (50-70) October 2018 – Target 80%** |        |         |           |         |          |           |     |
| Current month | 78.5%  | 75.5%   | 66.5%     | 58.8%   | 61.8%    | 61.4%     | 67.4%|
| Trend since last reported period | ↑      | ↑       | ↓          | ↑       | ↑        | ↑         | ↑   |

**Note:** Last reporting period, October 2018

**Key:**
- **Not achieving national standard**
- **Achieving national standard**
- **Worsening position**
- **Improving position**
- **Top Performer**
- **Worst performer**
### Cancer Screening: performance position and trend (2 of 2)

#### Cervical Cancer Coverage (25-49) October 2018 – Target 80%

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current month</td>
<td>72.3%</td>
<td>71.4%</td>
<td>65.3%</td>
<td>63.5%</td>
<td>66.8%</td>
<td>62.4%</td>
<td>66.1%</td>
</tr>
<tr>
<td>Trend since last reported period</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td></td>
</tr>
</tbody>
</table>

#### Cervical Cancer Coverage (50-64) October 2018 – Target 80%

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current month</td>
<td>77.2%</td>
<td>76.2%</td>
<td>73.9%</td>
<td>74.1%</td>
<td>76.0%</td>
<td>74.3%</td>
<td>75.3%</td>
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<tr>
<td>Trend since last reported period</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↑</td>
<td>↓</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Note:** Last reporting period, October 2018

**Key**
- Not achieving national standard
- Achieving national standard
- Worsening position
- Improving position
- Top Performer
- Worst performer

---

Tab 15 ENC G (i) - Non-acute assurance report June 2019
<table>
<thead>
<tr>
<th>Owner</th>
<th>High Impact Action</th>
<th>Expected completion date and status</th>
<th>Key risks to delivery of the action</th>
<th>Responsible Officer/ Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>Bowel screening - Implementing the pan London Faecal Immunochemical Test (FIT) screening, expected to start the service by end of February.</td>
<td>On-going</td>
<td>No risks identified</td>
<td>Head of Planned Care</td>
</tr>
<tr>
<td></td>
<td>Breast and cervical screening – Supporting the implementing of national Public Health programmes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All screening programmes - Working to increase collaboration between primary and secondary care to share best practice regarding referrals, early diagnosis and safety netting.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Bromley | Cervical screening  
  • Targeting poorer uptake areas regarding age and GP practice and inviting patients to a cervical education/screening event.  
  • Text reminder service rolled out across all of Bromley  
  • Working with Jo’s Cervical Cancer Trust to implement practice staff training  
  • Inclusion of cervical screening in core contract 19/20 | 2019 onwards | Lack of funding and cooperation of Primary Care | Cancer working group |
|       | Breast screening  
  • Trying to liaise with breast screening service to offer breast screening bus to attend screening events.  
  • GP core contract states practices need to contact patients not responding to national screening invites.  
  • GP local incentives to increase uptake of breast screening | | | |
|       | Bowel Screening  
  • Working with the national screening service and local mental health provider to target all patients over 50 with diagnosed LD to invite them for screening.  
  • One off bowel scope screening being rolled out across Bromley.  
  • GP core contract states practices need to contact patients not responding to national screening invites | | | |
|       | All screening programmes - Regular schedule of practice visits made by CRUK facilitator to discuss screening rates and other cancer data at practice level. | | | |
| Greenwich | Cervical Screening - KPI in GP Personal Medical Services (PMS) to increase uptake of cervical screening. Sign-up to text reminding service to increase uptake in cervical screening. On-going work to raise profile of cervical screening with patients (awareness campaign in collaboration Jo’s Cervical Cancer Trust & PHE) | On-going | Lack of funding for the clinical incentive scheme. Buy-in from practices | Cancer Steering Group and Director of planned care |
|        | Bowel Cancer  
  • Greenwich Clinical Incentive Scheme (CIS), which encourages practices to follow up on patients who have not returned their test kits  
  • Quarterly Cancer Screening steering group to monitor performance and review screening progress.  
  • Macmillan facilitator’s regular engagement with practice to offer relevant support around screening.  
  • Yearly Macmillan roadshows across Greenwich to promote cancer and screening awareness.  
  • Preparation for the Bowel Cancer screening programme pilot for LD patients to go live in Greenwich in 19/20  
  • Roll out for bowel scope screening for the six outstanding practices in Greenwich in June. | | | |
# Cancer Screening: summary of high impact actions

<table>
<thead>
<tr>
<th>Owner</th>
<th>High Impact Action</th>
<th>Expected completion date and status</th>
<th>Key risks to delivery of the action</th>
<th>Responsible Officer/ Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td><strong>Bowel cancer</strong> - Screening initiative in place, incentivising practices to contact non-responders of bowel cancer screening invitation as part of the PMS contract for 2018/19 and 2019/20. Focused support visits taking place where there is variation in achievement at practice level, supported by the CCG clinical leads for cancer and these are expected to be completed by end Q1 2019/20.</td>
<td>On-going</td>
<td>Practices don’t engage in the process even though they are incentivised. Patients do not engage in the screening programme</td>
<td>Service Redesign team and the Lambeth Cancer Working</td>
</tr>
<tr>
<td></td>
<td><strong>Bowel screening</strong> - The pan London Faecal Immunochemical Test (FIT) screening, expected to start the service 29th April. The Lambeth Communications team have actively promoted the new FIT screening and provided relevant information needed for the process to GP Practices.</td>
<td>On-going</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>All screening programmes</strong> - Regular schedule of practice visits made by Macmillan Nurse Facilitator, Macmillan GP lead and CRUK facilitator to discuss screening rates and other cancer data at practice level.</td>
<td>On-going</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Primary Care Workforce
Context

- Availability and retention of the clinical workforce is a widespread issue and is particularly challenging for GPs and Nurses in London. We have developed and submitted our primary workforce plans and trajectories to the national team. This planned trajectory will be approximately 70WTE GPs short of our proposed national target by September 2020.

- In support of our trajectories, we have made it clear that our strategy to increase clinical capacity in primary care does not only focus on recruitment but also on developing new roles and improved ways of working; up-skilling of the non-clinical workforce to reduce the administrative burden on the clinical workforce, support signposting and social prescribing; system and process improvements with a focus on digital; improved retention through initiatives to support the workforce and make SEL a more attractive place to work and develop.

- SEL is moving towards an ‘integrated’ and ‘at scale’ care model and is engaged in a range of activities at STP and local levels intended to create clinical capacity (‘Time to Care’) and reduce overall demand (e.g. reducing the administrative burden, supporting self-management and prevention). We are also looking at and implementing approaches to reduce turnover and sickness absence associated with pressure of work and/or job dissatisfaction.

Key drivers of performance

- **Lack of authority/direct control to deliver the primary care targets set by NHSE** – GP practices are independent contractors which limits our ability to control rates of retention and recruitment.

- **Variation in approach/lack of a joined up strategy across SEL** – work to develop an STP Primary Care Strategy and framework is in progress but will need to be underpinned by aligned local (place-based) delivery plans that are locally owned and adequately resourced.

- **Data quality issues** – there are known issues with the quality and completeness of general practice workforce data, making it difficult to understand both the baseline and progress. These concerns have been escalated and HLP have agreed to set up a task and finish group to review the data requirements and the relevant roles for different stakeholders within the system. The group will report into the London GPFV Workforce Delivery Group.

- **GPFV** – lack of assurance that CCGs are investing adequate funding in workforce development as per their local plans.
Overview of primary workforce trajectories submitted to the national team September 2018. Information refreshed to include September 2018 actuals

<table>
<thead>
<tr>
<th></th>
<th>Jun 17</th>
<th>Sep 17</th>
<th>Dec 17</th>
<th>Mar 18</th>
<th>Jun 18</th>
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<th>Sep 19</th>
<th>Sep 20</th>
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<tr>
<td><strong>GP FTEs</strong></td>
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<tr>
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<td>902</td>
<td>876</td>
<td>888</td>
<td>-</td>
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<td>Trajectory</td>
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<td>-</td>
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<tr>
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<td>389</td>
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<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>402</td>
<td>417</td>
<td></td>
</tr>
<tr>
<td><strong>Wider Clinical Workforce</strong></td>
<td>660</td>
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<td></td>
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</tr>
<tr>
<td>Actuals</td>
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<td>679</td>
<td>683</td>
<td>672</td>
<td>680</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Trajectory</td>
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<td>-</td>
<td>-</td>
<td>715</td>
<td>752</td>
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<tr>
<td><strong>Wider workforce</strong></td>
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<td></td>
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<td>Responsible Officer or Group</td>
<td>Expected completion date and status</td>
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</tr>
</tbody>
</table>
| General Practice Nurse Programme | SEL STP has established a GPN Strategy Group (GPNSG) to develop and take forward implementation of the GPN 10 point plan for SEL. | - Increase the capacity of the Practice Educator (PE) role to 0.8 WTE  
- Supplement the Practice Educator role with a Training and Placement Co-ordinator  
- Develop a practice nurse competency framework  
- Practice nurse and HCA training and development programmes | - Strategic leadership for the development of both pre & post registration primary care nursing  
- Competency framework to support consistent high quality GPN offer across SEL and clear career pathway that supports recruitment and retention.  
- Improved quality of HCA and nursing care | £100K investment | Led by Dir. of Quality & Chief Nurse, NHS Southwark CCG. | - Educator in post  
- Coordinator recruitment underway  
- GPN and HCA programmes drafted |
| International GP recruitment | Our initial phase will see GP’s employed in 4 of our 6 SEL boroughs. Our phase 4 cohort will be employed across SEL. | - Approved for 45 GP (phase 2) by April 2020 & a further 30 GP (phase 4). | - 75 Additional GP’s employed within SEL primary care  
- Assumption remodelled given poor uptake to 19 or 15.6 WTE | National level programme | National Level programme | Third GP joined in March. A fourth is expected in June. SEL is hoping to be prioritised in the subsequent wave (expected to be September) |
| Non-clinical Workforce Development Programme | Progression of development and implementation of a career pathway for non-clinical staff. | New cohort PC navigator/ MA trained (20 places) New cohort undergo coaching and mentoring qualification (15 places)  
Three cohorts of diploma level manager training: aspiring/ established/ advanced | Further evidence of the value in investing in the non-clinical workforce, in terms of enhanced administrative support creating ‘time to care’, signposting, care navigation and social prescribing skills, reducing the burden on clinical staff, improving the patient experience and offering staff the opportunity for development and career progression in support of recruitment and retention. | 75 staff developed | £91K investment | Led by OHSEL workforce team  
- On-line training ‘Go live’ 29/4 with 24 Level 2 staff piloting and working towards new ‘Certificate of Excellence in Healthcare Support’  
- 85 new staff to be enrolled across SEL  
- In discussions with HEE re access through E- Learning for Health platform; as part of a national ‘roll-out’  
- Next phase Level 3 GP/ Med Asst) training programme to be developed and piloted  
- PM (aspiring and established) training uptake below anticipated numbers, further promotion to follow  
- Access to advanced training to be discussed with emerging PCNs/ Training Hubs |
### Primary care workforce: high-impact actions (2 of 3)

<table>
<thead>
<tr>
<th>Title</th>
<th>Background</th>
<th>Deliverable</th>
<th>Intended benefit</th>
<th>Scale</th>
<th>Responsible Officer / Group</th>
<th>Expected completion date and status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Awareness &amp; Resilience</strong></td>
<td>Primary Care resilience is a significant issue linked to the increasing pressure on practice workforce and is causing high rates of sickness absence, increased turnover and difficulties in recruitment.</td>
<td>Six ‘Mental Health in the Workplace’ courses provided in 2018/19. Six ‘Wellbeing, Mindfulness and Resilience’ courses provided in 2018/19.</td>
<td>An ability to recognise, manage and/or respond appropriately to signs of mental health distress in oneself, other staff and patients could make a significant difference to both the workforce and patients.</td>
<td>Up to 180 Practice staff attend training. £30K investment</td>
<td>Led by OHSEL workforce team</td>
<td>Provider appointed and liaising directly with CEPNs to arrange workshops and recruitment</td>
</tr>
<tr>
<td><strong>Physicians Associate Development Programme</strong></td>
<td>Increasing GP practice uptake of Physicians Associates will enhance skill mix and adjustment in ways of working which benefit staff, patients and communities.</td>
<td>Development of: - a SE London learning agreement, - ‘grow your own’ strategy - supporting materials and a SEL recruitment drive targeted at the current undergraduate pool - Preceptorship programme &amp; support network - SEL workshop to raise awareness and encourage uptake</td>
<td>Additional and cost-effective capacity trained to support team working and patient centred care.</td>
<td>Overall target of 32 PAs employed in SEL GP practices by April 2020 Establishment of a PA network 50K investment</td>
<td>Targets are HEE “owned”. SEL task and finish group in place &amp; work led by OHSEL workforce team.</td>
<td>Ongoing work to minimum end 19/20. Working to identify training practices willing to offer placements and employ. Work with HEI commenced</td>
</tr>
<tr>
<td><strong>Ongoing work plan projects/ pilots</strong></td>
<td>Ongoing support to LCN development and achievement of CBC characteristics</td>
<td>Oversee delivery of 4 local projects supported by the STP in line with CBC strategy</td>
<td></td>
<td>Funds allocated from 2017/18 budget.</td>
<td>Led by OHSEL workforce team</td>
<td>Completed. Outcomes and learning to be collated and shared.</td>
</tr>
</tbody>
</table>
## Primary care workforce: high-impact actions (3 of 3)

<table>
<thead>
<tr>
<th>Title</th>
<th>Background</th>
<th>Deliverable</th>
<th>Intended benefit</th>
<th>Scale</th>
<th>Responsible Officer / Group</th>
<th>Expected completion date and status</th>
</tr>
</thead>
</table>
| Workforce analytics and modelling | Refreshed SEL CCG / STP workforce tool and practice level model available to support workforce understanding. | Supported roll out of tools across SEL through train the trainer approach, at scale promotion & local support | The CCG/ STP tool provides an overview of likely staff availability & supports scenario testing for at scale shifts in ways of working.  
The practice level tool is designed to test the impact of new ways of working on single, or small groups of practices. | Across whole of SEL Primary Care. | Led by OHSEL workforce team | To be reviewed in the context of LTP ask re local workforce planning and national modelling tool launch |
| GPFV retention                 | Local GPFV plans focused on a number of local recruitment & retention schemes | Various – see separate GPFV report                                         | - Creating 'Time to Care' through new roles and ways of working  
- Retaining GPs through Career Plus, portfolio careers etc  
- Increasing resilience  
- Improved patient care and enhanced self-management | Six CCG-led borough-wide programmes | Locally led projects. | Proposal for 19/20 funding submitted – a mixture of STP and locally coordinated activities |
| Retention Fund                | Informed by the above and locally suggested priorities and innovations and resourced by NHSE GP Retention Fund | - Five local schemes being supported through the fund  
- STP-led initiative to provide access to coaching and mentoring to mid- and late career GPs  
- Trained coaches to offer coaching and mentoring support to ‘First Five’ GPs  
- Three further schemes being supported. | - Time to Care (paramedics in general practice; e-hub network development; retention of new GPs through enhanced support offer – STP 3 ‘plus’; enhanced support for salaried and locum GPs, supporting recruitment & retention; flexible working, mentorship/buddying, matching suitable GPs to practices under the Retainer scheme.  
- Specific support to up to 12 mid- and late-career GPs targeting those who completed the SEL-wide recruitment & retention survey.  
- Increased job satisfaction for trained coaches & mentors and ‘first fives’ feeling better supported. | - Minimum 30,000 patients to Federation-wide  
- SEL-wide for up to 12 GPs  
- SEL-wide access to all ‘First Fives’ via Leadership Academy | Locally led projects. OHSEL workforce team oversight. | Due January 2020 |
South East London CCGs
Integrated Governance & Performance Committee
Performance Assurance Report
June 2019
This pack summarises the south east London performance position for all areas agreed as in-scope for the SEL Integrated Governance and Performance Committee:

- Referral-to-treatment waiting time standard (PTL; 52 and 18 week waits) 
  Page 3
- A&E 4 hour standard 
  Page 10
- London Ambulance Service performance 
  Page 13
- NHS 111 performance 
  Page 16
- Cancer waiting time standards 
  Page 19
- Diagnostic waiting time standard 
  Page 22
- Transforming Care Programme 
  Page 25
### RTT: performance headlines and month-on-month trend

#### 18 weeks RTT Incomplete pathway - % of patients waiting for 18 weeks or less (92%) – April 2019

<table>
<thead>
<tr>
<th>CCG</th>
<th>Current month</th>
<th>SPC position since Apr 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>81.33%</td>
<td>Below lower limit</td>
</tr>
<tr>
<td>Bromley</td>
<td>81.12%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Greenwich</td>
<td>85.27%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lambeth</td>
<td>84.54%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lewisham</td>
<td>84.30%</td>
<td>Below lower limit</td>
</tr>
<tr>
<td>Southwark</td>
<td>82.94%</td>
<td>Within limits</td>
</tr>
<tr>
<td>SEL CCGs</td>
<td>83.26%</td>
<td>-</td>
</tr>
<tr>
<td>GSTT</td>
<td>86.48%</td>
<td>Within limits</td>
</tr>
<tr>
<td>KCH</td>
<td>77.53%</td>
<td>Within limits</td>
</tr>
<tr>
<td>LGT</td>
<td>85.45%</td>
<td>Below lower limit</td>
</tr>
<tr>
<td>SEL Acute</td>
<td>82.69%</td>
<td>-</td>
</tr>
</tbody>
</table>

#### Number of patients on waiting list (PTL) over 18 weeks - April 2019

<table>
<thead>
<tr>
<th>CCG</th>
<th>Current month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>3,645</td>
</tr>
<tr>
<td>Bromley</td>
<td>5,839</td>
</tr>
<tr>
<td>Greenwich</td>
<td>3,355</td>
</tr>
<tr>
<td>Lambeth</td>
<td>4,252</td>
</tr>
<tr>
<td>Lewisham</td>
<td>4,592</td>
</tr>
<tr>
<td>Southwark</td>
<td>4,236</td>
</tr>
<tr>
<td>SEL CCGs</td>
<td>25,919</td>
</tr>
<tr>
<td>GSTT</td>
<td>10,487</td>
</tr>
<tr>
<td>KCH</td>
<td>17,543</td>
</tr>
<tr>
<td>LGT</td>
<td>5,699</td>
</tr>
<tr>
<td>SEL Acute</td>
<td>33,729</td>
</tr>
</tbody>
</table>

#### Number of patients on waiting list (PTL) over 52 weeks - April 2019

<table>
<thead>
<tr>
<th>CCG</th>
<th>Current month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>38</td>
</tr>
<tr>
<td>Bromley</td>
<td>14</td>
</tr>
<tr>
<td>Greenwich</td>
<td>9</td>
</tr>
<tr>
<td>Lambeth</td>
<td>35</td>
</tr>
<tr>
<td>Lewisham</td>
<td>22</td>
</tr>
<tr>
<td>Southwark</td>
<td>44</td>
</tr>
<tr>
<td>SEL CCGs</td>
<td>162</td>
</tr>
<tr>
<td>GSTT</td>
<td>42</td>
</tr>
<tr>
<td>KCH</td>
<td>170</td>
</tr>
<tr>
<td>LGT</td>
<td>2</td>
</tr>
<tr>
<td>SEL Acute</td>
<td>214</td>
</tr>
</tbody>
</table>

**Key**

- Not achieving national standard
- Outside of SPC process limit (good performance)
- Outside of SPC process limit (poor performance)
- Within SPC limits (within expected levels of variation)
## RTT PTL: summary of current position

### Summary of current south east London performance position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GSTT achieved trajectory in April. The PTL is predicted to grow in year but is expected to be within planned trajectory.</td>
<td>• The extent to which trusts are able to achieve their PTL trajectory is linked to the success of CCGs in optimising referrals and implementing the planned care strategies for 19/20.</td>
<td>• Trusts have developed performance improvement plans to deliver their trajectory for managing their RTT PTL and RTT 18 week performance.</td>
</tr>
<tr>
<td>• KCH were above trajectory in April but have a trajectory that reduces during 19/20.</td>
<td>• GSTT: Focus of trust is on delivering the 18 week performance trajectory rather than reduction in PTL size.</td>
<td>• Monthly performance meetings are in place with acute trusts to review progress against the trust specific trajectories.</td>
</tr>
<tr>
<td>• LGT achieved trajectory in April and have a trajectory that slightly reduces during 19/20.</td>
<td>• For both KCH and LGT a reduction in their PTL size is forecast with a small improvement in performance against the 92% standard.</td>
<td>• The individual trust performance improvement plans have been agreed between commissioners and providers, with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.</td>
</tr>
</tbody>
</table>

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

- If the Trust PTLs increase it can become harder to manage from an operational perspective. The ICDT are attending GSTT Trust internal RTT meetings and intend to do the same for KCH and LGT to gain assurance of operation grip.
- KCH and LGT have also been asked to provide evidence that their RTT governance processes and structures have been improved. GSTT has included specific actions relating to strengthening operational grip within their Performance Improvement Plan.
RTT PTL: monthly update

What has changed since last month?

<table>
<thead>
<tr>
<th>New actions taken in the last month</th>
</tr>
</thead>
<tbody>
<tr>
<td>All providers in SEL saw an increase in PTL size between March and April with the largest increase at GSTT.</td>
</tr>
<tr>
<td>Performance improvement plans are embedded and form part of the monthly performance meetings.</td>
</tr>
<tr>
<td>ICDT continued to work with Trust in monitoring PTL size and in refining KPI to measure delivery of key actions.</td>
</tr>
</tbody>
</table>

Proposed actions in the next quarter

<table>
<thead>
<tr>
<th>Proposed actions in the next quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGT and KCH will further refine performance improvement plans where needed to ensure that key challenges are fully addressed.</td>
</tr>
<tr>
<td>KCH are reviewing their process for managing RTT, including reviewing RTT performance at specialty level, setting targets for each specialty and actions associated to deliver this.</td>
</tr>
</tbody>
</table>

SEL BAF risk

<table>
<thead>
<tr>
<th>SEL BAF Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference: SEL-04</td>
</tr>
<tr>
<td>Current risk rating: 3 x 4 = 12 (medium risk)</td>
</tr>
</tbody>
</table>

What are your recommendations to the SEL IG&P Committee?

1. CCGs will need to fully engage in the planned care transformation agenda to ensure referrals to secondary care are optimised and the improvements experienced in 18/19 are sustained into 19/20.
2. CCGs should ensure that referrers are aware of the challenged specialties at local trusts, particularly at KCH and that at the point of referral this is taken into account. To continue to be highlighted in GP newsletters and on practice visits.
## RTT 52 week wait: summary of current position

### Summary of current south east London performance position

- There are more long waiters than expected across the sector however KCH & LGT met trajectory for April.
- There has been an increase in the number of long waiters at GSTT with the Trust adrift from trajectory in April.

### Main drivers of current performance position

- At KCH the main specialties with long waiters are orthopaedics and bariatrics. KCH long waiter specialities are likely to have a wide spread impact on SEL CCGs, with data for 18/19 showing Lambeth, Southwark and Bromley CCGs having more long waiting patients, and Lewisham and Greenwich CCGs still having long waiters at the trust but in slightly lower numbers.
- Although GSTT has specialities with long waiters and expect to have some through December 2019, the main specialty with long waiter are GMS (Upper GI & colorectal) and cleft surgery. Cleft surgery is a specialist service has a large catchment area and therefore will not necessarily include SEL CCG patients.
- LGT long waiters are limited to a single specialty with low numbers which are expected to be cleared by the end of Q1 with the exception of 1 patient. The number of patients from any one SEL CCG is expected to be low.

### High impact actions currently in place to address performance variance

- Trusts have developed performance improvement plans to deliver their reduction trajectory for long waiters.
- Monthly performance meetings are in place with acute trusts to review progress against the trust specific trajectories and ICDT team members attend additional internal RTT meetings at GSTT.
- GSTT and KCH performance improvement plans agreed between commissioners and providers with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly:
  - KCH to work with other providers to identify capacity and move patients for bariatrics and orthopaedics.
  - GSTT to work with other London providers to identify additional capacity to operate on cleft patients within the required timescales.

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

- Clinical Harm Reviews are undertaken for long waiting patients and updates are given at the relevant CQRG meetings.
**RTT 52 week wait: monthly update**

<table>
<thead>
<tr>
<th>What has changed since last month?</th>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
</table>
| • The pre-validated position shows deteriorated performance for May with both KCH and GSTT reporting more long waiters than their respective trajectory  
• LGT are expected to be within trajectory for May. | • Performance improvement plans are embedded and form part of the monthly performance meetings.  
• Increased frequency of review of long waiters by ICDT with Trusts. | • Reviewing and agreeing final performance improvement plans for KCH to ensure that the actions identified will deliver the improvement trajectory that has been agreed.  
• ICDT working with regional office to ensure any external support is fully utilised. | SEL BAF Reference:  
• SEL-03  
Current risk rating:  
• 3 x 4 = 12 (medium risk) |

**What are your recommendations to the SEL IG&P Committee?**

1. CCGs should ensure that referrers are aware of the challenged specialties at local trusts, particularly at KCH and that at the point of referral this is taken into account. To continue to be highlighted in GP newsletters and on practice visits.
RTT 18 week: summary of current position

Summary of current south east London performance position

<table>
<thead>
<tr>
<th>Main drivers of current performance position</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Both KCH and LGT are focusing on reducing PTL size.</td>
</tr>
<tr>
<td>• The extent to which trusts are able to achieve their PTL trajectory is linked to the success of CCGs in optimising referrals and implementing the planned care strategies for 19/20.</td>
</tr>
<tr>
<td>• GSTT: Focus of trust is on delivering the 18 week performance trajectory rather than reduction in PTL size.</td>
</tr>
<tr>
<td>• For both KCH and LGT a reduction in their PTL size is forecast with a small improvement in performance against the 92% standard.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trusts have developed performance improvement plans to deliver their reduction trajectory for long walters.</td>
</tr>
<tr>
<td>• Monthly performance meeting with acute trusts are in place to review progress against the trust specific trajectories and ICDT team members attend additional internal RTT meetings at GSTT and KCH.</td>
</tr>
<tr>
<td>• The individual trusts recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly:</td>
</tr>
<tr>
<td>• LGT and KCH plans both include a significant element relating to strengthening governance and processes, supporting RTT delivery.</td>
</tr>
<tr>
<td>• GSTT implementation of the acute trust aspects of the planned care strategy, including promoting Advice and Guidance, implementing Rapid Assessment services and enhanced clinical triage; transformation of outpatient processes and increasing theatre capacity both off and on site.</td>
</tr>
</tbody>
</table>

Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

• Patients are potentially experiencing longer waits for routine treatment than would be expected, provider Trusts have identified actions to address challenged specialties within their RTT Performance Improvement Plans. The plans will be monitored via the monthly performance meetings.
### What has changed since last month?

- GSTT and KCH’s performance has improved slightly compared to March but is below trajectory.
- Whilst LGT performance has improved slightly compared to March and is above trajectory.

### New actions taken in the last month

- Performance improvement plans are embedded and form part of the monthly performance meetings.
- ICDT continued to work with Trust in monitoring PTL size and in refining KPI to measure delivery of key actions.

### Proposed actions in the next quarter

- KCH are reviewing their process for managing RTT, including reviewing RTT performance at specialty level, setting targets for each specialty and actions associated to deliver this.
- ICDT working with regional office to ensure any external support is fully utilised.

### SEL BAF risk

- **SEL BAF Reference:**
  - SEL-05
- **Current risk rating:**
  - $3 \times 3 = 9$ (medium risk)

### What are your recommendations to the SEL IG&P Committee?

1. CCGs should ensure that referrers are aware of the challenged specialties at local trusts, particularly at KCH and that at the point of referral this is taken into account. To continue to be highlighted in GP newsletters and on practice visits.
## A&E and urgent care: performance headlines and month-on-month trend

### A&E 4 hour waits - 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – May 2019

<table>
<thead>
<tr>
<th></th>
<th>GSTT</th>
<th>KCH</th>
<th>LGT</th>
<th>SEL Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current month</strong></td>
<td>86.1%</td>
<td>73.5%</td>
<td>80.5%</td>
<td>79.5%</td>
</tr>
<tr>
<td><strong>SPC position since Apr 17</strong></td>
<td>Within limits</td>
<td>Below lower limit</td>
<td>Within limits</td>
<td>-</td>
</tr>
</tbody>
</table>

### Key

- **Performance position**
  - Not achieving national standard
  - Achieving national standard
- **Current month SPC position**
  - Compared to performance since April 2017
  - Outside of SPC process limit (good performance)
  - Outside of SPC process limit (poor performance)
  - Within SPC limits (within expected levels of variation)
A&E and urgent care: summary of current position

Summary of current south east London performance position

<table>
<thead>
<tr>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A mismatch between demand and capacity in both physical and staffing resource:</td>
<td>All trusts have developed performance improvement plans to deliver their trajectory for improving performance against the 4 hour standard and link to the SEL strategy for improvement in non-elective services:</td>
</tr>
<tr>
<td>• Increases in acuity leading to increased rates of admission</td>
<td>• KCH have established three performance improvement workstreams focused on “front”, “middle” and “back” with focused actions around improving flow in the emergency department and acute assessment, improving site management and improving length of stay and discharge processes on wards.</td>
</tr>
<tr>
<td>• Continuing pressure from patients presenting in ED with serious mental health issues</td>
<td>• The LGT performance improvement plan focus’ on the end to end pathway and includes developing a new clinical model and site reconfiguration to drive improved flow and performance.</td>
</tr>
<tr>
<td>• Challenges with patient flow, within the EDs, from EDs to ward areas and in timely discharge from hospital</td>
<td>• GSTTT actions are focused on addressing three elements - LAS Handover and RAT, throughput, and discharge and transfer. In addition, there are projects related to the Urgent Care Centre, looking at assessment, capacity and the environment. The final focus is staffing demand, with both a clinical and administrative focus.</td>
</tr>
<tr>
<td>• The variability in SEL of available appropriate alternative pathways e.g. to support streaming at the front door, admission avoidance or in and out of hospital services.</td>
<td>Monthly performance meetings with acute trusts are in place to review progress against the trust specific trajectories and ICDT Team members attend internal trust meetings relating to A&amp;E performance delivery.</td>
</tr>
</tbody>
</table>

Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

• Quality implications relating to sub optimal ED performance is a scheduled discussion at the three Trust CQRG meetings. Specific concerns/cases will be raised directly with the Trusts via the quality alert systems.
What has changed since last month?

- GSTT, KCH and LGT did not meet the A&E trajectory in April or May. Performance in May was similar to previous months for GSTT and KCH but declined for LGT.

New actions taken in the last month

- Performance improvement plans are embedded and form part of the monthly performance meetings.
- Trusts have been asked to update Performance Improvement Plans to reflect actions to improve ambulance handover performance and reduction in extended length of stay.
- Urgent and Emergency Care System review meetings have been scheduled with Trusts and respective system partners to understand drivers behind current performance, agree any wider system support or dependencies for delivering the agreed trajectory.

Proposed actions in the next quarter

- ICDT will be reviewing gaps in existing plans with a view to allocating or optimising external / internal support.

SEL BAF risk

- SEL BAF
  - Reference:
  - SEL-02
  - Current risk rating:
    - 3 x 4 = 12 (medium risk)

What are your recommendations to the SEL IG&P Committee?

1. CCGs should be fully engaged in the development and delivery of system wide Urgent and Emergency Care plans, including:
   - Equitable access to out of hospital services, including for patients not in the host hospital site
   - Provision of admission prevention services
   - Support for timely discharge
LAS: activity and performance headlines

<table>
<thead>
<tr>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAS activity (actual vs plan) – 2018/19 M1 – M12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Activity (Plan)</td>
<td>30,897</td>
<td>38,597</td>
<td>34,683</td>
<td>43,988</td>
<td>36,668</td>
<td>43,964</td>
</tr>
<tr>
<td>Total Activity (Actual)</td>
<td>31,166</td>
<td>39,635</td>
<td>36,741</td>
<td>44,751</td>
<td>36,815</td>
<td>44,376</td>
</tr>
<tr>
<td>Total activity - Variance</td>
<td>269</td>
<td>1,038</td>
<td>2,058</td>
<td>763</td>
<td>147</td>
<td>412</td>
</tr>
<tr>
<td>Total activity – Variance (%)</td>
<td>0.9%</td>
<td>2.7%</td>
<td>5.9%</td>
<td>1.7%</td>
<td>0.4%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

CCG delivery against ambulance response indicators – April 2019

<table>
<thead>
<tr>
<th>Category 1 Mean Target: 00:07:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:06:32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 1 90th centile Target: 00:15:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:10:18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2 Mean Target: 00:18:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:20:17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2 90th centile Target: 00:40:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:40:01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 3 Mean Target:01:00:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:45:40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 3 90th centile Target: 02:00:00</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Category 4 90th centile Target: 03:00:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>03:11:52</td>
</tr>
</tbody>
</table>

Definitions

**Category 1**
Life Threatening: A time critical life threatening event requiring immediate intervention or resuscitation.

**Category 2**
Emergency: Potentially serious conditions that may require rapid assessment and urgent on-scene intervention and/or urgent transport.

**Category 3**
An urgent problem (not immediately life threatening) that needs treatment to relieve suffering and transport or assessment and management at the scene with referral where needed within a clinically appropriate timeframe.

**Category 4**
Problems that are less urgent but require assessment and possibly transport within a clinically appropriate timeframe.
### LAS performance: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• April 2019 activity figures are not available until the Pan London contract is agreed for 2019/20.</td>
<td>• LAS ambulance response times in Bexley can be attributed to the distance ambulances need to travel to reach patients as there are no acute hospital sites in the Bexley area.</td>
<td>See following slide for planned actions.</td>
</tr>
<tr>
<td>• In April 2019, LAS met Category 1, 2 and 3 ambulance response time targets for SEL.</td>
<td>• Alternative care pathway (ACP) utilisation by LAS crews is low; however poor data recording by LAS does not show the scale of the problem or where efforts should be targeted.</td>
<td></td>
</tr>
<tr>
<td>• However, LAS was not able to achieved the Category 4 ambulance response time (3 hours) for Bexley, Lewisham and Southwark CCGs.</td>
<td>• LAS report an increase in acuity of patients, as seen elsewhere in the urgent care system.</td>
<td></td>
</tr>
<tr>
<td>• Across the 6 CCGs, LAS continues to struggle in maintaining targets mainly in Bexley.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

A representative for SEL CCGs attends the LAS CQRG meetings which oversee the delivery of high quality care, including review of Serious Incidents. The current report does not highlight any significant quality concerns relating to LAS delivery of performance standards.
**LAS performance: monthly update**

<table>
<thead>
<tr>
<th>What has changed since last month?</th>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 2019/20 Pan London LAS contract has been agreed in principle. STPs are waiting for further clarification around Hear &amp; Treat activity that LAS will undertake during 2019/20 which will lower the activity baseline for London.</td>
<td>A SEL LAS Demand Management meeting was held with all CCGs. Each CCG has been asked to identify the top 2 to 3 demand management schemes they will work on for 2019/20 which will have the largest impact on activity. This is in light of the overperformance of 2% for 2018/19 which is likely to continue in this financial year. A number of key areas were identified for further focus.</td>
<td>SEL commissioners will devise a plan and start to deliver the additional referral pathways for the LAS Clinical Hub. The plan is due by the end of June, with execution of the plan to occur in Q2. SEL CCGs will also develop their key demand management schemes for 2019/20 with detailed plans on how to decrease activity in their areas. Additional ACP referral pathways will be developed to help lower demand on Emergency Departments.</td>
<td></td>
</tr>
<tr>
<td>Commissioners will also be responsible for establishing additional referral pathways for the LAS Clinical Hub to use (so ambulances are not dispatched), SEL will need to deliver 1,162 referrals for 2019/20.</td>
<td>SEL commissioners met with LAS to review all codes used by crews and review all ACPs across SEL to ensure the correct information is being collected by LAS. This resulted in nearly half of all codes used in SEL being updated or removed. This process is being carried out in each STP to improve data collection.</td>
<td>CCGs will review all GP by-pass numbers listed in the Directory of Services to ensure that crews on the ground can quickly access GPs and possibly avoid any conveyances to hospital.</td>
<td></td>
</tr>
<tr>
<td>With the launch of the new 111 Integrated Urgent Care service for SEL, the new Clinical Assessment Service is revalidating Category 3 and 4 ambulances before they are sent to 999 for dispatch. In April, the 111 service was able to step down an additional 314 ambulances and redirect patients to different services.</td>
<td>SEL commissioners have been working with LAS and the NWL LAS Commissioning team around establishing the Hear &amp; Treat activity figures to help finalise the contract terms.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What are your recommendations to the SEL IG&P Committee?**

Note the progress on the Pan London contract for 2019/20.

**SEL BAF Reference:**
- SEL-07

**Current risk rating:**
- 4 x 3 = 12 (medium risk)
111 performance: headlines and month-on-month trend

<table>
<thead>
<tr>
<th></th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call volume</td>
<td>36,275</td>
<td>34,782</td>
<td>40,278</td>
<td>37,967</td>
</tr>
<tr>
<td>Calls answered in 60 seconds (target)</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Calls answered in 60 seconds (performance)</td>
<td>76.3%</td>
<td>76.2%</td>
<td>74.2%</td>
<td>85.1%</td>
</tr>
</tbody>
</table>

Urgent and Emergency Care Referrals from SEL 111 IUC

![Graph showing referral percentages]
**111 performance: summary of current position**

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The launch of the new SEL 111 Integrated Urgent Care (IUC) service began on the 29th January 2019 and was completed on the 8th May 2019.</td>
<td>• Workforce shortage across all skill sets; particularly call handlers and Advanced Nurse Practitioners (ANPs) continues. The call handler shortage has contributed to poor performance around the calls answered in 60 second performance target, although this is now showing signs of improvement.</td>
<td>• A Recovery Action Plan around the 60 second performance target has been agreed with LAS and is monitored via monthly contract management meetings.</td>
</tr>
<tr>
<td>• Calls answered within 60 seconds performance has improved since the launch of the new service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The proportion of 111 calls resulting in ambulance dispatch or referral to a ED/UTC has remained low through the launch period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• April 2019’s call volumes were 0.3% below forecast.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Impact or potential impact of the current performance position on the quality of care and mitigation actions in place**

• There is a London review of paediatrics in 111 pathways currently underway. A new SEL 111 IUC Quality and Safety Committee has been developed which will meet bi-monthly to oversee the quality and safety of care within the new service.
### 111 performance: monthly update

<table>
<thead>
<tr>
<th>What has changed since last month?</th>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Calls answered in 60 seconds performance has improved by almost 11% (from March to April 2019).</td>
<td>• LAS’s recovery action plan has been refreshed.</td>
<td>• Call handler training courses scheduled for May and June.</td>
<td><strong>SEL BAF Reference:</strong> No risks at this time. Not included on SEL BAF.</td>
</tr>
<tr>
<td>• The new SEL 111 IUC model has been fully rolled out, as of the 8th of May 2019.</td>
<td>• Additional employment of temporary agency staff.</td>
<td>• Rolling recruitment of call handlers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The ICDT has developed and rolled out a new governance structure for the SEL 111 IUC service which was approved by the newly structured 111 IUC Programme Board.</td>
<td>• Independent review of modelling and forecasting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Re-phasing of clinical workforce to address Clinical Assessment Service (CAS) performance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Deep dive reviews of the CAS to understand if the service is delivering the outcomes detailed in the national specification.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Meeting arranged with NHS England and HLP to discuss the progress of the service on the 31st of July.</td>
<td></td>
</tr>
</tbody>
</table>

### What are your recommendations to the SEL IG&P Committee?

Note the improved calls answered in 60 seconds performance target.
### Cancer waiting times: performance headlines and month-on-month trend

Tables on the following two pages set out the current performance position of each SEL CCG and provider against national standards. The position against the standard is RAG-rated and the position against the previous month’s performance is indicated by the arrow as per the below key.

#### Cancer 62 day waits - % of patients waiting 62 days or less from urgent GP referral (85%) – April 2019

<table>
<thead>
<tr>
<th>CCG/Provider</th>
<th>Current month</th>
<th>SPC position since Apr 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>78.18%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Bromley</td>
<td>71.72%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Greenwich</td>
<td>72.22%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lambeth</td>
<td>79.25%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lewisham</td>
<td>72.22%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Southwark</td>
<td>84.85%</td>
<td>Within limits</td>
</tr>
<tr>
<td>SEL CCGs</td>
<td>75.45%</td>
<td>-</td>
</tr>
<tr>
<td>GSTT</td>
<td>70.27%</td>
<td>Within limits</td>
</tr>
<tr>
<td>KCH</td>
<td>78.66%</td>
<td>Within limits</td>
</tr>
<tr>
<td>LGT</td>
<td>77.64%</td>
<td>Within limits</td>
</tr>
<tr>
<td>SEL Acute</td>
<td>75.19%</td>
<td>-</td>
</tr>
</tbody>
</table>

#### Cancer 31 day waits - % of patients waiting 31 days or less between definitive diagnosis and first treatment (96%) – April 2019

<table>
<thead>
<tr>
<th>CCG/Provider</th>
<th>Current month</th>
<th>SPC position since Apr 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>96.84%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Bromley</td>
<td>97.48%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Greenwich</td>
<td>96.00%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lambeth</td>
<td>96.59%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lewisham</td>
<td>92.77%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Southwark</td>
<td>97.18%</td>
<td>Within limits</td>
</tr>
<tr>
<td>SEL CCGs</td>
<td>96.32%</td>
<td>-</td>
</tr>
<tr>
<td>GSTT</td>
<td>96.06%</td>
<td>Within limits</td>
</tr>
<tr>
<td>KCH</td>
<td>96.48%</td>
<td>Within limits</td>
</tr>
<tr>
<td>LGT</td>
<td>94.90%</td>
<td>Within limits</td>
</tr>
<tr>
<td>SEL Acute</td>
<td>96.01%</td>
<td>-</td>
</tr>
</tbody>
</table>

#### Cancer 2 week waits - % of patients waiting two week or less between urgent GP referral and first appointment with a specialist (93%) – April 2019

<table>
<thead>
<tr>
<th>CCG/Provider</th>
<th>Current month</th>
<th>SPC position since Apr 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>94.01%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Bromley</td>
<td>93.04%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Greenwich</td>
<td>95.17%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lambeth</td>
<td>94.55%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Lewisham</td>
<td>94.53%</td>
<td>Within limits</td>
</tr>
<tr>
<td>Southwark</td>
<td>93.74%</td>
<td>Within limits</td>
</tr>
<tr>
<td>SEL CCGs</td>
<td>94.14%</td>
<td>-</td>
</tr>
<tr>
<td>GSTT</td>
<td>94.21%</td>
<td>Within limits</td>
</tr>
<tr>
<td>KCH</td>
<td>93.59%</td>
<td>Within limits</td>
</tr>
<tr>
<td>LGT</td>
<td>94.57%</td>
<td>Within limits</td>
</tr>
<tr>
<td>SEL Acute</td>
<td>94.10%</td>
<td>-</td>
</tr>
</tbody>
</table>

#### Key

- **Not achieving national standard**
- **Achieving national standard**
- **Outside of SPC process limit (good performance)**
- **Outside of SPC process limit (poor performance)**
- **Within SPC limits (within expected levels of variation)**
- **Worst performer**
- **Best performer**
Cancer waiting times – 62 day: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
</table>
| • SEL Trusts/CCGs have not met the 62 day performance in 18/19, and despite improvements at KCH over the course of 18/19, there has been a deterioration in performance at LGT, which results in the overall SEL remaining static. | At the start of the financial year, there are three key areas driving the current risk:  
• The overall performance at LGT and the timeliness of Inter Provider Transfers performance (IPT) for patients transferring from LGT to GSTT.  
• The timeliness of IPT performance for patients transferring from KCH to GSTT.  
• The ability for the treatment trust to treat the patients within the standard if the patient arrives late or not at a diagnostic stage that would support the start of treatment. | • Trusts have developed action plans to deliver their 62 day trajectory including a SEL recovery plan specifically focusing on shared pathway actions and performance.  
• Monthly performance meeting are in place with acute trusts – focus on internal trust performance and actions relating to them are in place. A monthly system leadership group – 62 day leadership meeting is in place, with a focus on the shared pathway actions and performance  
• The SEL recovery plan has been agreed between commissioners and trusts with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly:  
• Full utilisation of TP biopsy in outpatients. By Q1  
• Recruitment to 28 day faster diagnosis project lead for SEL. By Q1  
• Continue SEL cancer diagnostic fund for CT and MRI. By Q1  
• 1.2 million of transformation money has been assigned to a specialist SEL cancer management sector workforce to be recruited and based at individual Trust Sites. By Q2  
• Full utilisation of One Stop and Straight to Test pathways for key tumour sites: lung by Q2, gynaecology by Q1, breast by Q1, upper GI by Q2.  
• Endobronchial ultrasound (EBUS) services to begin at Woolwich and PRUH. By Q2  
• Additional lung and lower GI oncologists recruited at GSTT and oncology workforce review conducted by the ACN. By Q2  
• Implement a model to expedite abnormal CXRs to CT in the lung pathway within 48 hours. By Q2  
• Recruitment to joint urology workforce roles at the PRUH with Denmark Hill by Q3  
• Fully roll out telephone assessment clinic model for 100% of appropriate lower GI patients. By Q4. |
| • Due to the drivers behind performance against the 62 Day standard, there is differential impact by CCGs. Lambeth and Southwark CCGs will tend to be closer to delivering the 62 day standard because a higher proportion of their patients will start and finish their cancer pathway either within GSTT or KCH - Denmark Hill. |  | |
| • However, for Lewisham, Greenwich, Bexley and Bromley CCGs, patients will start their pathway at a local trust/site e.g. Princess Royal University Hospital (PRUH), University Hospital Lewisham, and for some treatment pathways will be transferred to GSTT or KCH - Denmark Hill for treatment. These patients are therefore more likely to have issues with meeting the required standards as the timeliness of transfers is one of the key drivers. |  | |

Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

• Individual trusts complete Root Cause Analysis of all patients that are treated beyond 62 days, for IPT patients this is a joint exercise between relevant Trusts. Findings are shared at the relevant SEL tumour group (clinically led meetings), and summary findings are shared at the 62 day group, to ensure that current actions match the emerging issues..
## Cancer waiting times – 62 day: monthly update

### What has changed since last month?

- All three Trusts and SEL as a sector missed the performance trajectory in April.

### New actions taken in the last month

- SEL Cancer Performance Improvement Plans (PIPs) agreed and submitted nationally.
- SEL bilateral meetings to review Trust level plans and review potential support held for all sites except DH (expected to occur in June).
- Shortfall highlighted in 2019/20 SEL Diagnostic Fund. Paper written with recommendation to increase contribution.
- Recruitment day for specialist cancer management sector workforce held. 50% of band 8C and 7 posts offered.

### Proposed actions in the next quarter

- Rapid Assessment Diagnostic Clinic (RADC) workshop to be held to review options for expanding RADCs across the system. Transformation funding available.
- Continued employment of remaining staff for specialist cancer management sector workforce.
- 62 Day group to have lung and urology deep dives, FDS dashboard and shared breach thematic report produced.
- Agree new 6 month outsourcing contract for sector CT and MRI.

### SEL BAF risk

- **Reference:**
  - SEL-01
- **Current risk rating:**
  - $3 \times 4 = 12$
  - (medium risk)

### What are your recommendations to the SEL IG&P Committee?

1. CCGs should be leading cancer locality meetings (with support from the SEL Cancer Alliance), with particular focus on:
   - stratified follow-up – to facilitate appropriate patients being managed in a non acute setting,
   - ensuring 2ww referrals are in line with agreed process e.g. full patient workup, appropriate documentation with referral, patients aware they are on a 2ww pathway etc,
   - working with providers to ensure that eRS is fit for purpose and support their referrals.
   - Improving uptake and roll out of FIT
   - Improve uptake of cancer screening
# Diagnostic waiting times: performance headlines and month-on-month trend

<table>
<thead>
<tr>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL CCGs</th>
<th>GSTT</th>
<th>KCH</th>
<th>LGT</th>
<th>SEL Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current month</strong></td>
<td><strong>4.56%</strong></td>
<td><strong>9.45%</strong></td>
<td><strong>3.55%</strong></td>
<td><strong>4.70%</strong></td>
<td><strong>3.05%</strong></td>
<td><strong>5.02%</strong></td>
<td><strong>5.14%</strong></td>
<td><strong>6.86%</strong></td>
<td><strong>8.20%</strong></td>
<td><strong>1.95%</strong></td>
</tr>
<tr>
<td><strong>SPC position since Apr 17</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Within limits</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Below lower limit</strong></td>
<td><strong>Below lower limit</strong></td>
</tr>
</tbody>
</table>

**Key**
- Performance position
  - Not achieving national standard
  - Achieving national standard
- Current month SPC position
  - (compared to performance since April 2017)
  - Outside of SPC process limit (good performance)
  - Outside of SPC process limit (poor performance)
  - Within SPC limits (within expected levels of variation)

- Worst performer
- Best performer

---

**6 weeks Diagnostics - % of patients waiting for 6 weeks of less (99%) – February 2019**

- **Current month:** 4.56%, 9.45%, 3.55%, 4.70%, 3.05%, 5.02%, 5.14%, 6.86%, 8.20%, 1.95%, 5.85%
- **SPC position since Apr 17:** Below lower limit, Within limits, Below lower limit, Below lower limit, Below lower limit, -
- **Outside of SPC process limit (poor performance):** Below lower limit, Below lower limit, Below lower limit, -
- **Within SPC limits (within expected levels of variation):** -
## Diagnostic waiting times: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GSTT have a trajectory that shows compliance with the national standard from January 2020. Performance for April is above the trajectory with more long waiters than planned.</td>
<td>• At GSTT MRI, endoscopy and echocardiology are the primary drivers of poor performance.</td>
<td>• Trusts have developed performance improvement plans to deliver their diagnostic trajectory.</td>
</tr>
<tr>
<td>• KCH have a trajectory that moves towards compliance in 19/20 and shows a compliant position from March 2020. Performance for April is below planned trajectory but is not compliant with the national standard.</td>
<td>• At KCH endoscopy on the PRUH site is the primary driver of poor performance.</td>
<td>• Monthly performance meeting are in place with acute trusts which will review progress against the trust specific trajectories.</td>
</tr>
<tr>
<td>• LGT have a trajectory that is compliant with the national standard throughout 19/20, however performance for April is above trajectory and is not compliant with the national standard.</td>
<td>• At LGT endoscopy, echocardiology and sleep studies are the primary drivers of poor performance.</td>
<td>• Individual trusts performance improvement plans agreed between commissioners and providers with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.</td>
</tr>
</tbody>
</table>

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

• Serious Incidents are under investigation at KCH (PRUH) relating to delayed diagnostics which resulted in a cancer diagnosis. A weekly endoscopy briefing is produced by the Trust which gives a detailed update on the serious incidents and harm review process which is being undertaken.

• Trusts have developed performance improvement plans to deliver their diagnostic trajectory.

• Monthly performance meeting are in place with acute trusts which will review progress against the trust specific trajectories.

• Individual trusts performance improvement plans agreed between commissioners and providers with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.

• The KCH plan focuses on echocardiography for Denmark Hill, and endoscopy for PRUH, including expanding capacity by utilising available in and outsourcing options.

• GSTT to establish additional MRI capacity through extended working hours at weekends.
# Diagnostic waiting times: monthly update

## What has changed since last month?

- GSTT have identified an additional challenge in non-obstetric ultrasound. This is yet to be quantified but as this is a high volume service it’s likely to have an impact on performance in May.
- KCH performance for April shows a worsening position compared to the previous month but is below planned trajectory.
- LGT had a higher number of breaches than expected in April due to capacity issues at UHL for Echocardiology. Provisional pre-validated data for May shows no breaches for echocardiology at UHL.

## New actions taken in the last month

- Performance improvement plans are embedded and form part of the monthly performance meetings.
- ICDT now takes part in the weekly endoscopy oversight meetings at KCH.
- ICDT are meeting with KCH to review demand and capacity model.

## Proposed actions in the next quarter

- ICDT will be requesting a performance improvement plan from LGT as their forecasted improved performance didn’t materialise in April.
- ICDT will be working with the regional team who are seeking solutions to pan-London capacity issues such as endoscopy.

## SEL BAF risk

*SEL BAF Reference:*
- SEL-06

*Current risk rating:*
- $4 \times 4 = 16$ (high risk)

## What are your recommendations to the SEL IG&P Committee?

1. CCGs to be aware of the prolonged waits for endoscopy services at the PRUH
2. CCGs to ensure referrals for endoscopy services are flagged appropriately as urgent
There are currently 75 adults inpatients*, 19 above the BRS target position of 56 by end June 2019.

- The TCP is forecasting an end March 2020 position of 64 adult inpatients, 14 above the BRS target of 50.
- The target was built on an analysis of the current cohort as well as a modelling based on review of the historical data and expected positive impact that new services will have in the trajectory.

*Position at 13/06/2019.

DATA SOURCE: SEL TCP inpatient tracker 20190613 version v.3
**Transforming Care: inpatient count position and trend (2 of 4)**

There are currently 82 inpatients*, meeting the recovery trajectory position for end June 2019.

<table>
<thead>
<tr>
<th>Inpatients</th>
<th>FY 17/18 Q4</th>
<th>FY 19/20 Q1</th>
<th>FY 19/20 Q2</th>
<th>FY 19/20 Q3</th>
<th>FY 19/20 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>Trajectories</td>
<td>TCP Forecast**</td>
<td>FY 19/20 Q1</td>
<td>FY 19/20 Q2</td>
<td>FY 19/20 Q3</td>
<td>FY 19/20 Q4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BRS Trajectory</td>
<td>FY 19/20 Q1</td>
<td>FY 19/20 Q2</td>
<td>FY 19/20 Q3</td>
<td>FY 19/20 Q4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recovery Trajectory</td>
<td>FY 19/20 Q1</td>
<td>FY 19/20 Q2</td>
<td>FY 19/20 Q3</td>
<td>FY 19/20 Q4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in month</td>
<td>Net</td>
<td>FY 19/20 Q1</td>
<td>FY 19/20 Q2</td>
<td>FY 19/20 Q3</td>
<td>FY 19/20 Q4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admissions</td>
<td>FY 19/20 Q1</td>
<td>FY 19/20 Q2</td>
<td>FY 19/20 Q3</td>
<td>FY 19/20 Q4</td>
</tr>
<tr>
<td></td>
<td>Jan-19 11</td>
<td>Feb-19 10</td>
<td>Mar-19 8</td>
<td>Apr-19 4</td>
<td>May-19 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharges</td>
<td>FY 19/20 Q1</td>
<td>FY 19/20 Q2</td>
<td>FY 19/20 Q3</td>
<td>FY 19/20 Q4</td>
</tr>
<tr>
<td></td>
<td>Jan-19 9</td>
<td>Feb-19 7</td>
<td>Mar-19 5</td>
<td>Apr-19 13</td>
<td>May-19 11</td>
</tr>
</tbody>
</table>

*Position at 13/06/2019.

*DATA SOURCE: SEL TCP inpatient tracker 20190613 version v.3*
Transforming Care: inpatient count position and trend (3 of 4)

Of 82 inpatients, 43 are estimated to be suitable for discharge by the end of March 2020.*

- 37 inpatients are not expected to be discharged before March 2020 (Black RAG rated), 28 of whom are Specialised Commissioning adults.
- The RAG rating for ‘TBC’ patients will be agreed at upcoming CTRs and the next TCP surgery on 01/07/2019.

<table>
<thead>
<tr>
<th>RAG</th>
<th>Estimated Discharge Date</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Spec Comm</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>April - June 2019</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Amber</td>
<td>July - September 2019</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Red</td>
<td>October - December 2019</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Purple</td>
<td>January - March 2020</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Black</td>
<td>After March 2020</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>28</td>
<td>37</td>
</tr>
<tr>
<td>TBC</td>
<td>To be confirmed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>CCG Adults</th>
<th>Spec Comm Adults</th>
<th>CYP</th>
</tr>
</thead>
<tbody>
<tr>
<td>April - June 2019</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>July - September 2019</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>October - December 2019</td>
<td>9</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>After March 2020</td>
<td>44</td>
<td>44</td>
<td>82</td>
</tr>
</tbody>
</table>

*Position at 13/06/2019.

DATA SOURCE: SEL TCP inpatient tracker 20190613 version v.3
Transforming Care: inpatient count position and trend (3 of 4)

There are currently 82 inpatients (75 x adult, 7 x children)*

- 65% of current adult inpatients were admitted to hospital due to other mental health diagnosis.
- 57% of current CYP patients were admitted to hospital due to other mental health diagnosis.

*Position at 13/06/2019.

DATA SOURCE: SEL TCP inpatient tracker 20190613 version v.3
**Transforming Care: Care Treatment Plan position and trend (1 of 3)**

- Progress has been made with current inpatient CTR completion but challenges remain with regard to completion of pre and post-admission CTRs.
- The TCP PMO team has been tracking issues beyond TCP control which have resulted in CTR non-compliance. These issues have been escalated to the Strategic Case Manger and NHSE regional team via monthly assurance meetings.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Admission</td>
<td>&gt;75%</td>
<td>100%</td>
<td>67%</td>
<td>25%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-Secure Adults in Hospital</td>
<td>&gt;75%</td>
<td>84%</td>
<td>82%</td>
<td>82%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Secure Adults in Hospital</td>
<td>&gt;75%</td>
<td>95%</td>
<td>92%</td>
<td>92%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Post Admission</td>
<td>&gt;90%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CYP (&lt;18 years)</td>
<td>&gt;90%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Position at 06/06/2019.

**DATA SOURCE:** SEL TCP inpatient tracker 20190606 version v.2
## Working assumptions:

1. Inpatients with a LOS of over 3 months move in to the 'current inpatients categories, regardless of CTR status.
2. Spec Comm adult inpatients are in secure accommodation. CCG adult inpatients are in non-secure accommodation.
3. Where the TCP patient level tracker does not contain a past CTR date, it is assumed that no CTR has taken place.
4. When patients have not been approved on the register by the Deputy SRO, these patients are not included.

- **Adopted inpatient metric**: Bexley Bromley Greenwich Lambeth Lewisham Southwark Spec Comm SEL

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Metric</th>
<th>Target</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Spec Comm</th>
<th>SEL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Post Admission (&gt;28 days)</td>
<td>• % admissions in rolling quarter with pre-admission CTR within 28 days or post-admission CTR within 28 days of admission</td>
<td>75%</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>(2) Non-Secure Adults in Hospital (After first CTR)</td>
<td>• % current non-secure inpatients with CTR in last 8 months</td>
<td>75%</td>
<td>4</td>
<td>0</td>
<td>100%</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>(3) Secure Adults in Hospital (Adult Spec Comm)</td>
<td>• % current secure inpatients with CTR in last 12 months</td>
<td>75%</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>CYP (&lt;18 years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Post Admission (&gt;28 days)</td>
<td>• % admissions in rolling quarter with pre-admission CTR within 28 days or post-admission CTR within 14 days of admission</td>
<td>90%</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(5) In Hospital (CYP Spec Comm)</td>
<td>• % current inpatients with CTR in last 3 months</td>
<td>90%</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

*Position at 06/06/2019.

DATA SOURCE: SEL TCP inpatient tracker 20190606 version v.2
*CTR Breaches for metrics 1 and 4:

CCG
- 1x CCG Adult patient has refused consent. Commissioners working with patient to reconsider.
- 1x CCG Adult due to be discharged in July. Will proceed with a CTR once settled.
- 1x CCG Adult recently transitioned to a new provider. Will proceed with a CTR once settled.

*CTR Breaches for metrics 2, 3 and 5:

CCG
- 1x CCG Adult patient had CTR cancelled due to challenging behaviour and a temporary stay in a PICU. As a result, CTR to be healed when patient is more stable.
- 1x CCG Adult due to be discharged in the next few weeks. Clear discharge plan identified.
- 1x CCG Adult patient has refused consent. Review of consent once patient mental state improves.
- 1x CCG Adult patient to have a CTR 4 weeks after breach date due to capacity issues with the current provider ward.
- 1x CCG Adult patient to have a CTR 4 months after breach date due to capacity issues with the current provider ward. Previous Care Coordinator was on long term leave, as a result leading to a delay in organising CTR.
- 1x CCG Adult patient ready for discharge with a discharge plan identified. A CTR is of being organised to review the discharge plan, this review is required due to funding dispute between Local Authority and CCG (Southwark).

Spec Comm
- 1x Spec Comm Adult patient transitioning into a provider. Will proceed with a CTR once settled.
- 1x Spec Comm Adult patient has refused consent. Patient has never consented to a CTR since being an inpatient.
- 1x Spec Comm Adult patient organised for 30 days deadline. Delay due to capacity issues with the current provider ward.

*Position at 06/06/2019.
DATA SOURCE: SEL TCP inpatient tracker 20190606 version v.2
### Transforming Care Programme: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
</table>
| • The south east London Transforming Care Partnership has been set a target of reducing transforming care inpatients from 71 to 58 by March 2019, in line with national Building the Right Support (BRS) bed reduction plans. | • The SEL inpatient cohort is complex which results in challenging discharge pathways. 54% of the current cohort is amenable to change and 46% is not (Black RAG rated) due to complex care needs and/or MoJ restrictions. These two distinct groups require different approaches to improve care and facilitate return to the community. | Discharge improvement:  
• Dedicated case managers in post.  
• Regular case management rhythm established.  
• Monthly inpatient surgeries.  
• Escalation channels open to SEL AO and NHSE national. |
| • This did not however allow for local demographic considerations and a significant increase in existing cohort numbers, as identified within the first year of the programme. | • There are a lack of local specialised support services for people living in the community with learning disabilities and/or autism and their families. | Admission prevention:  
• Introduction of compulsory root cause analysis.  
• PBS training to family carers and professional workforce.  
• Autism awareness training to professional workforce.  
• Borough level review of risk register processes, supported by central NHSE resource. |
| • Whilst the end of year inpatient position was 26 patients above the BRS trajectory, targeted interventions are in place, aimed at rapidly improving the performance position. | • CCGs, Local Authorities and providers do not always effectively share information regarding patients at risk of admission. This limits the ability of the TCP to put in place support to manage escalating crises in the community. | Capacity building:  
• Mobilisation of SLaM & Oxleas autism support services.  
• Mobilisation of new BBG intensive community support service.  
• Expansion of Lambeth Without Walls service.  
• Commissioning of Lewisham Intensive Community Support service.  
• New accommodation models under development. |
| • The TCP is maintaining a consistently high discharge rate, facilitated by increased case management and programme management support, however continuing pressure from admissions continues to impact net change. | • Care and Treatment Review (CTR) compliance is challenged for the pre/post admission KPIs. This is being driven by NHS England central co-ordination challenges, TCP capacity challenges and community risk information sharing issues. | |
| • SEL TCP was set a target of reducing TC adult inpatients from 84 to 50 by March 2020, in line with national Building the Right Support (BRS) bed reduction plans. However, this did not allow for local demographic considerations and a significant increase in existing cohort numbers, as identified within the first year of the programme. | | |
| • The Operational target agreed with NHS England for SEL TCP adult inpatients is 64, 14 above the BRS target. The non-compliant target was built on analysis of the current cohort as well as modelling based on analysis of the historical data and expected positive impact that new services will have in the trajectory. | | |
### Transforming Care Programme: monthly update

<table>
<thead>
<tr>
<th>High Impact Action</th>
<th>Expected completion date and status</th>
<th>Key risks to delivery of the action</th>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge improvement:</strong></td>
<td></td>
<td>• In place from May 2018.</td>
<td>• None, resources in place.</td>
</tr>
<tr>
<td>• Dedicated case managers recruited (2 x CCG, 2 x Spec Comm).</td>
<td>• In place from May 2018.</td>
<td>• None, processes in place.</td>
<td>• None, processes in place.</td>
</tr>
<tr>
<td>• Regular case management rhythm established including monthly surgery meetings chaired by Deputy SRO, supported by weekly case manager/ TCP PMO update and escalation calls.</td>
<td>• In place since September 2018.</td>
<td>• None, processes in place.</td>
<td>• None, processes in place.</td>
</tr>
</tbody>
</table>
| • Escalation channels open to SEL AO and NHSE national team. | | | **SEL BAF Reference:**  
| | | | • SEL-08                                                                                         |
| | | | **Current risk rating:**  
| | | | • 2 x 5 = 10  
| | | | (medium risk)                                                                                   |
| **Admission prevention:**           |                                     | • Reporting and processes implemented Q3 18/19.                                                      | • None, processes in place.                                                |
| • Introduction of compulsory root cause analysis for all admissions and fortnightly CTR exception reporting. | • Training to over 70 family carers complete. Workforce training to commence Q1 2019/20. | • Workforce training will only be available to select groups as identified by commissioners. | • Workforce training will only be available to select groups as identified by commissioners. |
| • Providing PBS training to family carers and professional workforce. | • Training successfully delivered in May/June 2019 for over 95 professionals. | • Prioritisation of TC by LAs and providers may impact pace of local process improvements. | • Prioritisation of TC by LAs and providers may impact pace of local process improvements. |
| • Providing autism awareness training to professional workforce. | | | **SEL BAF Reference:**  
| • Borough level review of risk register processes, supported by central NHSE resource. | | | • SEL-08                                                                                         |
| | | | **Current risk rating:**  
| | | | • 2 x 5 = 10  
| | | | (medium risk)                                                                                   |
| **Capacity building:**              |                                     | • SLaM service mobilised and operational. Oxleas service recruitment in progress.                    | • Availability of workforce limiting pace of mobilisation.                |
| • Mobilisation of SLaM & Oxleas autism support services. | • Services fully mobilised Q1 FY 19/20. | • Availability of workforce will limit pace of mobilisation. | • Service funding not agreed between CCG and TC, as well as the availability of workforce will limit pace of mobilisation |
| • Mobilisation of new BBG intensive community support service and expansion of Lambeth Without Walls service. | • Mobilisation date yet to be confirmed. | | **SEL BAF Reference:**  
| • Commissioning of Lewisham Intensive Community Support service. Funding yet to be confirmed. | | | • SEL-08                                                                                         |
| | | | **Current risk rating:**  
| | | | • 2 x 5 = 10  
| | | | (medium risk)                                                                                   |
CCG Finance Report 2019/20
Month 2
(Period to end of May 2019)

Integrated Governance & Performance Committee
## 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) – <strong>in year</strong></td>
<td>Break even</td>
<td>£14k</td>
<td></td>
<td>Break even</td>
<td>£50k</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>£82,933k</td>
<td>£80,861</td>
<td></td>
<td>£505,823</td>
<td>£493,423</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>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the allowance</td>
<td>£979k</td>
<td>£975</td>
<td></td>
<td>£5,875k</td>
<td>£5,836k</td>
<td></td>
</tr>
</tbody>
</table>

### Notes:

1. The above duties correspond to those reported in Note 17 of the 2017/18 Annual accounts, and represent the statutory duties of NHS Southwark Clinical Commissioning Group (‘the CCG’). The control total for 19-20 is break even in year. We have a brought forward surplus of £12,350k which we do not have approval to spend this year. As at month 2 we are achieving £14k better than that control total.

2. To support the delivery of the above, an in-year QIPP programme of £15,661k has been established. £1,548k is left unallocated but this is being funded non-recurrently in total from balance sheet movements.

3. There is no CCG IT capital budget at this stage, and NHSE has not yet invited bids for GP IT. We are currently rolling out equipment bought last financial year.

**Note:** a red negative sign indicates budget overspend
Summary of Position (1 of 2)

- This report is for the 2 month period to end of May 2019.
- At this time we have limited historic acute and prescribing information available, with the usual 1-2 month time lags.
- There is little budget movement at this stage, but there are some key risks to be managed by the CCG.
- This includes the current shortfall in delegated PC funding, following the transfer of funds by NHSE to set up the Negligence scheme for GP’s. They have not shared their methodology with us yet.
- In addition there is a shortfall on LAS contract following final negotiations, which at present cannot be met within the acute budgets, of £150k, this is shown in risks.
- The QIPP risk of £1,548k can be met non-recurrently, by using balance sheet accrued balances that have been reassessed now that we are almost 3 months after year end, and our accounts are validated for the old year.
- In addition, we have additional risk on some locally led QIPP schemes.
Summary of Position (2 of 2)

- Reserves have hardly been drawn on in setting the m.2 budget position, so remain at a value of just over £4.4M.
- This is before any potential calls to meet the cost pressure risks above, if these cannot be offset by underspends on other budget lines. At present the primary care, and further QIPP and contract risks, are presented as risks outside the break even position, until we can be sure on both mitigations and impact.
- End of year best and worst case will be completed from m.3 as more information becomes available.
- We have block contracts with tolerances for all our main Acute and MH providers. This lessens the risk in year as well.

Note: a red negative sign indicates budget overspend
<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>247,071</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Groups</td>
<td>89,193</td>
<td>106</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community &amp; Primary Care Health Services</td>
<td>48,360</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delegated Primary Care</td>
<td>47,153</td>
<td>-96</td>
<td>-578</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transformation</td>
<td>500</td>
<td>4</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>30,203</td>
<td>-30</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better Care Fund (excluding schemes totalling £5.39m reported elsewhere: total BCF £21.45m)</td>
<td>16,441</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Costs</td>
<td>4,264</td>
<td>13</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earmarked Budgets &amp; Reserves</td>
<td>4,415</td>
<td>10</td>
<td>578</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>12,350</td>
<td>2,058</td>
<td>12,350</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>499,948</strong></td>
<td><strong>2,068</strong></td>
<td><strong>12,361</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reserves not yet utilised in above position

| Reserves not yet utilised in above position (prev month for comparison) | 4,405 | 3,837 |

**Note:** a red negative sign indicates budget overspend
# CCG Running Costs Summary 2019/20 – Month 2

<table>
<thead>
<tr>
<th>Running Costs</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 12 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running costs</td>
<td>5,875</td>
<td>4</td>
<td>39</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Prev month for comparison*

**Notes:**

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

2. The running costs budget has reduced by 10% from the 19/20 allocation so as to ensure that the CCG is in a position to meet its overall cost savings target of a 12% reduction from 18-19 levels, from 20/21 onwards.

*Note: a red negative sign indicates budget overspend*
# Acute Financial Position 2019/20

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

<table>
<thead>
<tr>
<th>Acute Contract</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>King’s College Hospital NHS Foundation Trust</td>
<td>92,243</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Guy’s and St Thomas’ NHS Foundation Trust (excluding Community contract)</td>
<td>114,292</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham and Greenwich NHS Trust</td>
<td>4,465</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>University College London Hospital</td>
<td>2,421</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>London Ambulance</td>
<td>13,900</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other contracts and non-contracted activity</td>
<td>19,750</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Acute</strong></td>
<td><strong>247,071</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**Prev month for comparison**
Notes on Acute Budgets

- The year to date position is based on a risk assessment of the 2019/20 year-end financial position, due to the limited Month 1 information available.

- The position at Month 2 shows a break even position. Future months will provide a more accurate actual and forecast position once more months SLAM information is available.

- The predicted year end position is based on the risk assessment mentioned above. The forecast methodology will be updated as relevant information is received and has gone through a verification process to ensure that it is robust enough to use for forecasting purposes.

- Block contracts with tolerances are in place for all three main contracts with Guys, Kings, and LGT Trusts.

- London Ambulance has a risk of 150k to be funded potentially, this is not included in outturn at this stage, but in risks.
## Client Group Financial Position 2019/20

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Contracts</td>
<td>58,946</td>
<td>328</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Non Contract Activity</td>
<td>5,168</td>
<td>-120</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT)</td>
<td>3,894</td>
<td>-101</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger People with Physical Disabilities (YPD)</td>
<td>7,765</td>
<td>42</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td>4,280</td>
<td>-46</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care</td>
<td>1,036</td>
<td>-137</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Services</td>
<td>3,270</td>
<td>-235</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>1,859</td>
<td>37</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing Healthcare Assessment &amp; Support</td>
<td>775</td>
<td>-121</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Health Budgets</td>
<td>1,261</td>
<td>-37</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Client Group Budgets</td>
<td>937</td>
<td>496</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Client Groups</strong></td>
<td><strong>89,193</strong></td>
<td><strong>106</strong></td>
<td><strong>0</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*prev month (for comparison)*

**Note:** a red negative sign indicates budget overspend
As at month 2, there is an underspend of £106k on mental health and CHC is breaking even. The underspend on mental health is due to 18-19 benefit on the SLAM contract while CHC is breaking even.

There has been a QIPP target of £608k set for CHC in 19-20. The plans to meet this target include: Commissioning of specialist care, securing capacity for fast track reviews, and others.

It is expected that a more detailed budgetary analysis will be available in month 3 when more information is available.

Discussions are ongoing with Southwark Council over outstanding debt due to the CCG regarding Supported Housing Scheme costs.
<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Contract (GSTT)</td>
<td>39,367</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Contract (LGT)</td>
<td>701</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Primary Care Services</td>
<td>2,375</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population Health Management</td>
<td>1,259</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Forward View and Primary Care Investments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Transformation</td>
<td>475</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Primary Care Health Services</td>
<td>4,182</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48,359</strong></td>
<td><strong>2</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

*Note: a red negative sign indicates budget overspend*
Notes on Community & Primary Care Health Services 2019-20

- Community and Primary Care Health Services are currently performing broadly in line with plan in year.
  - The new IUC contract started in March 2019. The contract is breaking even as at month 2. The budget has been enhanced from last year for the full year effect of IUC.
  - £475k has been transferred from Transformation for Practice Transformation Funding

- It is expected that GPFV funding will be made available to SEL through Southwark CCG in coming months.

**Note:** a red negative sign indicates budget overspend
## Transformation 2019/20

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LCN development</td>
<td>194</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CES</td>
<td>148</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing (including recharges)</td>
<td>158</td>
<td>4</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
<td><strong>4</strong></td>
<td><strong>0</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*prev month for comparison*

- £475k of Transformation budget has been affected by an NHSE coding requirement. As a result of the requirement, this element of the Transformation budget has been moved in Month 2 to sit within the Community and Primary Care Health Services budgets reported on the previous pages.

**Note:** a red negative sign indicates budget overspend
### Prescribing Financial Position 2019/20

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Southwark</td>
<td>14,712</td>
<td>436</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Southwark</td>
<td>12,374</td>
<td>276</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing Incentive Scheme</td>
<td>200</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs held centrally</td>
<td>880</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personally Administered Drugs</td>
<td>940</td>
<td>294</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin and Other Prescribing</td>
<td>1,097</td>
<td>-1,036</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30,203</strong></td>
<td><strong>-30</strong></td>
<td><strong>0</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*prev month for comparison*

**Note:** a red negative sign indicates budget overspend
Notes on Prescribing Budgets

- No actual April or May data for GP Prescribing is available as at Month 2.
- The report is based on our estimated position.
- Detailed practice level budgets have been calculated within the overall amount, which was set on last year's outturn, adjusted for non-recurrent issues.
The Better Care Fund (BCF) is a pooled budget between the CCG and Southwark Council and is hosted by the Council.

The CCG’s contribution to the BCF in 2019/20 is £22m. This funds a number of schemes, some of which are led by Southwark Council, and some are led by the CCG. This has been uplifted by just under 2%, and we are awaiting national guidance as we develop our plans together for 19-20.

Under the pooled budget arrangement, there is no requirement to physically transfer cash to the host for the pooled budget to exist. On that basis, the CCG only transfers the proportion of its contribution needed to fund the Council led schemes.

The reporting of the BCF is split into two segments: the amount paid to the Council, and the CCG led schemes which are reported as part of the relevant directorate. The CCG led schemes have also been included as part of the BCF section of this report to provide transparency with regard to how the full CCG BCF contribution is spent.

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Care Fund: CCG Contribution to Southwark Council led Schemes</td>
<td>16,440</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16,440</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prev month for comparison</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: a red negative sign indicates budget overspend
## Better Care Fund 2019/20 (2 of 2)

### BCF schemes reported as part of other expenditure areas

<table>
<thead>
<tr>
<th>BCF schemes reported as part of other expenditure areas</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community GSTT schemes: Admission Avoidance</td>
<td>3,965</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary Health Services schemes: Self management, Enhanced primary care access</td>
<td>1,050</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>47</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Service Development and Change Management</td>
<td>332</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,394</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><em>prev month for comparison</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total CCG contribution to BCF

<table>
<thead>
<tr>
<th>Total CCG contribution to BCF</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total CCG Contribution to BCF</strong></td>
<td><strong>21,834</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

Note: a red negative sign indicates budget overspend
## Corporate Costs 2019/20

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP IT</td>
<td>621</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development Costs for Dulwich Health Centre and Other Projects</td>
<td>421</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estates Costs</td>
<td>1,853</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines Optimisation</td>
<td>751</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy London Partnership</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Corporate</td>
<td>2,166</td>
<td>13</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>-1548</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,264</strong></td>
<td><strong>13</strong></td>
<td><strong>11</strong></td>
<td><strong>11</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

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

- These costs are **not** counted against the CCG Running Costs allocation.

- **prev month for comparison**
Primary Care Co-commissioning 2019/20

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget £000's</th>
<th>YTD Budget £000's</th>
<th>YTD Actual Expenditure £000's</th>
<th>YTD Variance £000's</th>
<th>Forecast Outturn £000's</th>
<th>Forecast Variance £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Contract</td>
<td>30,655</td>
<td>5,109</td>
<td>5,112</td>
<td>-3</td>
<td>30,673</td>
<td>-18</td>
</tr>
<tr>
<td>Population/List growth ear-marked fund</td>
<td>470</td>
<td>78</td>
<td>74</td>
<td>4</td>
<td>451</td>
<td>19</td>
</tr>
<tr>
<td>Caretaking Management</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Premium Services</td>
<td>6,018</td>
<td>1,003</td>
<td>1,003</td>
<td>0</td>
<td>6,017</td>
<td>0</td>
</tr>
<tr>
<td>QOF</td>
<td>3,116</td>
<td>519</td>
<td>519</td>
<td>0</td>
<td>3,115</td>
<td>0</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>2,023</td>
<td>337</td>
<td>337</td>
<td>0</td>
<td>2,022</td>
<td>1</td>
</tr>
<tr>
<td>Premises and other reimbursements</td>
<td>4,360</td>
<td>727</td>
<td>727</td>
<td>0</td>
<td>4,363</td>
<td>-3</td>
</tr>
<tr>
<td>PCO administered</td>
<td>969</td>
<td>161</td>
<td>161</td>
<td>0</td>
<td>968</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>-458</td>
<td>-76</td>
<td>20</td>
<td>-96</td>
<td>120</td>
<td>-578</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47,153</strong></td>
<td><strong>7,858</strong></td>
<td><strong>7,954</strong></td>
<td><strong>-96</strong></td>
<td><strong>47,729</strong></td>
<td><strong>-578</strong></td>
</tr>
</tbody>
</table>

The primary care medical budget calculated for the CCG results in a funding gap of £578k against the 18/19 allocation of £47,153k. Most of this gap arises from the reduction in funding to set up the national clinical negligence scheme for GP’s.

The net year end position is an anticipated overspend of £578k.

Note: a red negative sign indicates budget overspend
## Earmarked Budgets and Reserves 2019/20 (1 of 2)

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency</td>
<td>2,415</td>
<td>10</td>
<td>578</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unallocated Reserves</td>
<td>1,300</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Acute Winter Pressures</td>
<td>700</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,415</strong></td>
<td><strong>10</strong></td>
<td><strong>578</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Reserves not yet utilised in above position | 4,405 | 3,837 | 0 | 0 |

- As described earlier in the report, the above represents the balance left in reserves, that is utilised to offset overspending areas in acute, CHC and elsewhere.
- Only £10k of reserves has been utilised to date. More may be required to deal with in year risks.

*Note: a red negative sign indicates budget overspend*
### Earmarked Budgets and Reserves 2019/20 (2 of 2)

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Surplus</td>
<td>12,350</td>
<td>2,058</td>
<td>2,058</td>
<td>12,350</td>
<td>12,350</td>
</tr>
</tbody>
</table>

*prev month for comparison*

**Note:** A red negative sign indicates budget overspend
## Running Costs 2019/20 (Separate Allocation)

<table>
<thead>
<tr>
<th>Budget heading</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>3,668</td>
<td>29</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSU Recharge</td>
<td>1,567</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Accommodation</td>
<td>438</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>202</td>
<td>-25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,875</td>
<td>4</td>
<td>40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**prev month for comparison**

- There are no significant variances to date.
- Budgets are on target to deliver the 661k savings required as part of the QIPP programme, and towards the 20-21 target level of expenditure.

**Note:** a red negative sign indicates budget overspend
### Capital 2019/20 (Separate Allocation)

<table>
<thead>
<tr>
<th>Capital Projects</th>
<th>Annual Budget (£000s)</th>
<th>Actual Spend to Month 2 (£000s)</th>
<th>Variance to Month 2 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>prev month for comparison</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- No capital allocations have been received to date.

**Note:** a red negative sign indicates budget overspend
QIPP Monitoring

- Total total annual plan for QIPP is £15,661k of which £1,548k was unallocated. This will be found by non-recurring means.
- Southwark CCG is currently forecasting to meet almost all of its QIPP this year.

### Annual Plan

<table>
<thead>
<tr>
<th>Category</th>
<th>QIPP Target 2019-20 (Post-RAG-Rating) (£k)</th>
<th>YTD Plan (£k)</th>
<th>YTD Actual (£k)</th>
<th>YTD Variance (£k)</th>
<th>YTD RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute/Community</td>
<td>8,940</td>
<td>1,490</td>
<td>1,446</td>
<td>-44</td>
<td>0.97</td>
</tr>
<tr>
<td>Primary Care Prescribing</td>
<td>2,209</td>
<td>284</td>
<td>284</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>Corporate</td>
<td>468</td>
<td>78</td>
<td>78</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>Community &amp; Primary Health Services</td>
<td>757</td>
<td>126</td>
<td>126</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>608</td>
<td>101</td>
<td>101</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>Transformation</td>
<td>370</td>
<td>62</td>
<td>62</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>Running Costs</td>
<td>661</td>
<td>110</td>
<td>110</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>1,548</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**Southwark CCG QIPP Target 2018/19** 15,661

### Year to Date

Ytd Shortfall from plan: -2.0%

### Forecast

<table>
<thead>
<tr>
<th>Outturn (£k)</th>
<th>Variance (£k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8,615</td>
<td>-325</td>
</tr>
<tr>
<td>2,209</td>
<td>0</td>
</tr>
<tr>
<td>468</td>
<td>0</td>
</tr>
<tr>
<td>757</td>
<td>0</td>
</tr>
<tr>
<td>608</td>
<td>0</td>
</tr>
<tr>
<td>370</td>
<td>0</td>
</tr>
<tr>
<td>661</td>
<td>0</td>
</tr>
<tr>
<td>1,548</td>
<td>0</td>
</tr>
</tbody>
</table>

**Forecast shortfall from plan:** -2.1%

*Note: a red negative sign indicates budget overspend*
The Maximum Cash Drawdown (after payments made on behalf of NHS Southwark CCG by NHS Business Services Authority – PPA & HOT) is £464,709k. The actual and forecast drawdown of cash is shown in the table below. We are running slightly ahead, due to clearing old year balances.

<table>
<thead>
<tr>
<th>Cash drawdown</th>
<th>Monthly Drawdown £000s</th>
<th>Cumulative Drawdown £000s</th>
<th>Proportion of Annual Cash Resource Limit</th>
<th>KPI - 1.25% of cash balance as drawdown £000s</th>
<th>Month end cash Bank Balance £000s</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTUAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr-19</td>
<td>34,500</td>
<td>34,500</td>
<td>7.4%</td>
<td>431</td>
<td>31</td>
<td>Pass</td>
</tr>
<tr>
<td>May-19</td>
<td>44,400</td>
<td>78,900</td>
<td>17.0%</td>
<td>463</td>
<td>54</td>
<td>Pass</td>
</tr>
<tr>
<td><strong>Forecast</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jun-19</td>
<td>37,500</td>
<td>116,400</td>
<td>25.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jul-19</td>
<td>38,701</td>
<td>155,101</td>
<td>33.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug-19</td>
<td>38,701</td>
<td>193,802</td>
<td>41.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep-19</td>
<td>38,701</td>
<td>232,503</td>
<td>50.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct-19</td>
<td>38,701</td>
<td>271,204</td>
<td>58.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov-19</td>
<td>38,701</td>
<td>309,905</td>
<td>66.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec-19</td>
<td>38,701</td>
<td>348,606</td>
<td>75.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan-20</td>
<td>38,701</td>
<td>387,307</td>
<td>83.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb-20</td>
<td>38,701</td>
<td>426,008</td>
<td>91.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-20</td>
<td>38,701</td>
<td>464,709</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Total</strong></td>
<td><strong>£464,709</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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. The CCG missed the target on both numbers and values of non-NHS invoices paid and on values of non-NHS invoices paid. Action has been taken to improve performance.
Aged Debtors (Receivables) 2019/20

- The value of overall outstanding debt has reduced by £4,001k compared to the level reported at Month 12. This is due to Southwark Council paying invoices which were due at month 12.

- The £2,263k non-NHS debt contains:
  - £429k relating to 2017/18 Section 75 mental health invoices to Southwark Council.
  - £1.6 million of invoices raised in 2019 to Southwark Council re residential services for 18-19.
  - A meeting is being held with the Council this week.
<table>
<thead>
<tr>
<th>Description</th>
<th>Admin (£000s)</th>
<th>Programme (£000s)</th>
<th>Total (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial CCG Programme Allocation 2019/20</td>
<td></td>
<td>487,598</td>
<td>487,598</td>
</tr>
<tr>
<td>Running Costs Allowance 2019/20</td>
<td></td>
<td>5,876</td>
<td>5,876</td>
</tr>
<tr>
<td>Brought forward surplus from 2018/19</td>
<td></td>
<td></td>
<td>12,349</td>
</tr>
<tr>
<td>2018/19 Opening Allocations</td>
<td>5,876</td>
<td>499,947</td>
<td>505,823</td>
</tr>
</tbody>
</table>

In year Allocations:
Recommendations

1. To note the budgets and position for the ‘Programme Budgets’ and the ‘Running Costs’ as at end of May 2019.

Malcolm Hines
Director of Finance
NHS Southwark CCG
18 June 2019
OHSEL finance update – 18/19 outturn
OHSEL finance update 18/19 outturn - key messages

Contents and basis of information presented
• This report provides a high level summary of the 18/19 financial outturn for the STP and its constituent NHS organisations, including some key messages thereon.

System summary
• Before Provider Sustainability Fund (PSF) distribution, the system at year-end showed an outturn of £242m deficit, an adverse variance of £42.5m against agreed control totals.
• This was £7.8m better than expected in the M11 forecast outturn.
• Central Provider Sustainability Fund (PSF) amounts brought the total variance in submitted accounts down to £26.3m adverse.
• Following final accounts, a further £1.9m of PSF was announced by NHS England and NHS Improvement as to be distributed to SEL Providers.
• Bexley CCG and King’s reported adverse variances against their control totals. All other SEL organisations delivered on or better than plan.
## 18/19 outturn position

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>Variance</td>
<td>Total</td>
<td></td>
<td>Variance</td>
</tr>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Bexley CCG</td>
<td>(199,013)</td>
<td>(241,561)</td>
<td>(42,548)</td>
<td>(123,582)</td>
<td>(149,895)</td>
<td>(26,313)</td>
</tr>
<tr>
<td>Bromley CCG</td>
<td>07Q 644</td>
<td>684 40 34</td>
<td>644 684 40</td>
<td>07Q 644</td>
<td>684 40 34</td>
<td>644 684 40</td>
</tr>
<tr>
<td>Greenwich CCG</td>
<td>08A 300</td>
<td>334 34 302</td>
<td>300 334 34</td>
<td>08A 300</td>
<td>334 34 302</td>
<td>300 334 34</td>
</tr>
<tr>
<td>Lambeth CCG</td>
<td>08K 988</td>
<td>1,290 302</td>
<td>988 1,290 302</td>
<td>08K 988</td>
<td>1,290 302</td>
<td>988 1,290 302</td>
</tr>
<tr>
<td>Lewisham CCG</td>
<td>08L 300</td>
<td>331 31</td>
<td>300 331 31</td>
<td>08L 300</td>
<td>331 31</td>
<td>300 331 31</td>
</tr>
<tr>
<td>Southwark CCG</td>
<td>08Q 989</td>
<td>1,275 286</td>
<td>989 1,275 286</td>
<td>08Q 989</td>
<td>1,275 286</td>
<td>989 1,275 286</td>
</tr>
<tr>
<td>Guy’s And St Thomas***</td>
<td>RJ1 7,784 11,114</td>
<td>27,740 55,128 27,388</td>
<td>RJ1 7,784 11,114</td>
<td>27,740 55,128 27,388</td>
<td></td>
<td></td>
</tr>
<tr>
<td>King’s College Hospital</td>
<td>RJZ 146,030</td>
<td>189,763</td>
<td>(43,733)</td>
<td>(124,498)</td>
<td>(180,086)</td>
<td>(55,588)</td>
</tr>
<tr>
<td>Lewisham and Greenwich**</td>
<td>RJ2 53,065</td>
<td>53,912</td>
<td>(847)</td>
<td>(35,470)</td>
<td>(30,601)</td>
<td>4,869</td>
</tr>
<tr>
<td>Oxleas</td>
<td>RPG 871</td>
<td>1,014 143</td>
<td>2,965 5,933 2,968</td>
<td>RPG 871</td>
<td>1,014 143</td>
<td>2,965 5,933 2,968</td>
</tr>
<tr>
<td>South London and Maudsley**</td>
<td>RV5 680</td>
<td>658 22</td>
<td>2,460 5,757 3,297</td>
<td>RV5 680</td>
<td>658 22</td>
<td>2,460 5,757 3,297</td>
</tr>
<tr>
<td><strong>CCG Total</strong></td>
<td>3,221</td>
<td>6,026</td>
<td>(9,247)</td>
<td>3,221</td>
<td>6,026</td>
<td>(9,247)</td>
</tr>
<tr>
<td><strong>Provider Total</strong></td>
<td>(202,234)</td>
<td>(236,535)</td>
<td>(33,301)</td>
<td>(126,803)</td>
<td>(143,869)</td>
<td>(17,066)</td>
</tr>
</tbody>
</table>

**These SEL Providers had further PSF amounts distributed after the submission of final accounts, totalling £1.9m**
Risk Highlight Report

Integrated Governance and Performance Committee

June 2019

The best possible health outcomes for Southwark people
### Summary of Risks in June 2019

#### Summary of Risks on the Board Assurance Framework

<table>
<thead>
<tr>
<th></th>
<th>Extreme risks</th>
<th>High risks</th>
<th>Moderate risks</th>
<th>Low risks</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
</tbody>
</table>

#### Summary of Risks on the Directorate Risk Registers

<table>
<thead>
<tr>
<th></th>
<th>Extreme risks</th>
<th>High risks</th>
<th>Moderate risks</th>
<th>Low risks</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>18</td>
</tr>
</tbody>
</table>

Note: This summary is based on residual risk scores
There are currently 4 extreme risks on the BAF as follows:

<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Initial Risk Score</th>
<th>Residual (current) risk score</th>
<th>Highlights of Controls</th>
</tr>
</thead>
</table>
| 1.  | IC-35| Integrated Commissioning | Risk that adverse CQC inspection outcomes for general practices in Southwark will negatively impact on quality of care provided to the registered populations. | 4x5=20             | 4x4=16                        | The outcome of the CQC inspection process has resulted in adverse outcomes for some Southwark practices. The current status is as follows:  
   2 practices rated inadequate receiving support from the CCG (includes Nexus Health Group). CCG monitors practices via the contract and has issued a remedial contractual notice. Nexus has responded to this notice and the team are in the process of formally responding.  
   Improvements are monitored under the CCG contract management framework. No practices under caretaking arrangements.  
   4 practices are rated as requires improvement:  
     - all of these practices have been followed up with support from the CCG teams and LMC; 3 of these have received contractual action and 1 has been asked to submit a formal action plan to the CCG to provide assurance all issues have been addressed.  
   Primary Care Commissioning Committee (PCCC) receives updates on progress against contractual actions and CQC status changes monthly. CCG works closely with NHSE's Medical Directorate on individual performers list issues.  
   Estates Strategy: Securing high quality GP service sites has also been a challenge as a result of practice changes where these have been owned by the current of ex contract holder and continues to be a high priority for the CCG in the short and long term. This is linked to the estates strategy. (See FB-39).  
   Resilience Funding: CCG, with input from federations, have prioritised 6 practices for funding and is working with them on their resilience plans. PCCC has received an outcome report after year end. The CCG is still waiting for the 2019/20 allocation which is being discussed at SEL level. The CCG has identified local practices which would benefit from this funding and had planned for this funding. |
<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Initial Risk Score</th>
<th>Residual (current) risk score</th>
<th>Highlights of Controls</th>
</tr>
</thead>
</table>
| 2   | IC-45 | Integrated Commissioning | Risk to the sustainability of GP practices across north and south Southwark due to workforce, workload, financial pressures and infrastructure, impacting on quality outcomes for Southwark primary care patients. | 4x5=20             | 4x4=16                        | Provider resilience plan for practices in place. The CCG support to practices provided as below:  
Workforce: Investment, guidance, support re different ways of working.  
Supporting federations to develop nurse leadership to lead and retain workforce  
Care redesign: Supporting practice mergers (e.g. Nexus); GP Federations and LCNs established, infrastructure funding for at scale working, leadership development; EPCS; Estates and Technology Transformation Fund (ETTF) bids to test self care apps.  
Practice Infrastructure development, Workload management. IT support issue is affecting GP practices ability to deliver services efficiency, this issue is reported through the IG&P.  
Commissioning: Working at scale through federations will provide practices with opportunity to share resources particularly workforce which will maximise NHS resources within the contractual offer. Access tool to enable practices to identify and provide good access as rated by patients through experience (GP surgery and Family Friends Test) being implemented by practices from March 2019. (See BAF for more details)  
All practices have signed up to the Primary Care Networks as per the new GP contract that started in April 2019. The CCG is awaiting confirmation from NHS England on the application to have 2 PCNs in Southwark working with the 2 GP Federations and the coverage of patient population, 145k patients in the south through Improvement Health Limited (IHL) and 190k in the north through Quay Health Solutions (QHS). |
### Extreme Risks on BAF.. (3)

<table>
<thead>
<tr>
<th>No</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Previous score</th>
<th>Current score</th>
<th>Highlights of Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>FB-36</td>
<td>Finance and Business</td>
<td>CSU Performance: Risk that North East London Commissioning Support Unit (NEL CSU) does not deliver high quality support to Southwark CCG GP practices impacting on ability to discharge business processes and access referral pathways</td>
<td>4x4=16</td>
<td>4x4=16</td>
<td>Formal SLA monitoring process in place which take place on a monthly basis. CSU are working to an improvement plan with milestones tracked via action tracker. Managing Director working with CSU on improvements. Southwark CCG reps regularly meet with CSU around CCG and GPIT on assurance and this work is being led on our behalf by Jo Steranka. CSU reporting on fortnightly basis on progress on actions, this is also being monitored by the Lambeth and Southwark IT and Informatics Steering Group. Primary care staff have been involved in IT workshop. Regular attendance by CSU IT at PM forum re-introduced. Renegotiation of contracts for next 2 years completed. Oversight board established by Director of Commissioning Operations and IT board in place.</td>
</tr>
<tr>
<td>4</td>
<td>QN-33</td>
<td>Quality and Safety</td>
<td>Financial and Assurance Risks of the Local Authority’s Service of Notice on the CHC Discharge to Assess Pathway</td>
<td>4x4=16</td>
<td>4x4=16</td>
<td>On 10 May 2019 Southwark Council issued an open letter to Southwark CCG and local partners including GST, KCH, Lambeth Council and CCG giving four calendar days’ notice on agreed arrangements for the CHC Discharge to Assess pathway. The letter included an expectation that the CCG take full responsibility for funding the pathway at the end of the notice period. The financial risk of taking on the pathway in its current form is estimated to be between £500,000 and £750,000. CHC assessment outside of a hospital setting is NHS England’s main assurance priority for CHC, so there is a high assurance risk of not having the pathway in place. Discussions with Southwark Council and the CCG are ongoing. Council has agreed to outline its proposal but no firm proposal has been agreed; meetings have been scheduled to address the issue.</td>
</tr>
</tbody>
</table>
New/ Closed BAF risks this month

There were no new risks and no risks were closed on the BAF in June.
BAF risks: de-escalation/ escalation

No risk was escalated/de-escalated on the BAF in June
<table>
<thead>
<tr>
<th>No</th>
<th>Risk ID</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Previous risk score</th>
<th>Current risk score</th>
<th>Background and Controls/ Reason for closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CHC-01</td>
<td>Quality and Nursing</td>
<td>Failure to maintain CHC financial controls affecting CCG’s QIPP target</td>
<td>$4 \times 4 = 16$</td>
<td>$2 \times 4 = 8$</td>
<td>De-escalated. QIPP programme set up and agreed.</td>
</tr>
<tr>
<td>2.</td>
<td>QN-19</td>
<td>Quality and Nursing</td>
<td>Capacity and capability issues in the Adult CHC team may impact on patient outcomes.</td>
<td>$2 \times 3 = 6$</td>
<td>$1 \times 3 = 3$</td>
<td>Risk closed. The team has recruited to its full staffing complement and regular meetings have been agreed to develop the new staff’s understanding of their role</td>
</tr>
<tr>
<td>3.</td>
<td>IC-60</td>
<td>Integrated Commissioning</td>
<td>Risk that patients registered with practices that have now closed do not re-register with other practices leading to continuity of care issues of them and impact on ED.</td>
<td>$2 \times 3 = 6$</td>
<td>$2 \times 2 = 4$</td>
<td>Risk de-escalated as no impact seen and CCG constantly reviewing impact of closed lists on patients. National procedure for allocation of patients when they remain on a closed list has been implemented for SEL.</td>
</tr>
</tbody>
</table>
Recommendations

Note and approve the contents of the report specifically:

1. Note the changes to BAF risks with respect to updates provided by the teams, and receive assurance on the proactive management of strategic risks;

2. Note the highlights on directorate risk registers;

3. Note the current extreme risks for the CCG and the BAF risk profile depicted in the Heat Map;

4. Note OHSEL/STP BAF risks (Enc B iii) as supplied by the team for June 2019. This is a BAF risk highlight report and where applicable, this report will show the change in scores and provide explanation.

5. Approve the report and recommend it to the Governing Body.
South East London CCGs
Integrated Governance & Performance Committee
Board Assurance Framework
21 June 2019
Introduction and recommendations to the committee

• This SEL Integrated Governance & Performance Committee Board Assurance Framework is designed to support the SEL IG&P committee to provide oversight of the strategic risks that relate to all areas deemed to be within the committee’s scope as defined in the terms of reference endorsed by CCG governing bodies in November 2018 and revised in May 2019.

• The over-arching purpose of the BAF is enable the SEL IG&P committee, CCG governing bodies and any delegated local committees to be kept suitably informed of significant risks or issues and their associated mitigation plans.

• The SEL IG&P should use this document to ensure that all risks and issues related to in-scope areas are included in the BAF; that the risk-score is accurate for each; that mitigation actions are robust and achievable; that gaps are clearly identified and that assurances are noted for the purpose of verification.

• In undertaking these activities, the committee should follow the South East London CCGs Integrated Governance & Performance Committee Risk Management Framework, which sets out in detail the agreed approach to the management of risk.

• This BAF will be made available to CCGs on a monthly basis and it is proposed that this document is made available together with the CCG BAF as part of CCG Governing Body papers.

The SEL IG&P Committee is asked to undertake the following:

1. Agree that each risk / issue is accurately described

2. Review and agree the risk / issue score for each risk included in the BAF

3. Review the mitigations in place and confirm that these represent a comprehensive approach to taking action to reduce both the likelihood and potential impact of each risk. Note any gaps in risk mitigations.

4. Note any additional oversight arrangements to be set-up to provide additional levels of assurance for particular risks / issues.
The below table presents a summary of the risks related to all SEL IG&P in-scope areas. The current risk rating the is headline risk-rating post mitigations being applied. Full details of the status of each risk are provided on the following pages.

<table>
<thead>
<tr>
<th>Risk / issue reference</th>
<th>Risk / issue description</th>
<th>Current rating</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-01</td>
<td>STP for the 62 day referral-to-treatment cancer standard</td>
<td>12</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-02</td>
<td>STP trusts are not able to achieve their trajectories for timely access to emergency services as measured by the 4 hour A&amp;E target</td>
<td>12</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-03</td>
<td>STP acute trusts do not meet their monthly improvement trajectories to clear long waiters by the end of Q3</td>
<td>12</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-04</td>
<td>STP acute trusts are not able to achieve their trajectories for the number of patients on elective waiting lists</td>
<td>12</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-05</td>
<td>STP acute trusts are not able to achieve their improvement trajectories for the access to planned care as measured by the 18 week standard</td>
<td>9</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-06</td>
<td>STP acute trusts do not achieve the monthly improvement trajectories for the access to timely diagnostics as measured by the standard for diagnostic access</td>
<td>16</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-07</td>
<td>LAS contract for 19/20 will go to national arbitration and likely to result in financial pressures on all CCGs across SEL</td>
<td>12</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-08</td>
<td>The TCP will not achieve the BRS target by March 2020.</td>
<td>10</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-10</td>
<td>Ability to reduce running costs to target by 31 March 2020.</td>
<td>8</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEL-11</td>
<td>Activity related expenditure is greater than budget leading to inability to deliver the SEL and CCG control totals and financial duties.</td>
<td>15</td>
<td>x</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

Note: risk SEL-09 was closed at the SEL IG&P Committee in May 2019
## Risk 1: Cancer 62 day pathways

<table>
<thead>
<tr>
<th>Risk</th>
<th>Issue</th>
<th>Relating to which period?</th>
<th>CCGs impacted by this risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-01</td>
<td>The risk that the STP acute trusts do not achieve the monthly improvement trajectory for the access to cancer treatment as measured by the standard for 62 days from GP referral to treatment.</td>
<td>April 19 – March 20</td>
<td>Bexley Bromley Greenwich Lambeth Lewisham Southwark SEL-wide</td>
</tr>
</tbody>
</table>

### Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-01 | The risk that the STP acute trusts do not achieve the monthly improvement trajectory for the access to cancer treatment as measured by the standard for 62 days from GP referral to treatment. | 3 | 4 | 12 | • Trusts have developed actions plans to deliver their 62 day trajectory including a SEL Recovery Plan specifically focusing on shared pathway actions and performance.  
• Monthly performance meetings with acute trusts – focus on internal trust performance and actions relating to them. This covers areas not picked up by the 62 day Leadership Group (see below)  
• Monthly System Leadership Group – 62 day leadership meeting with a focus on the shared pathway actions and performance  
• The SCCD (Shared Care Cancer Delivery Team) the operational arm of the ACN – virtual team including commissioners to progress actions on a day to day basis. Monthly ACN Steering group.  
• Monthly Members Board – a trust CEO, COO board which will facilitate trust level escalation where plans are not being progressed. | 3 x 4 = 12 | • The SEL recovery plan with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.  
• Trust performance reports for performance meetings; monthly performance against trajectory by trust and CCG; minutes of performance meetings.  
• Trust performance report to 62 day leadership group showing progress updates for actions by trust and tumour type; minutes and action log from 62 day leadership meeting.  
• SEL sector dashboards showing information such as median wait to first outpatient, diagnostic turnaround time.  
• Project summary highlight reports with RAG ratings.  
• Papers and minutes of the monthly Members Board. |

### Forward-view on this risk / issue:

**Further comments and additional planned mitigations to be enacted:***

- Employment of additional staff to create a specialist cancer management sector workforce, including senior operational management, junior operational management and patient navigator roles for relevant trusts sites. The aim of this recruitment is to deliver sector commitments in relation to improving performance and delivering timed pathways, and also provide support and buddying/mentoring for trust staff in more general roles involving cancer. £1.2million of transformation funding has been assigned to this new team.
- A review of trust-level plans to ensure that they meet the requirements of the overall SEL plan – these have been done for 4 or the 5 sites, with the final meeting in June/July.
## Risk 2: A&E 4 hour target

### Ref Description and key drivers

**Likelihood Impact**

<table>
<thead>
<tr>
<th>Initial Risk Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Trusts have developed action plans to deliver their trajectory for improving performance against the 4 hour standard. These plans are linked to the SEL strategy for improvement in non-elective services.</td>
</tr>
<tr>
<td></td>
<td>Monthly performance meeting with acute trusts reviews progress against the trust specific trajectories.</td>
</tr>
<tr>
<td></td>
<td>ICDT team members attend internal trust meetings relating to A&amp;E performance delivery.</td>
</tr>
<tr>
<td></td>
<td>Monthly A&amp;E delivery boards at both local and SEL-level provide oversight on system delivery for non-elective services.</td>
</tr>
</tbody>
</table>

### Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-02</td>
<td>The risk that the STP acute trusts are not able to achieve their trajectories for timely access to emergency services as measured by the 4 hour target. In 2019/20, trust trajectories are to deliver improvements in the timeliness of access rather than achieve the national standard of 95%, which is reflective of the challenges faced by all acute providers in SEL.</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>4 x 3 = 12</td>
<td>• The individual trusts recovery plans with SMART actions and senior level action owners; KPIs to measure delivery of the actions; risk and issues log – all of which will be updated monthly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Trust reports to their internal A&amp;E delivery meetings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Monthly reports, papers and minutes of A&amp;E delivery boards.</td>
</tr>
</tbody>
</table>

### Risk Issues

- Relating to which period?
  - April 19 – March 20

### CCGs impacted by this risk

- Bexley
- Bromley
- Greenwich
- Lambeth
- Lewisham
- Southwark
- SEL-wide

### Forward-view on this risk / issue:

Further comments and additional planned mitigations to be enacted:

- UEC System meeting with each site and respective CCG, community and primary care colleagues to assess current performance against plan and establish if any further system-wide support or external support is required to ensure delivery of the trajectory.
# Risk 3: 52 week waiters

## Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-1003</td>
<td>The risk that the STP acute trusts do not meet their monthly improvement trajectories to clear long waiters by the end of Q3. Long waiters are defined as any patient referred by a GP who has been waiting more than 52 weeks and is still waiting at month end. The count of long waiters is a monthly census.</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>• Trusts have developed actions plans to deliver their reduction trajectory for long waiters.</td>
<td>3 x 4 = 12</td>
<td>• GSTT and KCH recovery plans with SMART actions and senior level action owners; KPIs to measure delivery of the actions; and a risk and issues log, all of which will be updated monthly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Monthly performance meeting with acute trusts will review progress against the trust specific trajectories.</td>
<td></td>
<td>• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• ICDT team members attend additional internal RTT meetings at GSTT and KCH.</td>
<td></td>
<td>• Additional weekly report on current long waiters at KCH.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Detailed monthly report on current and prospective long waiters at KCH.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Clinical Harm Reviews are undertaken for long waiting patients and updates are given at the relevant CQRG meetings.</td>
</tr>
</tbody>
</table>

## Forward-view on this risk / issue:

- Reviewing and agreeing final performance improvement plans for KCH.
## Risk 4: RTT waiting list (PTL) size

### Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-04 | The risk that the STP acute trusts are not able to achieve their trajectories for the number of patients on the waiting list (patient tracking list or ‘PTL’ size). | 3 | 4 | 12 | • Trusts have developed actions plans to deliver their trajectory for managing their RTT performance and RTT 18 week performance.  
  • Monthly performance meeting with acute trusts will review progress against the trust specific trajectories. | 3 x 4 = 12 | • The individual trusts recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly. However, the ICDT have requested LGT and KCH to further develop their performance improvement plans, to ensure that key challenges are fully addressed.  
  • Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risks and issues; minutes of performance meetings. |

### Impact on CCGs:

- **Bexley**
- **Bromley**
- **Greenwich**
- **Lambeth**
- **Lewisham**
- **Southwark**
- **SEL-wide**

### Forward-view on this risk / issue:

- Further refinement for the KCH and LGT performance improvement plans

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### Notes:

- April 19 – March 20
- CCGs impacted by this risk
- Risk Issue Relating to which period?
### Risk 5: Achievement of 18 week RTT standard

**Risk status:**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-05 | The risk that the STP acute trusts are not able to achieve their improvement trajectories for the access to planned care as measured by the 18 week standard for patients being referred by a GP for treatment. | 3           | 3      | 9             | • Trusts have developed actions plans to deliver their trajectory for managing their RTT performance.  
• Monthly performance meeting with acute trusts will review progress against the trust specific trajectories.  
• ICDT team members attend additional internal RTT meetings at GSTT and KCH. | $3 \times 3 = 9$ | • The individual trusts recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.  
• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings. |

**CCGs impacted by this risk:**

<table>
<thead>
<tr>
<th>CCG</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**Relating to which period?**

April 19 – March 20

**Impacted by risk**

- x

---

**Forward-view on this risk / issue:**

- Further comments and additional planned mitigations to be enacted:
  - Further refinement for the KCH and LGT performance improvement plans

---

**Governing Body 11.7.19-11/07/19**
## Risk 6: Access to diagnostics

### Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-06 | The risk that the STP acute trusts do not achieve the monthly improvement trajectories for the access to timely diagnostics as measured by the standard for diagnostic access. The diagnostic standard assesses a basket of diagnostic tests against the requirement that collectively no more than 1% of patients should be waiting more than 6 weeks at the end of each month. | 4          | 4      | 16            | • Trusts have developed actions plans to deliver their diagnostic trajectory.  
• Monthly performance meeting with acute trusts will review progress against the trust specific trajectories.  
• Additional meetings are being held with PRUH site lead to oversee the delivery of the PRUH trajectory. | 16           | • The individual trusts recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.  
• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings. |

### Forward-view on this risk / issue:

- ICDT now takes part in the weekly endoscopy oversight meetings at KCH and are meeting with KCH to review demand and capacity model.
- LGT to produce a performance improvement plan for diagnostics, as recent performance has not been in line with expectations – i.e. compliance with national thresholds.
## Risk 7: Agreement of LAS contract for 2019/20

### Ref Description and key drivers

<table>
<thead>
<tr>
<th>Risk</th>
<th>Issue</th>
<th>Relating to which period?</th>
<th>CCGs impacted by this risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-07</td>
<td>-</td>
<td>April 19 – March 20</td>
<td>X</td>
</tr>
</tbody>
</table>

### Likelihood Impact

- **Initial Risk Score:**
  - SEL-07: 4 x 3 = 12

### On-going controls (pan-SEL) and frequency

- Negotiation is ongoing between the NWL LAS commissioning team and LAS around the Hear & Treat activity figures. SEL commissioners are involved in the discussions to help devise a reasonable plan.
- Ongoing communication from the NWL LAS commission team to all STPs to inform ongoing discussions.

### Residual Score Assurances

- SEL Exec has been kept appraised of the current status of negotiations by the SEL ICDT.
- Updates have also been provided via the SEL Finance Planning and Delivery Committee.

### Forward-view on this risk / issue:

- **Further comments and additional planned mitigations to be enacted:**
  - To be specified following next stage of arbitration process.
## Risk 8: SEL Transforming Care BRS target 2019/20

### Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Risk Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL- 08</td>
<td>The TCP will not achieve the Building the Right Support (BRS) target by March 2020.</td>
<td>4</td>
<td>4</td>
<td>15</td>
<td>Weekly Programme meeting with SROs (Neil Kennett-Brown and Fiona Connolly) for risk and issues escalations.</td>
<td>2 x 5 = 10</td>
<td>Monthly assurance meetings with NHS England.</td>
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<td></td>
<td>TCP PMO fortnightly risk and issue review.</td>
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<td>Monthly reporting to SEL IG&amp;P</td>
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<td>Monthly inpatient surgery to review case management and ensuring that patients are able to return to the community as soon as clinically appropriate</td>
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<td></td>
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<td></td>
<td>Monthly TCP Operational and Strategy board meetings with health and social care stakeholders.</td>
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<td></td>
<td>CCG governing bodies, SEL Executives and DASS to be updated regularly throughout 2019-20.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Forward-view on this risk / issue:

- Established additional programme management and case management resource with a focus on actions to improve discharge processes, admissions management and building capacity in the community to reduce of length of stay.
- Building capacity in the community by the establishment of Autism Support Services across South East London and new intensive community support for Lewisham, Bexley, Bromley and Greenwich and expansion of Lambeth Without Walls services to ensure that more people are cared for in the community.
- Mobilising additional positive behavioural support training offered to family carers of people with learning disabilities and autism who exhibit behaviours that challenge to prevent admissions.
- Established enhanced data analysis to inform decision making, with regard to patient care and required targeted support to understand the current service provision locally for the transforming care cohort.
- Development of accommodation models for the cohort in collaboration with DASS, to support complex cases.

### CCGs impacted by this risk

- Bexley
- Bromley
- Greenwich
- Lambeth
- Lewisham
- Southwark
- SEL-wide

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</tr>
</thead>
</table>

### Relating to which period?
- March 19 – March 20
## Risk 10: Delivery of CCG running cost reduction

### Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Risk Assurances</th>
</tr>
</thead>
</table>
| SEL-10 | Risk that CCGs will not achieve the running costs reduction target by 31 March 2020. Actions include the review of CCG functions, structures, governance and future model. | 3 | 4 | 12 | • Budgets have been set net of the required running cost reduction and all CCGs are in the process of finalising plans to deliver this saving in 2019-20.  
• CCG financial governance in place and overseen by governing bodies and delegated committees (where relevant), SELCA Executive and SEL IG&P.  
• Recruitment controls are in place across SEL CCGs panel made up of AO, CFO and Director of System Reform | 2 x 4 = 8 | Monthly reporting to SEL IG&P CCG governing bodies to be updated by CFO / SELCA finance team / DoFs in April and regularly throughout 2019-20. |

### Further CCG-specific risk controls in place:

**Further CCG-specific actions**

- CCG-specific updates will be completed following review of M2 financial performance reports with CCG DoFs and finance teams (scheduled for mid-to-late June 2019).

### Forward-view on this risk / issue:

**Further comments and additional planned mitigations to be enacted:**

- CCG-specific updates will be completed following review of M2 financial performance reports with CCG DoFs and finance teams (scheduled for mid-to-late June 2019).
### Risk 11: Delivery of SEL and individual CCG control totals in 2019/20

#### Risk status:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Risk Assurances</th>
</tr>
</thead>
</table>
| SEL-11 | **Risk that expenditure in 19/20 is greater than plan/budget leading to:**  
  1. inability to deliver the SEL CCG collective and/or individual CCG control totals in 19/20.  
  2. inability to deliver Individual CCG CTs and financial duties                                                                                                                  | 3          | 5      | 15                 | • Budgets in process of being set per the submitted operating plans that achieve the control total. The budgets to be taken to CCG governing bodies in May 2019 for approval.  
  • Acute contracts all signed and contract form mitigates the majority of in-year acute overperformance risk  
  • CCG financial governance in place and overseen by governing bodies and committees, SELCA Executive and SEL IG&P.  
  • SEL risk-share arrangement currently being reviewed and refreshed for 2019-20 and taken through required CCG governance in July.  
  • CFO/AO led CCG specific and SEL-wide monthly finance & QIPP assurance meetings in place for improved scrutiny assurance.                                                                 | 3 x 5 = 15 | Monthly financial review meetings with NHS England  
  Monthly reporting to SEL IG&P  
  CCG governing bodies updated by CFO / SELCA finance team / DoFs in April and regularly throughout 2019-20.  
  Block contract agreed for SEL providers  
  0.5% general contingency in CCG plans |

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### Further CCG-specific risk controls in place:

#### Further CCG-led actions

**Bexley:** highest risks CCG. CCG-specific updates will be completed following availability of M2 financial performance reports.

**Other SEL CCGs:** CCG-specific updates will be completed should financial performance data show adverse forecast position.

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### Forward-view on this risk / issue:

**Further comments and additional planned mitigations to be enacted:**

- Section will be completed following review of M2 finance data.
NHS Southwark CCG Audit Committee

Minutes of the meeting on 18 April 2019

Room 117 Tooley Street

Present: Richard Gibbs Lay Member, SCCG (Chair) [RG]
Dr. Noel Baxter GP Clinical Lead [NB]
Joy Ellery Lay Member, SCCG [JE]
Andrew Nebel Lay Member, SCCG [AN]
Dr. Yvonneke Roe GP Clinical Lead [YR]

In attendance: Melanie Alflatt Counter Fraud Specialist, TIAA [MA]
Halima Begum Sr. Financial Accountant, NEL [HB]
Janice Fris Sr. Financial Control Manager, NEL [JF]
Heather Gava Interim Corporate Secretary, SCCG [HG]
Malcolm Hines Director of Finance, SCCG [MH]
Vince Kelly Senior Finance Manager, SCCG [VK]
Dr. Olufemi Osonuga Council of Members representative [OO]
Neil Thomas External Auditor, KPMG [NT]
Sartaj Virdil Internal Audit Manager, RSM UK [SV]

Apologies: Nick Atkinson Internal Auditor, RSM UK [NA]
Ali Azam External Audit Manager, KPMG [AA]
Andrew Bland Accountable Officer, SCCG [AB]
Inge Damiaens Security Management Specialist, TIAA [ID]
Ross Graves Managing Director, SCCG [RGr]
Usman Niazi Chief Financial Officer, SCCG [UN]
Robert Park Lay member, SCCG [RP]

1. Introductions and apologies

The Chair welcomed everyone to the meeting and there was a round of introductions.

Apologies were noted.

2. Declarations of Interest

A round of declaration of interests was conducted. No changes and no conflicts relating to items on the agenda were declared.

The interests sheet was circulated for signing.

3. Minutes of the meeting held on 27 March 2019

ACTIONEE

Chair: Jonty Heaversedge
Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people
The minutes were approved as an accurate record of the meeting.

4. **Enc B - Matters arising – Action Log**
   - The completion deadline for four actions on the log was rolled forward to May 2019.
   - All other actions were confirmed as completed and agreed to be closed.

5. **Director of Finance’s report**
   - MH introduced his report by summarising the financial year 2018/19. The CCG had started with low opening reserves and there had been in-year cost pressures. Block contracts and local risk share arrangements with King’s, GSTT, and SLaM had afforded a degree of protection, and year-end positions had been agreed with all three providers. These were outlined, together with the main factors contributing to them. The CCG had delivered over 95% of its QIPP programme. Overspends and underspends in some specific areas had emerged at year end, but the CCG had achieved a surplus of £1269, compared with a control total of £989K.
   - The Committee noted the CCG’s overall financial performance for 2018/19 and commended the finance team and all others who had contributed to a successful outcome.

**Enc C – Draft Annual Report**
   - The draft report and the Annual Governance Statement had both been circulated in draft prior to the meeting, and comments had been received and taken into account.
   - There were no further comments on the main body of the report or the Annual Governance Statement, which were approved by the Committee. JE requested that the summary Annual Report should be available in ‘Easy Read’ format.

**Action:** This request to be passed to the Communications lead for actioning.

It was noted that in the Members’ Report AB and UN were shown as persons with significant management control and MH explained that this treatment was on the advice of the External Auditor, given that these two officers’ roles covered more than one CCG. Their costs, together with those of MH, had been split and recharged as appropriate across the relevant CCGs, and this was reflected in the Remuneration Report. The Committee noted the tables for senior manager remuneration, and for pension benefits. It was also noted that in the Staff Report the total of 146 employees reflected posts hosted by the CCG as well as its own employees. The reported level of sickness was 1.25%. The Committee...
noted the expenditure on consultancy and contingent labour, and the information on off-payroll engagements.

Referring to the Staff Report, AN queried the number of lay members shown in table 1.1.1.1, and the split by gender for clinical leads. He also asked why such a high proportion of consultancy and contingent labour costs related to core CCG business, given the significant amount of work being undertaken through STP programmes.

**Action:** Additional information about STP/CCG spend on consultancy and contingent labour costs to be added.

The Members’ report, the Remuneration Report, and the Staff Report were approved by the Committee, subject to the inclusion of the additional information on consultancy and contingent labour costs.

**Enc D – Draft Annual Accounts**

MH outlined the primary statements and accompanying notes to the accounts for 2018/19, which had been submitted to NHS England the previous evening, along with the Annual report. The following points were noted:

- The majority of the CCG’s ‘income’ was in the form of allocations.
- Non-current assets held by the CCG were mostly IT equipment. The cost of all GP IT was charged back to NHS England.
- Taxpayers’ equity showed a net liability, as was the case for all CCGs.
- The year-end cash position was very satisfactory (£21K).
- The accounting policies had been reviewed by the Committee at its March meeting.
- There was no deferred income.
- Expenditure on employee benefits had fallen to £7.6m compared with £9.1m in 2017/18, but there had been an increase in STP costs which partly offset this.
- The number of people employed had increased, but overall staff costs had fallen.
- No exit packages had been agreed during 2018/19.
- Prescribing costs had fallen by over £1m compared with 2017/18.
- The increase in expenditure on services from trusts of just under 3% reflected tariff uplifts and increased activity.
- Overall performance against the Better Payment Practice Code was good, though the 95% target had been narrowly missed for non-NHS invoices.
- Additions to property, plant and equipment all related to IT and the majority had been covered by allocations from NHS England.
- Receivables showed little year on year movement.
The payables figure was high at £49m, and represented a significant increase over the previous year’s figure of £35m. This had been checked by the Finance Team and confirmed as being in line with the agreement of balances, and included £3-4m in respect of the agreed year end positions with the CCG’s main provider trusts.

The 2017/18 provision of £277K had related to HMRC liabilities in respect of Board members. Settlement for 2017/18 had been agreed with HMRC during 2018/19 and this was no longer an issue as Board members were now on the CCG’s payroll.

Note 15 related to pooled budgets, of which the Better Care Fund was the only one.

The table of related party transactions showed Robert Park in relation to the Nunhead Surgery and this was an error (Yvonneke Roe should replace Robert Park).

MH answered a number of questions from Committee members:

- RGi asked about the General Fund figure of £38,218K shown in the Statement of Financial Position, and it was noted that this was not the same thing as the reserves shown in the CCG’s budget.
- AN asked about the £597K shown for ‘other professional fees’ in the analysis of operating expenses. This had been nil in 2017/18. It was noted that this reflected a difference in how professional fees had been categorised.
- OO noted that GP contract expenditure had fallen by about £1m compared with the previous year. It was noted that none of the CCG’s work with practices had ceased during 2018/19 and that the previous year figure was likely to include some non-recurrent expenditure.
- RGi asked why expenditure on the Chair and non-executive members had increased from £87K in 2017/18 to £145K in 2018/19. It was noted that there had been some one-off adjustments relating to pension contributions in 2018/19.
- RGi noted table 8.2 which showed that receivables past their due date but not impaired had fallen compared with 2017/18, and it was noted that the introduction of IFRS 9 had required 2017/18 balances to be restated. IFRS 9 set out how provisions for bad debts were to be stated.
- Table 10 (payables) was discussed, in particular the increase in non-NHS accruals from £17m to £23m compared with 2017/18. MH explained that much of this related to non-contracted activity, with high levels of accruals in place for Continuing Health Care and Children’s. This was a timing issue rather than one of volume, reflecting in part the CCG’s under-utilisation of its cash drawdown facility for March.
- OO asked whether vacancy levels posed a risk and it was acknowledged that the position was more challenging than in 2017/18.
The Committee approved the draft accounts for 2018/19.

**Service Auditor Report**

It was noted that the Capita report had been received and would be circulated to the Committee. The CSU assurance report would also be circulated when received.

### 6. Internal Audit

**Enc E – Head of Internal Audit Opinion**

SV presented the draft opinion for 2018/19, which was ‘green’. The final opinion would be issued once the two outstanding internal audit reports had been finalised, and the service auditor report had been received. The final opinion would be reported to the Committee at its May meeting.

**Enc F – Progress Report**

The Committee noted the progress report.

### 7. External Audit

It was noted that the audit of the year end accounts was about to commence.

### 8. Counter Fraud

**Enc G – Counter Fraud Self Review Tool**

MA presented the results of the self-review. The overall result was ‘green’ with only one area assessed as amber, around pre-employment checks for staff. Checks carried out by the CSU HR function in relation to staff employed directly by the CCG complied with NHS guidelines, and a review of agency pre-employment checks was scheduled for Q1 of 2019/20. The review would also cover the process for ensuring that any change in status which occurred during employment was identified and addressed. MA confirmed that all CCGs were being rated as amber on this issue until the review had been carried out.

In response to a request from AN, MA gave a brief description of the fraud cases currently under investigation.

### 9. Any other business

There was no other business.
<table>
<thead>
<tr>
<th></th>
<th>Date of the next Audit Committee:</th>
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<tbody>
<tr>
<td></td>
<td>Friday 24 May 2019</td>
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</table>
1 Welcome, introductions and apologies for absence

JE welcomed everyone and invited introductions from members.

JE noted apologies of absence

A Register of Interests was circulated for individual update. No conflicts of interest were noted.

2 Minutes of previous meeting (February 2019), actions and matters arising meeting

The meeting agreed the minutes held on 7 February 2019 as an accurate record.

Order of agenda changed to accommodate early departure of RG.

Actions from previous meeting

Actions from previous meetings were noted as completed or being progressed as noted below:

- JE reminded the meeting to share lessons learnt from trainings attended and suggested such updates as a standing agenda item.
• Draft patient choice policy to be completed by summer 2019. RW noted that delay on finalising the policy is due to the planned care team in Southwark no longer existing as staff have moved into south east London teams. RW to liaise with RG to close action.
• Update on Healthwatch report on crisis and mental health at June meeting

Matter Arising
• RW referred the meeting to page three of 7 February 2019 minutes about challenges faced by refugees and asylum seekers in relation to local GP registration. She added that the CCG is working with Doctors of the World on a ‘Safe Surgery Initiative’ and further noted that the update delivered by colleagues in the Adult Safeguarding Team was given a positive reception at the Forum for Equality and Human Rights in Southwark meeting. YR added that this initiative was advertised at a recent Protected Learning Time event to ensure all GP surgeries are following the correct GP registration process.
• JE confirmed that the latest Patient and Community Engagement Indicator, CCG Improvement and Assessment Framework was duly submitted and thanked EPEC members for their contribution at the previous meeting to updating required information for Southwark CCG.

3 Report of the engagement that took place in Southwark as part of the review of the interpreting and translation service.

RW noted that Lewisham CCG are the coordinating commissioner for the service. Points from the engagement undertaken include:
  o Targeted engagement was undertaken with members of identified groups in the top languages requested by Southwark patients: Spanish, Mandarin, Cantonese, Portuguese and Vietnamese.
  o However, there are no community centres in Southwark working with Mandarin and Cantonese speakers and so engagement with them was led by Lambeth CCG via the Lambeth Chinese Community Association.
  o The survey was translated into the top nine languages across the three boroughs involved
  o Audio files in translation and a BSL film were also produced to enable access to the survey to promote inclusion
  o Page ten of the report highlight a list of organisations contacted including those who did not respond.
  o The survey was promoted on the CCG website, via social media, Southwark eBulletin and through extensive outreach activities to advertise the engagement widely.

RW noted that Lambeth and Lewisham have their own independent reports on the engagement and circulated an executive summary of the overall report.

RW highlighted some demographic information from survey respondents.

It was noted that a key learning from the outreach aspect of the engagement is to ensure that Southwark CCG forges independent links with emerging communities.

It was also noted that better use of resources at GP practices would support a more targeted engagement campaign.
It was suggested that adult education establishments could also contribute to a targeted engagement campaign.

DC remarked that immigration status may hinder effective engagement with some people from emerging communities.

RW advised that there will be further discussion with colleagues in Lambeth and Lewisham on how to action engagement findings including what needs to be done in relation to comprehensive training with quality assurance processes. JE noted that to avoid blurring the lines, it must be highlighted that interpreters are not advocates.

RW noted the following survey findings:
- 44% of Southwark respondents did not require an interpreter
- 57% of respondents had not been told about the interpreting or translation service
- 44% of respondents noted that they had requested for an interpreter, but told they couldn’t have one
- Some respondents have been asked to bring along a family member
- Some respondents noted that they have opted to bring a family member
- 22 comments about what could be improved in the service were submitted
- Better knowledge of medical terminology for interpreters
- 65% of respondents said they would consider using a video service for interpreting or translation

RW further highlighted issues noted in relation to primary care. These include:
- Preference by some of face to face interpreting service due to concern about quality of over the telephone service
- Ability to book telephone interpreting on same day Set up time of telephone interpreting service that often impacts on consultation time
- Variation in dialect was highlighted

In summary, RW noted that there are three separate CCG reports and one overarching report in place for the engagement to inform the commissioners. RW added the three boroughs spoke directly to 263 people, 238 patients completed the survey across three boroughs and 216 members of staff across the three boroughs completed the survey.

RW further highlighted that there were similar issues raised by respondents across the three boroughs. JE noted that similarity in findings across the three boroughs constitute added assurance and sought further clarification on whether there are languages requested that the service cannot provide interpreters for. RW clarified that in 2017/18, no language request was turned down.

To this end, JE added that it is important to ensure that findings from the engagement is used to shape the future development of the service. She invited further comments on the engagement to which members of the committee noted that they were assured of the engagement undertaken and further noted that the report on the engagement was good.

It was noted that the committee was assured of the engagement undertaken.
### 4 Review of Membership, Engagement and Equalities Workplan 2018/2019

One of the roles of EPEC is to monitor the engagement workplan. To this end, RW highlighted the engagement team workplan for 2018/19 including:

- Developing a regular PPG Network meeting
- Developing training on running effective PPGs, including a bespoke training for Nexus
- Updating PPG top tips (February 2019)
- Meeting with PPG groups
- Ongoing meetings with equalities group and action plan is monitored through the equalities leadership group
- RW noted that the team continues to support OHSEL, which is the Sustainability and Transformation Programme for South East London as required.
- Supported Local Care Network (LCN) to run focus groups in September 2018 to explore what is important to people locally
- Further update on Partnership Southwark to be shared with EPEC. RG added that this links in with role of GP federation and LCN.
- Support for Lambeth and Southwark Strategic Partnership in terms of contributing to the planning of the engagement meetings in April 2018 and March 2019
- Mental health and wellbeing implementation strategy meeting in autumn 2018
- Ongoing engagement in the development of the health centre in Dulwich
- Involvement of member practices including GP bulletin
- CCG lead for the 360° stakeholder survey
- Patient films and case studies for Governing Body meetings
- Analysing the staff survey results through an equalities lens

JE further noted that it is important for the engagement team’s workplan to align with the work of Partnership Southwark. She further noted the large amount of work that the team had undertaken in 2018/19.

The committee were assured in the delivery of the 2018/2019 membership, engagement and equality workplan.

### 5 Update from member groups and organisations

**North locality PPG, 6 March 2019.** It was noted that the meeting took place at a new venue.

Items discussed include:

- LCN and better understanding of neighbourhood work
- Update by Healthwatch including invitation to attend a Lambeth and Southwark Strategic Partnership event on 20 March 2019

**South locality PPG, 12 March 2019.**

Items discussed include:

- Launch of the new NHS App
- Development of the health centre in Dulwich. [A fly through can be found on the Southwark CCG website](#)

**PPG Network, 26 February 2019.**

- It was noted that 19 people attended, which was far less than the number who had booked to attend via Eventbrite.
- Training on social media as part of a suite of communication tools for PPGs
- A reminder of next PPG Network meeting on 12 June 2019, as part of PPG Awareness week.

Healthwatch

NL shared current activities being undertaken by Healthwatch Southwark. These include:
- Joint Lambeth and Southwark Strategic Partnership event on 20 March 2019 exploring how health and care services can support the future of Lambeth and Southwark communities. It was noted that 92 people attended the event and a top-line review of the event highlighted need for more representation from young people.
- Southwark faith and health summit took place on 26 February 2019 to discuss the progress faith groups have made in various health and wellbeing initiatives and how faith groups can make more positive contributions in this regard. It was noted that an event is planned to support faith groups in accessing funds more effectively.
- Working on patient’s experience on social prescribing
- Enter and view at Tower Bridge Care Home
- Solution focussed event on responding to issues raised in the LGBT survey scheduled to take place in June.

DC suggested linking PPGs to their local faith groups to contribute to raising awareness for PPGs.

Forum for Equalities & Human Rights in Southwark (FEHRS). It was noted that the latest FEHRS newsletter will be circulated via email in due course.

PPV training:
- DC stated that he was unable to attend training as booked.
- MC attended the three-day Effective Lay Partner Programme at the London Leadership Academy and reported that she would recommend the training; it covered the Long Term Plan and new service models, quality improvement approaches, co-production and how to influence to bring about change
- JK noted that he had attended the two day PPV partners training course

RW further highlighted some relevant future training provided by NHS England that was in the flyer sent out with the paper for the meeting. She noted that BO will continue to send out relevant training to EPEC members highlighting which is relevant to patient reps as opposed to that aimed at staff.

### Engagement activity report October 2018 - March 2019

As an item for discussion, BO highlighted the engagement activities the CCG has undertaken from October 2018 to March 2019, noting:
- engagement activities with partners like Southwark Council and voluntary sector organisations
- developing patient films about what it is like to live with multiple long term conditions
- north and south locality PPG meetings
- PPG training for running better PPG meetings
- various outreach meetings - often as part of the Interpreting and Translation Service review
- PPG resources – updated PPG top tips
AOB
DC shared information about a proposed new centre for eye care, research and education by Moorfields Eye Hospital. It was noted that this new facility would bring together clinical care, research and education expertise in one flexible, fully integrated facility, while being focused on patients and attracting and retaining the best clinicians, scientists and educators. The project is being led by Camden CCG on behalf of Islington CCG. DC added that the new centre will be benefit all Londoners.

As a volunteer, KC was part of a small group that edited an NHS England complaints letter to make the letter shorter and easier to read. It was noted that the revised letter will be trialled from 26 April 2019 for three months to see if the return rate improves. RW to share further suggested amendments with KC.

JE thanked everyone for their input and brought the meeting to a close.

Future meetings:
- 6 June, 5pm; 2 August, 2pm.
# Outstanding actions from previous meetings

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Agenda item</th>
<th>Action Point</th>
<th>Update</th>
<th>Date to be completed</th>
<th>Lead</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 December 2018</td>
<td>Feedback from north and south PPG meetings</td>
<td>To raise issues about the draft patient choice policy and how to advertise it with the planned care team</td>
<td>Comments raised by members of PPGs have been fed back to planned care team to be incorporated into next draft for discussion at locality meetings before agreement at IG&amp;P. RW to comments on the draft patient choice policy and the EPEC discussion about how to advertise patient choice.</td>
<td>Summer 2019</td>
<td>RW/RG</td>
<td>In progress</td>
</tr>
<tr>
<td>7 December 2018</td>
<td>Feedback from Healthwatch</td>
<td>To have an agenda item on the Healthwatch report on Crisis and Mental Health at the June meeting</td>
<td>This has been added to the agenda forward planner</td>
<td>June 2019</td>
<td>RW/NL</td>
<td>In progress</td>
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</tbody>
</table>
The Chair welcomed all to the meeting.

Apologies were noted.

Welcome

Introductions and apologies for absence

Apologies were noted.
Declaration of interests

All members were asked to declare any change in interest and any conflicts relating to items on the agenda. JE declared a new interest: she had recently been appointed as lay member on the NICE Guidelines Committee on heart valve disease and treatment. Other than this there were no changes, and no potential conflicts were identified.

The declaration of interests register was circulated for signing.

Minutes of previous meeting, action log and matters arising

The minutes of the meeting held on 28 March 2019 were agreed as an accurate record of the meeting, subject to the following amendments:

- Agenda item 6: ‘RGi highlighted the overspend on Children’s Services’ to read ‘...overspend on client group Children’s Services.’
- Agenda item 7: ‘It was noted that the risk of harm to patients was perceived to be low, though there was no evidence to support this position’ to read ‘...low, evidence to support this position was being provided.’

The action log was reviewed, and updates and completed actions noted.

With reference to the Quality Report, JE asked whether the meeting with Guy’s to discuss patients lost to follow up had taken place. JF confirmed that it had and would provide an update outside the meeting. JF added that the position at King’s was better than originally thought, with the number of patients categorised as lost to follow up being largely historic.

CCG Board Assurance Framework update and SEL Board Assurance Framework

RGr presented a brief report explaining that the CCG’s Board Assurance Framework was in the process of being refreshed following the recent Governing Body risk workshop. The updated BAF would be presented to the Committee in May.

The Committee noted the CCG Board Assurance Framework update and the SEL Board Assurance Framework.

CCG finance report 2018/19 (M12) and SEL finance report 2018/19 (M11)

MH presented the finance report for month 12, which indicated that subject to audit, the CCG had met all its statutory financial duties in 2018/19. It was noted that the CCG had achieved a surplus of £1275K, which was higher than the control total requirement of £989K and slightly better than previously reported. The audit had commenced and was expected to take two to three weeks to complete.

The Committee noted the cumulative surplus of £12,349K, and the year-end reserves of £2m which remained following the application of some reserves to programme budgets. MH summarised the outturn position for acute, client groups, delegated primary care, and prescribing. The QIPP programme of £16.5m had not been achieved in full, with a shortfall of
The best possible health outcomes for Southwark people

£400K. However, this represented a very good performance, and it was noted that Southwark had consistently delivered 95-100% of its QIPP programmes, compared with a London average of 80-85%. The aged debtors analysis was noted, with £2m in the current period relating to a s75 invoice to Southwark Council which had since been paid. Most of the £1.7m in the 60-90 days band related to 2018/19 invoices to the Council, whilst the majority of the £561K in the over 180 days band related to a Council invoice from 2017/18, which was being followed up. Appropriate provision for doubtful debts had been made in the year-end accounts. The figures in the year-end accounts differed slightly from those presented because of the requirement to apply FRS9.

NK asked for further information about the outturn for mental health and aged debt with Southwark Council relating to mental health. MH explained that the programme budget outturn reflected the year end position agreed with SLaM. The agreed position was for £1.5m over contract, which had been covered from reserves. The majority of the outstanding debt with Southwark Council related to supported housing, £429K of which related to 2017/18 invoices.

RGi congratulated all involved in achieving a commendable year end position, which was endorsed by the Committee. It was also noted that the CCG had received a ‘green’ Head of Internal Audit Opinion for 2018/19, reflecting its robust systems and sound management. Southwark was the only one of RSM’s 50 CCG clients to receive this rating.

The Committee noted the CCG finance report for month 12 and the SEL finance report for month 11.

Quality update

JF presented this paper, which updated the Committee on current quality and safety issues, and assurance and improvement activity. The report covered the possible revision of the Friends and Family Test, CQC inspections at the CCG’s main providers, details of serious incidents and never events, and quality alerts.

It was noted that since the report had been written the warning notice at SLaM had been lifted, and that initial feedback following inspections at GSTT was that they seemed to have gone well. It was also noted that NHSE had commissioned an independent investigation into a serious incident at SLaM involving a Southwark resident – the incident had been an alleged homicide.

There was a brief update on developments at King’s, including improved performance against the 52 week waiters target, and a verbal report on a visit to GSTT by BB and NB. The visit had focused on gastrointestinal services, a key area for ‘patients lost to follow up’. It was noted that there were significant differences between facilities at St Thomas’ and at Guy’s, with the IT system at the latter being out-dated and difficult to use, resulting in a higher level of errors. Staff turnover at Guy’s was also a factor. These observations had been discussed at the Guy’s CQRG that morning, but the underlying issues remained unresolved.

The Committee noted the quality update.

SEL/CCG assurance reports (M12)
It was noted that the pack now included three summary slides with cross references to the main pack, and there was some discussion about non-acute areas still shown as red. However, the efficacy of action taken by management was unclear and there was concern that much of the data and the actions being taken to address under-performance appeared to be out of date. It was acknowledged that CCG management had not had sufficient input into the development of the pack. The Committee concluded that although the current format was an improvement on that originally provided, there was still significant room for improvement, especially around developing the Southwark summary. A systematic approach to ensuring executive input to the reports was required, before the reports were presented to the Committee.

Deep dive – delayed transfers of care

SH provided a verbal update, explaining that performance against target had deteriorated over the last three months, with Southwark now the third worst in London. The Better Care Fund Panel had started an in-depth review but some data was not available and there were also concerns about data quality. There were differences in recording across Trusts, and some of the individuals were not known to Adult Social Care. The first step was to validate the current figure, and the next would be to investigate the increase year on year – 718 days delayed in the current year, compared with 274 in February 2018. SH emphasised the need to address the underlying system issues as soon as possible, and undertook to provide a further update to the Committee’s May meeting.

The Committee noted the SEL/CCG assurance reports for month 12 and the update on delayed transfers of care.

SEL Integrated Governance and Performance Committee – review of the pilot phase and next steps

RGr presented this report, which was seeking the Committee’s endorsement of an increase in scope for the SEL IGP, and accompanying delegated decision-making powers.

As part of the establishment of the SEL IGP in November 2018, it was agreed that following an initial pilot phase, a review would be undertaken to recommend its future scope. That review had now been undertaken, and as a result it was being recommended that the SEL committee’s scope be widened to cover the full range of acute indicators, including A&E, and Transforming Care. It was also recommended that the SEL committee should assume responsibility for quality in relation to its widened scope.

The SEL IGP would provide assurance to Governing Bodies on those areas within its remit, with local committees focusing on non-acute performance. A further review was proposed in six months’ time, which would consider whether the SEL committee should also assume responsibility for non-acute performance.

The proposals were discussed and it was noted that there was no indication of where responsibility would sit for the quality of those services which were provided in an acute setting, but for which there were no national indicators – such as maternity and children’s services.

There was also concern expressed that the proposals failed to take account of the interrelationships between acute and non-acute services, such as mental health.
It was acknowledged that any discussion of the future role of the Southwark committee would need to fit with how ‘place’ was being developed, and that this needed bottom-up input from the CCG as well as top-down from the STP.

Concern was expressed that there seemed to be a lack of clarity around exactly what delegated powers the SEL committee required, and it was noted that the Accountable Officer’s personal delegated powers could be used on behalf of the SEL committee.

The Committee approved the direction of travel of the SEL IGP as reflected in the proposals, but required further assurance around quality reporting, and more detail about the decision-making powers being sought.

### GP IT update

RGr presented this report, which provided the Committee with an update on progress across key IT and digital workstreams. He informed the meeting that the Southwark IT Steering Group had met the previous day, and now had regular monthly meetings which provided the content for the update to this Committee.

The main points to note were around the roll-out of the Health and Social Care Network (HSCN), and IT Service Desk performance. The HSCN project was underway but some progress was slower than envisaged as this was a complex environment involving multiple suppliers and significant installation challenges. IT Service Desk performance had dipped significantly during Q4, and a detailed action plan was now in place. It was noted that NEL faced a range of recruitment and workforce issues and that any major improvement in performance was unlikely to be evident until May.

The Committee noted the GP IT update

### Brexit update

RGr provided a brief verbal update on Brexit preparedness. The CCG was fully prepared, in accordance with national and regional requirements, and arrangements were now on hold. They would be reactivated as the 31 October deadline approached.

The Committee noted the update on Brexit preparedness.

### Final opening budget framework 2019/20

MH presented this report, which was an update of the paper received by the Governing Body in March. The main change since then had been the conclusion of contract negotiations with SEL’s five main providers, as reported to the Committee by Sarah Cottingham at its last meeting.

A further development had been a significant reduction in the CCG’s funding for delegated primary care, with the original allocation having been reduced by NHS England by £1.4m to fund the new national clinical negligence scheme for GPs. Given that this budget had previously been assumed to be fully committed, this represented a financial risk to the CCG. Work was underway to understand the basis for the reduction.

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The best possible health outcomes for Southwark people
It was noted that unidentified QIPP now stood at £1.5m, an improvement on the previously reported figure of £2.5m. MH explained that it was possible that some of the shortfall might be met on a non-recurrent basis, but this was not assumed in the paper.

Opening reserves remained at £4.5m, and it was noted that the SEL transformation reserve had been applied to the acute and mental health contract packages.

Budgets were in the process of being finalised, and would be loaded on to the ledger within the next two to three weeks. In-year reporting would start with M2, which would come to the Committee in June.

RGI asked about the £1.5m which had been transferred from Southwark to Bexley CCG under the risk share agreement in 2018/19. The report stated that both Southwark and Lambeth CCGs were expecting repayment in early 2019/20, and that the £1.5m was not included in the budgets set out in the report. MH explained that the £1.5m could be repaid to the CCG, but could possibly be required for a fresh risk share payment in 2019/20. It was noted that there was no formal risk share policy in place for 2019/20, and that one would need to be agreed before any payments could be made in the current year.

RGr informed the Committee that some of the potential schemes for closing the QIPP gap arose from budget or contract review, whilst others were transformational in nature and would impact later in the year.

The Committee:

- approved the financial framework for 2019-20;
- approved the Control Total target of achieving breakeven in year;
- noted the work being done to achieve the CCG’s financial position;
- noted the actions being taken to agree additional QIPP;
- agreed to recommend the budgets to the Governing Body in May, and to endorse the Governing Body’s recommendation of them to the Council of Members.

Mental health complex care rehabilitative placements – Memorandum of Understanding

SH explained that this was a South London Memorandum of Understanding (MoU) which had been agreed as part of the contract negotiations with SLaM as the direction of travel. The MoU encompassed Southwark CCG, the other south London CCGs, and the South London Mental Health and Community Partnership. The draft MoU was the result of extensive work and it was noted that each borough would proceed at a pace appropriate to its engagement with its local council.

SH highlighted two areas where further consideration could be required: section 3, which allowed for only two designated commissioners; and section 8, which lacked detail about savings and costs.

Subject to possible changes to sections 3 and 8, and other final edits if necessary, the Committee agreed to delegate to Ross Graves, Managing Director, authority to sign the MOU for Southwark CCG.
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<tr>
<th>14</th>
<th>Estates Developments Programme Board – terms of reference</th>
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<td></td>
<td>GO presented the draft terms of reference, which had been based on the original terms of reference for the Dulwich Programme Board. It was noted that the Board’s approach would be consensual, and that it had no decision-making powers.</td>
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<td>There was a brief discussion about whether the Chair of the Board should be a lay member, as proposed, or a clinician, and it was agreed that this would be finalised outside of the meeting.</td>
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<td><strong>Subject to agreeing on the matter of a Chair, the Committee approved the terms of reference of the Estates Development Programme Board.</strong></td>
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<th>15</th>
<th>Sub-committees’ report, including non-medical prescribing policy</th>
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<td>NB introduced the policy, which had been discussed at the Medicines Management Committee and would enhance patient safety. It was noted that Southwark’s approach was more robust than that of other CCGs, and Helen Magnusen-Baker was commended for her work developing the policy.</td>
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<td><strong>The Committee noted the sub-committees’ report and approved the non-medical prescribing policy.</strong></td>
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<th>16</th>
<th>Safeguarding Declaration</th>
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<td>The Committee noted the updated Safeguarding Declaration.</td>
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<th>Minutes of sub-committees</th>
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<td>The Committee noted the following sets of minutes:</td>
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<td>• Quality and Safety Committee – 7 March 2019</td>
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<tr>
<th>18</th>
<th>Committee forward agenda plan</th>
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<td>The Committee noted the forward plan.</td>
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<tr>
<th>19</th>
<th>Any other business</th>
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<tr>
<td></td>
<td>There was no other business</td>
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<tr>
<th>20</th>
<th>Close of meeting</th>
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<td>The meeting closed at 17.20.</td>
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<td>Date of next meeting</td>
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<td>15.00-17.30, Thursday 23 May 2019</td>
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Southwark CCG Integrated Governance & Performance Committee

23 May 2019
Room 132, 160 Tooley Street
MINUTES

Members present:
Andrew Nebel Lay Member, Chair of the Committee
Dr Robert Davidson Clinical Lead
Joy Ellery (JE) Lay Member
Dr Emily Gibbs Clinical Lead
Richard Gibbs (RGi) Lay Member
Ross Graves (RGr) Managing Director
Dr Jonty Heaversedge (JH) Chair of the CCG (item 7 onwards, other than items 9 and 12)
Sam Hepplewhite (SH) Director of Integrated Commissioning (item 7 onwards, other than item 9)
Malcolm Hines (MH) Director of Finance (item 7 onwards)
Dr Mike Khan (MK) Secondary Care Doctor Member
Dr Nancy Küchemann (NK) Clinical Lead
Kate Moriarty-Baker Director of Quality and Chief Nurse
Robert Park Lay Member
Dr Yvonneke Roe (YR) Clinical Lead

Attending:
Jacquie Foster (JF) Head of Quality (item 6 onwards)
Heather Gava (HG) Interim Corporate Secretary
Mathew Griffiths (MG) Continuing Care Development Manager (item 11)
Nick Harris (NH) Programme Manager, Clinical Effectiveness Southwark (item 10)
Dr Payam Torabi (PT) Clinical Lead, Clinical Effectiveness Southwark (item 10)
Garrett Turbett (GT) Head of Programmes

Apologies:
Dr Noel Baxter Clinical Lead
Linda Drake Practice Nurse Member
Usman Niazi Chief Financial Officer

1 Welcome
The Chair welcomed all to the meeting.

2 Introductions and apologies for absence
Apologies were noted.

3 Declaration of interests
All members were asked to declare any change in interest and any conflicts relating to items on the agenda. There were no changes, and no potential conflicts were identified.

The declaration of interests register was circulated for signing.

Minutes of previous meeting, action log and matters arising

The minutes of the meeting held on 25 April 2019 were agreed as an accurate record of the meeting.

The action log was reviewed, and updates and completed actions noted. It was agreed that the action dating from November 2018 should be closed.

CCG Risk Report and Board Assurance Framework M1/SEL Board Assurance Framework M12

RGr explained that following the update of the CCG’s corporate objectives, the BAF and directorate risk registers had been subject to a detailed refresh to provide a full and accurate view of the risks now facing the organisation. The report therefore detailed more changes than usual, and these were set out in full in the report.

Referring to risk QN33 on the BAF, RGi asked for an update and whether the situation represented a deterioration in relations with Southwark Council. KMB explained that the Council had acted on a very strict interpretation of legal advice about funding for the CHC Discharge to Assess pathway. The CCG was in the process of working through the issues with Council colleagues, with the aim of avoiding the cost pressure of £500-750K, though this remained a risk. It was noted that other discharge pathways were available, and that work on these alternatives was underway. RGr added that overall relations with the Council had improved, though particular challenges remained.

Referring to risk FB41 on the BAF, RP asked when Governing Body members would see how the £1.5m shortfall on QIPP schemes would be closed. RGr explained that the gap had been partially closed through review of budget lines and use of balance sheet flexibilities, and that discretionary spend was still being looked at. An updated position statement would be brought to the Committee’s June meeting.

The Committee noted the CCG Risk Report and Board Assurance Framework M1 and the SEL Board Assurance Framework M12.

Quality Update

KMB presented this paper, which updated the Committee on current quality and safety issues, and assurance and improvement activity. KMB informed the Committee that more people had been affected by the measles outbreak at a primary school in Bermondsey. A number of probable cases were linked to the existing outbreak, but some were not. KMB assured the Committee that the CCG was working with Public Health and the Communications Team, and referred them to the letter sent to Southwark GPs by Public Health England, which was appended to the report.
KMB referred to the BBC’s Panorama programme which had been aired the previous evening, and which concerned people with learning difficulties and autism who were being cared for in a facility run by Cygnet Health Care (Whorlton Hall). KMB had issued a briefing paper to GB members in advance of the screening, and assured the Committee that the CCG had no patients at Whorlton Hall, or at Thors Park, another Cygnet unit for people with learning disabilities, where allegations of assault were being investigated by the police. There were three Southwark residents at Bostall House, a unit in Greenwich also operated by Cygnet. Bostall House currently had a ‘Good’ CQC rating and no safeguarding concerns had been raised about the welfare of the CCG’s patients. ALL CCG patients in Cygnet facilities were being visited by the SLaM Mental health and Learning Disabilities Placement Coordinator, which was expected to surface any concerns.

KMB also updated the Committee on the position at Glenside Manor. The CCG’s one patient had been moved from the Old Vicarage to alternative accommodation but a further move was very likely.

A ‘Future of Quality’ workshop had been held on 16 May, focusing on quality in a place-based organisation. It was noted that a position paper was nearing completion.

The report included a new Immunisation Strategy and Action Plan, which had been reviewed and endorsed by the Quality and Safety Sub-committee. The IGP committee was being asked to further endorse the Strategy and the direction of travel. There was a brief discussion about how the Strategy would be delivered and links to other groups. The Strategy included data on variations in uptake with coverage for shingles demonstrating the widest variance, and it was noted that this was a complicated immunisation programme to deliver.

There was a brief discussion about the Transforming Care programme, and it was noted that the focus was towards inpatient provision because of the associated costs. It was acknowledged however that there also needed to be adequate focus on preventative support.

AN noted that the Quality Workshop had been very helpful and asked how the outputs were being taken forward. KMB explained that the Directors of Quality Forum had been asked to consider what aspects of quality would be best handled at scale and what aspects locally, and she had shared the Workshop agenda with fellow Directors of Quality.

The Committee noted the Quality Update and endorsed the Immunisation Strategy and Action Plan 2019/21.

CCG Assurance Reports (M1) and update on delayed transfers of care

SH presented this report for information, which provided the committee with assurance that the Better Care Fund Group was progressing work to better understand the causes of the recent growth in delayed transfers of care.

RP asked for an explanation of the patient choice delays referred to in the report. SH explained that delays might occur during the process of choosing a residential or nursing home while the family visited a number of homes; or if the family was waiting for an offer from its preferred choice of home. It was noted that this was not a new problem.

There was a short discussion about the availability of integrated care beds, and it was noted that there were questions about the accuracy of the data because there was no single
consistent approach to data collection across all Trusts. The Better Care Fund Group had seen a proposal for more integrated care beds, but further work was needed.

Referring to Appendix 2, NK whether placements for people with EMI were into residential care or nursing homes, and it was noted that EMI was an optional registration for both.

JE asked whether homelessness was a factor, and it was noted that a BCF proposal had been considered for a dedicated Housing Liaison Officer.

The Committee noted the update on delayed transfers of care.

Proposal for thematic approach to assurance and scrutiny

SH presented a proposal for a thematic approach to assurance and scrutiny, recognising the wider scope of the SEL IGP. The proposal had been discussed by the senior management team and would represent a move away from the established approach, involving input from a wider group of people including providers and clinicians. The identification of areas for review could be based on a number of indicators including performance, risk, and quality. There would be a short programme of reviews to reflect the limited time the Committee had before the next review of the SEL IGP terms of reference in September.

The Committee approved the proposal for a thematic approach and asked the Senior Management Team to agree the programme.

CCG Operating Plan

RGr presented a discussion draft of the Operating Plan for 2019/20, explaining that the planning round had been very different from that of previous years and it had not been possible therefore to simply update the previous year’s Plan. Planning had taken a common approach towards key commissioned services across all six CCGs and the draft Plan provided a Southwark perspective. RGr outlined the content of each section of the Plan, covering the response to the Long Term Plan, Partnership Southwark, key deliverables, and the financial and budgetary framework. The draft Plan had been taken to the Locality Meetings that day, but at very short notice, and the intention was to re-present it at the June meetings. It was hoped that the Plan could be finalised by the end of June.

RD noted that slide 16, which set out key deliverables, made no mention of outcomes.

Referring to slide 43, NK felt that the work done needed to be put into context and that a significant amount of work had been carried out over a number of years. She confirmed that there were Alcohol Care teams in place at local provider hospitals.

RG noted that it was difficult to distinguish the Southwark perspective from the SEL one in parts of the Plan. Referring to the ‘consistent set of SEL-wide commissioning intentions and priorities’ mentioned on slide 9 he went on to ask whether this was actually the case. RGr explained that commissioning intentions had been developed for acute provision and built into the 2019/20 contract negotiations.

Referring to slide 14, JE asked how people would have greater control over their own health and wellbeing. Residents needed to be able to understand what this meant in practice.
<table>
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<tr>
<th>10</th>
<th>CES Evaluation Update</th>
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<tr>
<td>NH summarised the main points in the report. A PLT had taken place since the last report to IGP and template usage had increased. Work had begun on the evaluation being undertaken by King’s College and there had been some challenges around data extraction which were noted in the report. The analysis of data was using an interrupted time series methodology, and the work would be intensifying over the next few months. PT explained that the evaluation data was affected by seasonal variations, and varied across practices and socio-economic groups.</td>
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<td>AN noted that the AF template had been accessed considerably fewer times than the others, and NH explained that this reflected the prevalence of AF.</td>
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<td>AN also noted that the report did not contain any budgetary information, and NMB explained that financial reporting was to the Programme Board.</td>
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<td>The Committee noted the CES evaluation update.</td>
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<th>11</th>
<th>Quarterly CHC Update (Q4)</th>
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<td>MG presented an update on work during Q4 of 2018/19. Overall numbers had stabilised during 2018/19, compared with year on year increase before that. The CCG had achieved its Quality Premium measures during 2018/19 though Q4 had been challenging for the reasons set out in the report. It was noted that to date 2019/20 was also proving to be challenging. The QIPP programme for 2018/19 had been largely achieved.</td>
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<td>It was noted that 103 out of about 500 reviews remained outstanding at the end of the quarter and that this had been due to staff vacancies on the team on GSTT that carried out the reviews. The vacancies had been filled and the position was improving. KMB informed the Committee that Southwark was the only CCG in SEL to use an external team, and that this resulted in less control over the review process.</td>
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<td>RP asked whether any review had carried out to ensure that QIPP projects had not had any adverse effects on quality or safety. MG explained that there was no process of formal retrospective review, but that complex care meetings were held every week at case level.</td>
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<td>RGr commended the work carried out by MG and KMB.</td>
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<td>The Committee noted the quarterly CHC update.</td>
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| 12 | GP IT Update |

RGr asked for any further comments within the next week, so that the Plan could be updated for re-circulation to the Locality Meetings. A revised draft would be brought back to the Committee in June.

The Committee noted the draft Operating Plan for 2019/20.
The report was taken as read, and RGr updated the meeting about the situation which had arisen during the week at The Lister Practice. Multiple significant IT issues at the practice, especially with desktop PCs, and the failure of the CSU to respond adequately had resulted in the lead partner escalating matters to the CCG. The CCG’s own team had begun to install new desktops, with the work due for completion that day. This had alleviated many of the problems and RGr hope to be able to report soon that all issues logged with the CSU had been resolved. MH explained that new PCs and printers were being rolled out to all practices over the next few months, and that because of the problems they were experiencing The Lister Practice had been prioritised.

AN asked whether any progress was being made regarding CSU performance. RGr acknowledged that there had been significant issues with response times, which had been linked to staff vacancies. New staff were now in post, and the service was being managed via the contract management process. He stated though that some major issues, such as the existing IT architecture and legacy issues were unlikely to be addressed in full during 2019/20.

The Committee noted the GP IT Update.

<table>
<thead>
<tr>
<th>IGP Committee – revised terms of reference</th>
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<tr>
<td>RGr explained that the Committee’s terms of reference had been updated to reflect the changes in the scope of the SEL IGP’s responsibilities. The approach had been designed to accommodate further changes as the two committees evolved.</td>
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<td>RGi felt that the sections dealing with financial monitoring lacked clarity and appeared contradictory. He also queried the quorum as set out in section 7.</td>
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<td>In the interests of transparency, the revised terms of reference had been circulated with tracked changes, but this was confusing in places.</td>
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The Committee asked for the terms of reference to be resubmitted at the June meeting.

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<th>Capability Procedure</th>
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<td>RGr presented this procedure for approval. It set out the principles and processes to be followed for ensuring fair treatment for employees whose performance gave cause for concern. It was noted that staff had been consulted but no comments had been received.</td>
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Subject to agreeing on the matter of a Chair, the Committee approved the terms of reference of the Estates Development Programme Board.

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<th>Minutes of sub-committees</th>
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<tr>
<td>The Committee noted the following sets of minutes:</td>
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<tr>
<td>- Quality and Safety Committee – 7 March 2019</td>
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Meeting: OHSEL Board in Public
Date: Thursday 28th March 2019, 16:00 – 17:00
Location: Garry Weston Library, Southwark Cathedral
Chair: Andrew Bland, STP Lead & Accountable Officer for Bexley, Bromley, Greenwich, Lewisham and Southwark CCGs

MINUTES

Attendees:

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Andrew Bland (AB)</td>
<td>OHSEL</td>
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<td>Andrew Eyres (AE)</td>
<td>Lambeth CCG</td>
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<tr>
<td>Colin Roberts (CR)</td>
<td>PPAG</td>
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<tr>
<td>Siddharth Deshmukh (SD)</td>
<td>Bexley CCG</td>
</tr>
<tr>
<td>Faruk Majid (FM)</td>
<td>Lewisham CCG</td>
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<tr>
<td>Julie Lowe (JL)</td>
<td>OHSEL</td>
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<tr>
<td>Adrian MacLachlan (AM)</td>
<td>Lambeth CCG</td>
</tr>
<tr>
<td>Elizabeth Youard (EY)</td>
<td>Guy’s and St. Thomas’ NHS Foundation Trust</td>
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<tr>
<td>Tony Read (TR)</td>
<td>OHSEL</td>
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<tr>
<td>Vicky Scott (VS)</td>
<td>OHSEL</td>
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<tr>
<td>Christina Windle (CW)</td>
<td>OHSEL</td>
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<tr>
<td>Ash Vithaldas (AV)</td>
<td>London Ambulance Service</td>
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<tr>
<td>Jade Ackers (JA)</td>
<td>NHS England (Specialised Commissioning)</td>
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<td>Angela Bhan (ABh)</td>
<td>Bromley CCG</td>
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<td>Kate Radcliffe (KR)</td>
<td>OHSEL</td>
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<td>Mark Edginton (ME)</td>
<td>OHSEL</td>
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</tbody>
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In attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>Peter Gluckman (PG)</td>
<td>Independent Chair of the SEL Equalities Steering Group and Independent Chair of the SEL Stakeholder Reference Group</td>
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</table>

Apologies:

<table>
<thead>
<tr>
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<th>Organisation</th>
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</thead>
<tbody>
<tr>
<td>Amanda Pritchard</td>
<td>Guy’s and St. Thomas’ NHS Foundation Trust</td>
</tr>
<tr>
<td>Aileen Buckton</td>
<td>Lewisham Council</td>
</tr>
<tr>
<td>Neil Kennett-Brown</td>
<td>Greenwich &amp; Bexley CCGs</td>
</tr>
<tr>
<td>John King</td>
<td>Patient and Public Advisory Group</td>
</tr>
<tr>
<td>Andrew Parson</td>
<td>Bromley CCG</td>
</tr>
<tr>
<td>Rebecca Rosen</td>
<td>Greenwich GP Federation</td>
</tr>
<tr>
<td>Matthew Trainer</td>
<td>Oxleas NHS Foundation Trust</td>
</tr>
<tr>
<td>Ben Travis</td>
<td>Lewisham and Greenwich NHS Trust</td>
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<tr>
<td>Angela Flaherty</td>
<td>London Ambulance Service</td>
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<tr>
<td>Therese Fletcher</td>
<td>Lambeth GP Federation</td>
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<tr>
<td>Rikki Garcia</td>
<td>Healthwatch Greenwich</td>
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<tr>
<td>Jen Leonard</td>
<td>NHS Improvement</td>
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<tr>
<td>Matthew Patrick</td>
<td>South London and Maudsley NHS Foundation Trust</td>
</tr>
<tr>
<td>Krishna Subbarayan</td>
<td>Greenwich CCG</td>
</tr>
<tr>
<td>Martin Wilkinson</td>
<td>Lewisham CCG</td>
</tr>
<tr>
<td>Louise Ashley</td>
<td>Dartford and Gravesham NHS Foundation Trust</td>
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1. WELCOME AND INTRODUCTIONS

The Chair opened the meeting, welcomed members and this was followed by introductions. Apologies were noted.

The Chair welcomed members of the public to the meeting

2. QUESTIONS FROM THE PUBLIC

Gay Lee representing South East London Save our NHS (SELSON), stated that notification was previously received that there would be written responses to questions put forward in advance.

Gay Lee read out the questions.

2.1 Pathology

- What are the clinical (as opposed to the financial) advantages of the change of service to a very large-scale pathology network? What evidence is relied on for the benefit of mergers to form such a huge network? This relates to the tender for a large pathology network that includes most of the trusts in SE London. There is an understanding that there are several private companies are bidding for the tender. There is concern that this is being undertaken without public knowledge or public consultation.

- Could you provide examples of other large pathology networks which have proven to be value for money?

  *It was agreed that a written response will be provided to this question. (Please refer to Annex I, page 10)*

- Would you provide us with the evidence of due diligence done over the potential conflict of interest of Lord Patrick Carter who is the Chair of Health Services Laboratories which we understand is one of the bidders for the contract? Lord Carter is also on the NHSI Board which approved this new pathology provision policy. He also wrote the report on which this policy is based.

- Could you explain how this competitive procurement process for a large pathology network is in keeping with the intentions of the NHS Long term Plan to reduce competition and to increase place-based care?

  *It was agreed that a written response will be provided to this question. (Please refer to Annex I, page 11)*

2.1.1 ABI invited JL to respond. JL is the SRO for the SE London pathology programme. JL provided background information and context. Presently, pathology services in SE London are provided by a range of providers.
LGT has an in-house pathology service which also provides direct access 
GP pathology services to the boroughs of Lewisham, Greenwich and 
Bexley. There is also a joint public private partnership venture between 
GSTT, KCHT and a private partner that run a company called Viapath. 
They provide pathology services for GSTT, for KCHT and for the 
community services of Lambeth, Southwark and Bromley. They also 
provide GP services for those areas, as well as some pathology services 
and specialist work on behalf of other organisations.

2.1.2 JL reported that the current Viapath contract is 10 years old and therefore 
GSTT and KCHT are required to re-procure a new contract to start in 
2020. This is a matter of public record and has been the case since that 
contract was let in 2009. The decision on how best to re-procure was 
made in line with NHSI guidance to establish a SE London-wide 
pathology network and take forward pathology services for the whole of 
SE London for the next decade and beyond. This is also in line with the 
Long Term Plan.

2.1.3 Presently, procurement is underway, and the bidding process is 
commercial in confidence.

2.1.4 In response to the clinical and financial advantages, JL stated 
that pathology services have developed and where it used to be the case that 
every hospital would have had their own pathology services, more and 
more hub and spoke models are being created and this is the 
recommendation from NHSI. This is already occurring in other places.

2.1.5 JL provided some reasons why a network approach is important. One of 
the big drivers is workforce. There is a need for more flexible capacity 
across larger areas and this leads to benefits for patients such as quicker 
turn-around times and resilience ensuring that services are always 
available. It also helps to support greater specialisation and sub-
specialisation for scientists and consultants, and this is only possible 
through a larger geography.

2.1.6 The development of the genomics services which are regionally 
networked, is also key.

2.1.7 There are only seven laboratories nationally, therefore, linking into a 
networked model ensures that laboratories in the SE London network will 
remain able to undertake leading research with KHP. JL noted that 
although LGT have chosen not to be involved in the current procurement, 
discussions are underway with other providers and they will become part 
of a larger network. Individual hospitals running their own pathology 
services will not be sustainable.
2.2 As requested, JL read out the questions put forward by Councillor Jonathan Bartley from the London Borough of Lambeth.

- Provide examples of the impact and risk assessment of the bidding companies getting into financial difficulties as with, for example, Carillion or acting irregularly as with Serco/Viapath in 2014?
- Provide examples of the impact and risk assessment on the risk of failure to deliver timely and accurate test results to a diverse and fragmented group of NHS providers?
- Provide examples on the impact and risk assessment of failure to provide clinical pathology advice to clinicians in primary care and hospitals as is the norm with NHS-provided pathology services currently?

2.2.1 JL stated that the provision of clinical pathology advice to clinicians would form a key part of the proposed clinical model and there is very clear guidance on due diligence prior to the award of the contract.

It was agreed that a written response will also be provided to this question. (Please refer to Annex I, page 12)

2.2.2 Tony O’Sullivan, retired consultant paediatrician and Co-Chair of the national organisation Keep Our NHS Public (KONP) responded as follows:

2.2.3 The answers provided are self-evident that networking in the NHS must take place and this is welcomed, however, there is little information on why this is outside of the NHS. This is a serious risk and must be addressed in the written response.

2.2.4 Tony O’Sullivan stated that it is recognised that information is commercially sensitive however, the unsatisfactory nature of many of the deliveries of service by the Viapath contract, centre around the breakdown and delays between clinicians in primary care particularly hospitals being able to discuss results promptly from the Viapath pathologists.

2.2.5 Tony O’Sullivan stated that teamwork in the NHS is a priority and is highly valued by clinicians. It is self-evident, that consultation with GPs and the cost of clinicians is important but there is a risk that this will not be a priority for a private company. It would have been incumbent on the pathology board to make it clear that the NHS should have been involved in providing this service. The breakdown of the NHS into smaller parts is occurring. Large contracts are only awarded to private companies. As this is a large configuration Tony O’Sullivan sought clarity on why the obligation to consult with the public was not fulfilled.

2.2.6 JL stated that the tender was published, and any public or private company is welcome to bid for the tender. It was highlighted that the commercial model has not been decided and may result in a joint venture
approach. Further information on the scale and scope of a commercial model will be provided, together with detail and an explanation on the way the specification and the contract are written. This will be provided in the written answer.

2.2.7 JL stated that it would not be appropriate for this Board to comment on the concerns raised regarding the performance of Viapath.

ACTION: It was agreed to provide written answers as agreed.

3. MINUTES AND MATTERS ARISING

Following review, the minutes were approved.

4. PROGRAMME UPDATE

4.1 JL referred to the programme highlight reports (month 11) and these were noted. Presently, work is underway on the SEL response to the LTP and therefore grouping programmes into overarching themes – community-based care, acute base care, mental health and enabler programmes.

4.2 The refreshed risks and issues relate to being able to create a financial sustainable system, to achieve the constitutional standards and addressing issues regarding finding the right workforce to enable delivery of modern standards to the SEL population.

4.3 Additional focus is the development of Primary Care Networks and this will be discussed further under agenda item 8. The population-based health narrative will be updated to explain how working at network, borough and system level can improve clinical outcomes for patients and their experience.

4.4 JL highlighted that the system improvement plan details the short-term actions that would enable a starting point for an integrated care system.

4.5 A successful pan-London pharmacy event took place and enabled shared learning. As pharmacy is often the first point of contact for patients, discussions are also taking place on better utilisation of funding that is spent on medicines and more improved use of prescribed medicines to achieve better outcomes for patients.

4.6 JL reported that the digital agenda is key to transforming our services in line with the LTP. Ian Riley has been appointed to undertake the role of Chief Information Officer. Ian Riley starts on the 1st May 2019.

4.7 The partnership update was noted for information.

4.8 Finance update

4.8.1 TR reported on the period from Month 11 up to end of February 2019 focussing on key exceptions and differences.

4.8.2 For 19/20 the underlying deficit is recognised by NHS England and NHS Improvement. This has been built into the calculation for next year’s control total target for organisations as an aggregate across the SE London system.

4.8.3 Further to the published NHS Planning Guidance, and the planning and contracting round requirements, priorities were agreed for the system and ways to deliver plans and contracts within the timetable.
4.8.4 TR was pleased to report that each organisation has submitted draft plans and across SE London contracts have been agreed and signed.

5. SEL EQUALITIES STEERING GROUP UPDATE

5.1 ABI welcomed Peter Gluckman, Independent Chair of the SEL Equalities Steering Group and Independent Chair of the SEL Stakeholder Reference Group.

5.2 VS provided an overview of the Equalities Steering Group. For the past two years, the SEL Equalities Steering group has been scrutinising STP plans. The group is a valuable mechanism for ensuring that OHSEL workstreams continue to consider equalities within planning and activities. The comprehensive report circulated details the work of the ESG, the areas of focus and positive changes that have been made as a result of the input provided by the ESG.

5.3 VS expressed appreciation to the group and to PG for their helpful work over the past two years.

5.4 Good progress has been made however this is an opportunity to review the LTP and address health inequalities, strongly linking with the ICS. Health inequalities features prominently in the LTP.

5.5 VS highlighted that patients from the protected characteristics group can experience health inequalities, in particular, accessing health services. The publication of the LTP provides an opportunity to undertake deep dive work into how the work of the STP can impact positively on the protected characteristic groups’ experience and access to healthcare.

5.6 The proposed recommendation to the Board is that the ESG is discontinued and that in its place an approach is developed which will enable the STP to address both our response to the NHS Long Term Plan and our ambitions as an integrated Care System. As part of preliminary work, there is an opportunity to take advantage of the lived experience of residents in SEL to inform future.

5.7 PG highlighted that The Consultation Institute commended SEL for having an STP wide equalities group and highly recommended this to be implemented in other areas across the country as a model of best practice.

5.8 PG stated that discrimination and disadvantage still exists in the system for the core protected characteristics groups. PG emphasised that there is a need for a mechanism for keeping the focus on inequalities.

5.9 PG expressed appreciation to the ESG for its support and for making equalities a priority within the programme.

AGREED: The board welcomed the ESG report and endorsed the proposed approach and to take forward the health inequalities agenda.

6. STAKEHOLDER REFERENCE GROUP UPDATE

6.1 JL reported that the role of the SRG, is to advise on how best to engage with the public and other stakeholders, including elected representatives, to review the work programme and any proposed changes.

6.2 The areas of the LTP were reviewed by the group and this was helpful. The group
met and evaluated the long term plan, highlighting areas which they felt were priority areas for engagement eg outpatients. The group agreed to a new approach to meetings which would be topic focused and organised as required.

6.3 JL sought endorsement from the board to maintain the SRG but to change its role and format as described above.

6.4 PG stated that SEL is recognised nationally as very good in the way it takes forward and sets out engagement plans. The SRG was the first forum in the country to recommend an EIA on the STP. It also recommended the set up of PPAG. PG emphasised that there is a need in the system for a mechanism to consult across SE London.

6.5 CW highlighted that the proposal is welcome and the flexible workshop initiative is a good approach. CW stated it would be important to ensure that the group is multi-disciplinary so a range of views are heard and also to receive feedback in a timely fashion.

AGREED: The board noted the SRG annual report, welcomed and endorsed the proposed approach (to continue the stakeholder reference group meetings, with a revised role and format.)

7. SE LONDON TREATMENT ACCESS POLICY (TAP) UPDATE

7.1 ABh reported that the TAP policy has been in place previously across SEL and SEL has been regarded as having a good best practice model. A working multi-disciplinary group was formed to review the policy, to look at improving the effectiveness of patient care and maximise the best use of resources.

7.2 ABh stated that nationally, 17 evidence-based interventions were incorporated into the SEL TAP to replace local interventions.

7.3 The London Choosing Widely scheme has also focused on adopting several other procedures such as knee arthroplasty and hip arthroplasty. There are 8 evidence-based interventions under this programme

7.4 The recommendation is that changes to the following four procedures are adopted into the SEL TAP in order to be compliant with NICE or recognised Royal College / professional bodies;
- Earwax Removal
- Excision of bunions
- Surgery for female pelvic organ prolapse
- Bariatric Surgery

7.5 Concerns regarding the safety of mesh devices during surgery for female pelvic organ prolapse has arisen, relating to side effects. A national pause is implemented to review the use of this, and this is reflected in the guidance.

7.6 ABh stated that the full TAP policy was submitted to all CCG governing bodies in March 2019 and a process of engagement with SEL CCG Chairs, OSC and local patient advisory groups was undertaken, as part of the implementation of the revised policy.

AGREED: There were no objections received with the revised SEL TAP policy and the board agreed with the policy and recommended changes.
8. PRIMARY CARE NETWORKS UPDATE

8.1 ME introduced this item and stated that the Long Term Plan describes the benefits that can be achieved by bringing clusters of general practices together to create primary care networks.

8.2 This builds on work to date in SE London with larger scale general practice collaboration. The benefits have been realised with the delivery of patient access to GP appointments 0800-2000 seven days a week.

8.3 A short animation film produced by the Healthy London Partnership was shown.

8.4 ME stated that there is a rapid timetable in place for all PCNs to be agreed by July 2019. Initial views will be sought from practices on PCN arrangements with footprints agreed by 15th May. Work will be undertaken to support practices to ensure that PCNs are at an optimal model and size and to ensure that PCNs meet the needs of local populations.

9. ANY OTHER BUSINESS

None

The meeting closed at 1700.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>EIA</td>
<td>Equality Impact Assessment</td>
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<tr>
<td>ESG</td>
<td>Equalities Steering Group</td>
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<tr>
<td>GSTT</td>
<td>Guy’s and St. Thomas’ NHS Foundation Trust</td>
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<tr>
<td>ICS</td>
<td>Integrated Care System</td>
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<tr>
<td>KCHT</td>
<td>King’s College Hospital NHS Foundation Trust</td>
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<td>KHP</td>
<td>King’s Health Partners</td>
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<tr>
<td>LGT</td>
<td>Lewisham and Greenwich NHS Trust</td>
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<td>LTP</td>
<td>Long Term Plan</td>
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<tr>
<td>NICE</td>
<td>The National Institute for Health and Care Excellence</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHS Improvement</td>
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<td>Our Healthier South East London</td>
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<td>Oversight and Scrutiny Committee</td>
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<td>Primary Care Networks</td>
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<td>Public and Patient Advisory Group</td>
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<td>South East London</td>
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<td>South East London Save our NHS</td>
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<td>Stakeholder Reference Group</td>
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<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
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<td>TAP</td>
<td>Treatment Access Policy</td>
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ANNEX I

Gay Lee on behalf of SELON

1. What are the clinical (as opposed to the financial) advantages of this change of service to a very large-scale pathology network? What evidence is relied on for the benefit of mergers to form such a huge network?

In addition to the financial and efficiency benefits of creating a SEL pathology network, there are significant clinical benefits of implementing a shared pathology network across a wider geography which will directly support high quality patient care, these include:

- Networked digital pathology: For example the current provision of histopathology support and interpretation is often provided in isolation by consultants operating from different locations. It will be key for the long term clinical sustainability of all Trusts across the network to implement a digital histopathology model that allows for greater coordination, collaboration and integration of histopathology consultants and provision of integrated reporting across the sector.

- Development of Point of Care Testing (PoCT) and Near Patient Testing (NPT): Changes in technology are pushing more tests to be performed outside the laboratories enabling clinicians to access results faster and change clinical decisions for the benefits of patients. A new service provider across the network will be contracted to ensure that they are able to adapt to the evolving needs of clinical users of the service for both POCT and NPT by participating proactively in the redesign of patient pathways and evaluation of clinical benefits.

- Developments in personalised medicine and Genomics: The GSTT and KCH consortium have recently been awarded the contract for one of the 7 national Genomic Centralised Laboratory Hubs. This service has been commissioned by NHS England as a regionally networked service and by implementing this as part of a SEL Pathology Network as a whole it will help ensure that the benefits of this kind of cutting edge medicine are rolled out consistently across patients whose care is provided by the Trusts in the network.

- Service resilience: By implementing creating a hub and spoke network this means that capacity can be used more flexibly across south east London to meet demand as a whole – this in turn means that turnaround times for tests can be better maintained equitably for all patients in SEL.

- Research and Development: KCH and GSTT are both R&D focused institutions and the development of research programmes is key to keeping the Trusts at the forefront of clinical development. The new networked operating model will ensure the development of R&D as a key priority, enhancing the links with the KHP Institute, University and other research organisations.

- Teaching and training: As University hospitals it is key to maintain and develop the training programmes for consultant pathologists as well as to enable and facilitate the training of doctors, building on the relationships already established with the Deanery and universities. Doing this in a networked way across all organisations makes this both more practical and ensures coordination across the sector.
2. Could you provide examples of other large pathology networks which have proven to be value for money?

The implementation of the SEL Pathology Network is part of NHS Improvement’s drive to transform pathology services through creating 29 pathology networks across England. This programme aims to bring together clinical expertise and allow pathology services to become more efficient in order to deliver better value, high quality care for patients. As well as enhancing the careers of pathology staff, it will also improve the productivity of labs and how much they cost to run.

In 2017, NHS Improvements’ analysis showed that the 105 hospitals in England which provide pathology services typically do 1.12 billion tests per year at a cost of £2.2 billion. The new pathology networks are expected to save the NHS at least £200 million pounds by 2020-2021. At that point the hospitals that had already started to implement a network approach saved £33.6 million, with a further £30 million of savings predicted for 2018/19.

3. Would you provide us with the evidence of due diligence done over the potential conflict of interest of Lord Patrick Carter who is the Chair of Health Services Laboratories which we understand is one of the bidders for the contract? Lord Carter is also on the NHSI Board which approved this new pathology provision policy. He also wrote the report on which this policy is based.

As this procurement exercise is currently underway we cannot comment on the bidders that are being considered. Similarly we cannot comment on Lord Carter’s role at NHS Improvement, any questions about this would need to be asked directly to NHS Improvement.

As with any contract of this size and nature financial and legal due diligence will be conducted prior to a contract being awarded. The contract will be awarded later in 2019 and the new service model will be operational in September 2020.

4. Could you explain how this competitive procurement process for a large pathology network is in keeping with the intentions of the NHS Long term Plan to reduce competition and to increase place-based care?

The Long Term Plan aims to deliver greater collaboration between local organisations so that care can be more joined up and patient centred. To enable this, everywhere in the country will move to become an Integrated Care System by April 2021 which means that commissioners and providers can make shared decisions on population health, service redesign and Long Term Plan implementation together.

To create the South East London Pathology Network, the participating provider Trusts and CCGs are already working in a collaborative way to create a single shared model and are using a procurement process to consider the range of ways this could be delivered. Service models put forward by bidders may include NHS provided options as well as those delivered by external providers or a partnership. All options will be evaluated equally and transparently to ensure that a high-quality service for patients is created that is both clinically and financially sustainable and delivers value for money.
Cllr Jonathan Bartley - Leader of the Green Group, Lambeth Council

Why has there been no public consultation on such a huge change of service provision, involving a very long term contract (15 years with the option to extend to 20 years) and a huge contract value of £2.25bn?

The implementation of the new SEL pathology network will not change where or how any patient services are delivered. The procurement relates solely to how best to deliver a networked laboratory service that best supports patient facing care in our hospitals and communities.

The network proposals and the procurement approach have been discussed with local councillors from the six south east London boroughs at the Joint Overview and Scrutiny Committee (JHOSC). The JHOSC provide public scrutiny for any substantial service change across South East London Health services and decide if proposed changes meet the legal threshold for a formal public consultation.

Throughout the programme we have been committed to communicating transparently with the public, ensuring that information and updates are made available at the appropriate points in the procurement process.

What impact and risk assessments have been done?

As with any large scale procurement or transformation programme risks and impacts are considered constantly throughout the development process and are suitably mitigated prior to moving to implementation.

We cannot comment on any of the bidders in the procurement as this information is commercially in confidence. However, bidders for the SEL pathology contract have only been taken forward in the procurement if they are able to pass a series of hurdle criteria. These hurdle criteria include being able to demonstrate that they are able to access sufficient funding to support a contract of this size and nature, are able to meet the financial requirements in the specification and are able to demonstrate financial standing through standard accounting means. Further due diligence will be undertaken prior to any contract award in line with relevant procurement and contract law requirements.

During the procurement bidders’ proposed service models are discussed and evaluated against a number of criteria including their ability to deliver consistent, timely and accurate results to all clinical services. The service will be delivered under a single agreed specification for all the NHS organisations that are procuring services and will managed collectively by the NHS organisations in the network.
1.0 Introduction
Introductions and apologies were noted as above.

1.1 Declarations of Interest
The group were asked to declare if there had been changes to their interests and if they had a conflict with an agenda item. All members confirmed no changes to their declarations. EG confirmed that she worked for Nexus Health Group as a salaried GP which was on the agenda for decision and therefore EG would not partake in this agenda item.

KV noted that the LMC welcomed discussions with the CCG in relation to workforce.
2.0 Minutes from the last meeting
The minutes were agreed as an accurate record. The attendees will be updated to reflect that JW attended the meeting.

The actions were discussed as follows:

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Action number</th>
<th>Action Point</th>
<th>Lead</th>
<th>Status</th>
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<tr>
<td>23.01.18</td>
<td>4</td>
<td>To create a principles document for mergers</td>
<td>RD</td>
<td>On agenda for discussion. Closed</td>
</tr>
<tr>
<td>24.07.18</td>
<td>3</td>
<td>To present a review of the relocation of Silverlock at a future Committee.</td>
<td>RD</td>
<td>On agenda for discussion. Closed.</td>
</tr>
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<td>22.01.19</td>
<td>1</td>
<td>To share general practice workforce data for Southwark.</td>
<td>RD</td>
<td>RD shared data with members of the public and the Committee which showed that Southwark data was in line with the NHS London average for number of GPs per 1000 patients. Closed.</td>
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3.0 Public Open Space
Bob Skelly thanked the CCG for the workforce data presented as requested at the last meeting.

Elizabeth Rylance-Watson echoed thanks for the workforce data and noted that the CCG should have oversight of workforce. ERW asked about the £659k possible cost pressure due to GP at hand in the November 2019 papers. MH confirmed that this was no longer a risk and costs in relation to GP at hand did not sit with the CCG.

4.0 PCCC decisions to note
The Committee noted the paper which reported the urgent planned decisions the Committee had taken on 5 December 2018 and 26 February 2019.

5.0 Contract Action Log
NL presented the paper. It was noted that New Mill Street had submitted additional information that the CCG was reviewing. It was also noted that Camberwell Green Surgery had made an improvement grant application as part of the infection control compliance works that needed to be completed on the premises and that this action would remain on the log until complete.

6.0 Quality Report
JF presented the report and noted that Lordship Lane Surgery was now rated good in all areas by the CQC. It was noted that Nexus Health Group had been placed in special measures following an inadequate rating of the first inspection of the Group provider.

JF noted that the infection control nurse working for the CCG was developing an infection control policy to support practices implement consistent processes. AD noted that practices did not have to agree for an infection control audit and asked if this was appropriate. RD explained that if a practice did not agree to an infection control audit, they would have to provide assurance to the CCG that they were completing internal annual audits to the same standard as the audit delivered by the commissioning support unit. KV noted that the infection control audit had support from the LMC and they welcomed further training for practices.

JF commended the work of Kate Moriarty-Baker to support nurse development across south-east London.

7.0 Primary Care Commissioning Principles
SH noted that the document had been developed as a request of the Committee. It was noted that the document has been developed before the guidance issued on the new GP contract. It was noted that a significant part of the new GP contract related to primary care networks and the principles will need to consider how they support a bringing together of practices and other providers in primary care networks, but more detail is needed on the new contract.

CA noted that Healthwatch comments in relation to patient engagement had been included in the document. CA questioned how the CCG would ensure patient choice when considering mergers. SH noted that this would be considered with mergers but that it was the CCG’s role to ensure that quality services were provided to patients and that GPs were attracted to work and stay in Southwark.

RDa raised that it was important that the principles were not rules and that each business case would have to be considered based on the context at the time. The Committee acknowledged that this was a document at a point in time, but it would continue to evolve.

KV noted that the LMC comments had been incorporated but asked for some more time for others to comments. This was agreed.

8.0 Nexus Health Group – Issue of contract remedial notice following CQC inspection on 1 November 2018

NL explained that the CQC had inspection Nexus Health Group’s Princess Street site on 1 November 2018 and issued two warning notices following the inspection and then carried out further inspection of other Nexus branch sites throughout November. It was noted that following the inspections the CQC rated the provider as inadequate and placed them in special measures. It was noted that the London standard operating procedure for when practices were inadequate
was to issue a breach notice as they have breached the contract as they have failed to comply with all relevant legislation.

It was noted that a remedial notice would be issued in response to those areas of contractual compliance which have not yet been resolved. The Committee agreed with the recommendation to issue a breach and remedial notice in line with the London standard operating procedure.

CN asked what learning had come from the inspection which could be shared with other practice and if Nexus’s action plan could be shared.

JF noted that the CCG declared a serious incident to ensure that learning was investigated and to enable sharing across practices. It was explained that the CCG had worked closely with Nexus and that the incident would only be closed once the root cause had been addressed. It was noted that the Royal College of General Practitioners had been supporting Nexus. SH noted that the Nexus inspection was a pilot inspection of general practice at scale and that there was learning for Nexus, the CCG and CQC. It was explained that the CCG thought the action plan could be shared but would check with Nexus.

SH noted that the CCG had a positive contract management meeting with Nexus and they were engaging with the CCG and other organisations that were providing support. RG noted that he was pleased to see a root cause analysis was being completed but asked how the clinical issues raised would be monitored. It was noted that this was being monitored through Integrated Governance and Performance Committee and the Quality and Safety Committee with updated coming to the Primary Care Commissioning Committee.

9.0 New GP Contract

SH noted that this item was coming to the Committee to provide the Committee with more detail about the new GP contract. It was noted that the new contract was only part of the changes to the whole health and care system which is articulated in the NHS Long Term Plan. It was noted that the primary care networks as part of the new contract had the majority of focus as they had to be agreed by July 2019. It was noted that the details of the network agreements, the job description of the network directors were not known and the specification were due at the end of March.

It was noted that the workforce element of the contract provided opportunities for practices and there were also proposal to resolve indemnity challenges for practices.

CA asked if GPs were having to pool budgets. SH noted that the CCG had developed a funding diagram and that this would be shared with Healthwatch. CA asked if the neighbourhood work being progressed as part of the local care networks would be replaced by the primary care networks. SH noted that the CCG was keen to build on existing neighbourhoods but that the primary care networks had to community providers as well as practices. It was noted that CCG would be holding patient meeting to engage patients with the new contract.
KV noted that the new contract was a directed enhanced service which practices could chose to sign up to. SH noted that the Primary Care Commissioning Committee will oversee the delivery of the new contract and that the CCG had a requirement to ensure all patients were covered by primary care networks.

It was noted that the CCG will review governance for the agreement of primary care networks but that the CCG would be making a recommendation to NHS England for ratification.

10.0 Silverlock Medical Centre Relocation Lessons Learnt
RD presented the paper. It was noted that 4% of patients registered with Silverlock registered with local practices and that it had therefore been interpreted that patients were willing to travel to the new premises to access general practice services. It was noted that the CCG had received one complaint in relation to the relocation and that other practices had not contacted the CCG in relation to patient registering with them following the relocation. It was noted that the number of patients engaged with as part of the relocation and that the CCG should consider how to engage with patients in other ways to seek more people’s views. RG noted that the CCG could consider how social media as part of patient engagement to try to capture as many views as possible.

It was noted that the lessons learnt in relation to IT had resulted in processes being changed to avoid these being repeated. It was also noted that the relocation had enabled AT Medics to deliver more services to patients which was shown through an increase in the number of patients receiving health checks and other additional services.

RP noted the document was really useful and provided useful learning for Dulwich which would see two practices move in to the new Health Centre.

11.0 Public Open Space

ERW asked if Nexus outsourced their centralised admin functions and IT. RD noted that the CCG commissioned north-east London commissioning support unit to support IT across all practices in Southwark. It was noted that Nexus did not outsource admin functions and that these were delivered by Nexus employed staff.

12.0 AOB
None declared

13.0 Close
Meeting closed 3.30pm
South East London
Integrated Governance & Performance Committee

Minutes

5 April 2019

Present

Ray Warburton (RW) Independent Lay Member & Meeting Chair
Andrew Bland (AB) Accountable Officer, SEL Commissioning Alliance (SELCA) ¹
Andrew Eyres (AE) Accountable Officer, Lambeth CCG
Usman Niazi (UN) Chief Financial Officer, SEL Commissioning Alliance (SELCA)
Christine Caton (CC) Chief Financial Officer, Lambeth CCG
Simon MacKenzie (SM) Secondary Care Doctor, Lewisham CCG
Martin Wilkinson (MW) Managing Director, Lewisham CCG
Christina Windle (CW) Director of Commissioning Operations, SELCA
Siddharth Deshmukh (SD) Chair, Bexley CCG
Angela Bhan (ABh) Managing Director, Bromley CCG
Nancy Kuchemann (NK) Clinical Lead, Southwark CCG
Harvey Guntrip (HG) Lay Member, Bromley CCG
David Smith (DS) Associate Director of Performance, ICDT
Omar Al-Ramadhani (OAR) SEL Assurance Team, SELCA
Sarah Cottingham (SC) Director ICDT, SELCA
Ross Graves (RGr) Managing Director, Southwark CCG
Neil Kennett-Brown (NKB) Managing Director, Greenwich CCG

Apologies

Richard Gibbs (RG) Lay Member, Southwark CCG
Amana Humayun (AH) Lay Member, Greenwich CCG
Kieran Swann (KSw) SEL Assurance Team, SELCA
David Maloney (DM) Chief Financial Officer, Greenwich & Lewisham CCGs
Mark Cheung (MC) Director of Integration, Bromley CCG
Keith Wood (KW) Lay Member, Bexley CCG
Andrew Parson (AP) Chair, Bromley CCG
Emir Feisal (EF) Lay Member, Lambeth CCG
Adrian McLachlan (AM) Chair, Lambeth CCG
Sue Gallagher (SG) Lay Member, Lambeth CCG
Yvonneke Roe (YR) Clinical Lead, Southwark CCG
Jacqueline McLeod (JM) Clinical Lead, Lewisham CCG
Malcolm Hines (MH) Director of Finance, Southwark, Bromley & Bexley CCGs
Krishna Subbarayan (KS) Chair, Greenwich CCG

¹ (Bromley, Bexley, Lewisham, Greenwich and Southwark CCGs)
1. **Introductions, apologies and declarations of interest**

   RW welcomed members to the meeting. Apologies were noted as above.

   The Chair welcomed NK to the meeting who was deputising for YR.

   No interests conflicting with the business of the meeting or changes to existing interests were declared.

2. **Minutes of the last meeting – 8 March 2019**

   The minutes were approved as an accurate record.

   The committee reviewed the action log and noted all actions due for April 2019 as being complete.

   Following the discussion at the previous meeting, the committee discussed the wider circulation of the minutes particularly with the OHSEL board. The committee agreed to review further suggestions at the next meeting – **Action CW**.

   CW updated the committee that progress was being made in formalising the recently agreed changes to the committee’s scope. A summary report detailing next steps has been drafted and the SEL Assurance Team is working with governance leads to transact the changes at May governing body meetings. The content of the committee papers in May will include the new areas covered by the extended scope.

   The committee noted little change to the BAF for April and therefore that it was included as a for information paper. All in-scope performance indicators will be included in May’s BAF which will be focused on 2019/20 delivery plans.
3. Feedback on the content and layout of papers

RW thanked KS, HG and SM for contributing ideas to the paper. RW then summarised the recommendations. Future papers should be concise and highlight the key issues and significant changes from the previous period to allow maximum time for discussion. He also noted that an executive response had been made to the recommendations, which he welcomed.

CW further highlighted that future approaches for committee reports would be developed and acknowledged the need for them to be fit for purpose. She assured the committee that options for a dashboard were being considered and options would be brought back to the committee and in the mean-time reports will be synthesised with large appendices.

Touching on one of the recommendations, RW explained the benefits of using statistical process control (SPC) to highlight significant changes in performance. SM endorsed this view and further highlighted the benefits of the SPC approach and its wide use amongst providers - Action CW to follow up with SM about the potential of including SPC in the development of the dashboard.

The committee endorsed the recommendations of the report.

4. SEL CCG Performance Assurance Report

SC introduced the report and provided summaries for the acute performance sections:

A&E performance – the committee noted that the four-hour trajectories were not predicated on delivery of the 95% target and also noted deteriorating performance in Q4 2018/19. The drivers of performance were high acuity attendances, high bed occupancy levels, surges in activity and workforce issues. Improvement plans are in place and the ICDT is recommending that a single plan is produced and adhered to for the whole of 2019/20. The committee noted pressure on A&Es due to patients presenting with mental health issues had reduced from previous winters.

Cancer performance – performance has improved at King’s College Hospital NHS foundation Trust (KCH) over the last few months, however that improvement has been offset by deterioration at Lewisham and Greenwich NHS Trust (LGT). The focus now is to support KCH to maintain improvement and understand what is driving the deterioration at LGT and ensure the trust receives sufficient support from the accountable cancer network.

RTT/planned care performance – the committee noted the on-going improvement in the utilisation of consultant connect; plans to roll out referral assessment services (RAS) on the electronic referral system (e-RS); and other transformation plans. It was noted that LGT are expected to meet the PTL target, however the other south east London providers will not. Assurance was provided that good progress was being made to reduce the number of 52-week waiters and KCH had met their revised trajectory, however LGT were unexpectedly reporting 15 at the end of march.

Diagnostics performance – south east London performance deteriorated in January with performance falling at Guy’s and St Thomas’ NHS Foundation Trust (GSTT) although this may
potentially be short term. Performance at KCH remains challenged particularly at the PRUH site. The backlog of endoscopy had increased and quality and safety issues are becoming a concern so an urgent summit meeting is being planned with KCH. Currently the trust does not have the equipment to deliver the required level of activity. At GSTT there is an MRI demand and capacity issue, however additional in-house capacity should help recover performance. The committee noted that due to these challenges it will take the whole of 2019/20 to recover performance.

SM highlighted some of the gaps in planned and actual A&E performance and emphasised the need for the committee to be clear on the risks of non-delivery. SC acknowledged this but highlighted the challenging dynamic of setting realistic plans against regulator expectations. Regulators have three tests for A&E performance which they expect to be met; to demonstrate continuous improvement; a month-on-month improvement in performance compared to the previous year and an aggregate 90% performance. Although it will be challenging to meet these tests, plans for 2019/20 were realistic and build-in material stretch.

To support performance improvement, the committee highlighted the importance of reducing demand particularly on EDs. The committee discussed how to address the variation in service provision and pathways across the boroughs; the need to focus on effective communication with patients and the public; how the committee can be assured on demand management; and which structures were overseeing the delivery of demand management programmes.

SC added that discharge and patient flow through acute services were also a challenge but investments have been made in out of hospital services as part of the wider system development.

NK asked if there was any evidence that using e-RS had helped to speed up the process and improve flow for booking radiology slots; if provider systems were impacting on responsiveness; and if reporting times are monitored. SC clarified that she was not aware that e-RS had made a significant impact and the main issues were still the gaps in demand and capacity, equipment failures and juggling two-week wait diagnostics demand. The ICDT do receive some feedback when there are reporting delays but this is not routinely reported – Action SC to consider including some information on reporting delays in future reports.

RW enquired why the RAG rating for the high impact action ‘Ensuring Trusts are improving rhythm of diagnostic performance management’ (page 26 of the performance assurance report) had changed from amber to red. SC confirmed that this change was due to deteriorating performance in the last month and work is on-going with providers to setup a similar rhythm to that in place for RTT.

The committee discussed which forums could best address the demand management issues and other strategic considerations. CW suggested that issues would need collaborative discussion between commissioners and providers. RW asked if CW might give some thought to how this group links into and is appraised of these activities - Action CW.

AB highlighted that south east London would benefit from deploying a consistent approach to demand management and having a central forum to address and respond to challenges. He reminded the committee that south east London has proposed consistent commissioning intentions and system improvement plans with the acute trusts and together these agreements will have an impact on reducing costs and improving performance.
Notwithstanding the above comments, the committee noted its assurance on the SEL CCGs’ acute performance position.

5. Proposed Schedule of deep dives

In response to two queries from RW on the schedule of deep dives, SC confirmed there would be a deep dive on each area covered by the scope of the committee and there was flexibility on the order. She explained that the May review would be on the operating plan submissions which would provide the committee the context to understand and assess risks for 2019/20. Finance and activity could be presented in June to enable the committee to understand what the plans are predicated on, the risks and issues. RW added that April’s deep dive on demand management had been agreed in December 2018.

MW asked how quality and safety would be built into the schedule - it was agreed there would be a quality and safety lens for each deep dive.

HG asked if the deep dives could encompass a range of evidence and insight from a variety of sources. CW responded in the first instance that the Committee should explore in greater depth, and with more time, the data that it already receives.

SC cautioned that there needs to be clarity on the scope and level of detail required of deep dives to ensure sufficient resource is available to produce them along with the regular committee reports. The committee continued to discuss this and broadly agreed the reviews should focus on appraising the committee that action plans are being implemented and are having the required impact.

In response to a query from NK, CW clarified that mental health was beyond the current scope of the committee. She added that the purpose of the committee was to focus on acute services which could free up CCG committees to discuss local ways to support providers.

The committee endorsed the schedule and agreed to review it after the July deep dive.

6. Deep dive – impact of demand management/referral optimisation

DS introduced the review. The committee was reminded that the previous update in December 2018 reported significant year-on-year growth in referrals for the first five months of the year (5.1%) and that each CCG and Planned Care Board were implementing approaches to optimise the value and quality of referrals. DS reported that referral levels for month 6-10 had now dropped by 0.3% compared to the same period last year, however there is variation amongst the CCGs with referral levels still growing in Lambeth and Southwark. Those two CCGs pioneered the planned care schemes early on and now need to maximise utilisation and sustain improvement or develop new approaches.

DS explained that a key area of focus would be to continue to develop referral assessment services which will help to ensure patients are seen in the right service, first time and reduce inappropriate referrals to secondary care and reduce waiting times. The implementation of referral assessment services has already had a positive impact on the dermatology and ophthalmology pathways.
HG asked if there was an overall annual increase in referrals this year and how much of this was being driven by population growth. DS confirmed there had been an overall increase in referrals and the year-end target of 0.8% will not be met, however there was no clear link that this was being driven by population increase.

AB highlighted the need to carry out a stocktake of the different approaches being taken across south east London and to better understand their impact.

The committee discussed the challenges posed by patient expectations and, as expressed by UN, the need to address patient and population OD and to adopt a transformational approach to stem the number of referrals. DS acknowledged the challenge GPs were facing due to patient expectations and highlighted that the advice and guidance services being implemented were helping GPs to manage patient expectations and manage difficult conversations. He assured the committee that the planned care programme is looking at transforming services, particularly outpatients and discharge processes.

RW commended the review and highlighted it as an exemplar for future deep dives. He stressed the need for an OD approach.

The committee noted the review and endorsed the recommendations.

SEL CCGs Month 11 Finance Report

UN presented the M11 report. He reported a combined forecast deficit of £6.2m and the collective M11 position as being £9.4m away from the SEL control total, which is primarily driven by an overspend by Bexley CCG of £10m.

QIPP delivery is forecast at £91m, representing 87% delivery against the plan of £105m, however there is significant variation in delivery across south east London.

There will be an on-going focus on the underlying position going into 2019/20 and the current underlying deficit for 2018/19 is £27.3m as opposed to the £9.3m that had been previously reported. A number of non-recurrent actions have been taken with a value of £18m to support the position and will make 2019/20 more challenging.

NK asked for more information on the nature of the aged debtors for the different boroughs and the factors driving the overspend in continuing healthcare. UN clarified that the majority of aged debt over 91 days sits with Greenwich CCG and it relates to bills with the local authority – Action UN will provide further commentary on the aged debtor position in next month’s report. UN explained that the largest overspend was in Bexley due to under-delivery of QIPP. The committee noted historic and on-going comparative benchmarking work that will help ensure a consistent and more cost-effective approach is taken across the boroughs.

NKB added that all CCGs are under average on CHC spending and for 2019/20 south east London will aim to have a single policy and consistent framework.

The committee noted the current financial position and registered its assurance on the CCG’s delivery of their financial duties.
South East London 2019/20 Planning Stocktake

SC introduced the item and noted that the paper had been circulated to regulators for the second stocktake meeting. The paper sets out the priorities for 2019/20; the approach to planning; the outcome of the contracting round; and financial risks and how they will be managed as a system.

Since the stocktake there have been some changes on the financial risks and performance trajectories which were included in the operating plan submissions on 4 April. It was noted that regulators are pleased with the finance plan particularly because of the significant financial risk that has existed within the system. The committee noted in 2019/20 there would be greater consistency across the plans and contracts in south east London.

Key next steps will be to work with the system to de-risk CCG QIPP and provider cost improvement plans and ensure robust performance and activity management plans are developed.

HG highlighted the importance of having 'a single version of the truth' understanding of the system when undertaking the planning process. He noted the level of interaction that was happening in other areas between non-executives from across the system and asked if this was happening in south east London.

SC highlighted the level of engagement that had taken place with provider CEOs and Chairs to agree improvement plans and contracts, however she acknowledged that more could probably be done. HG emphasised that non-executive directors from across the system are generally not sufficiently sighted on the planning process and the outcomes. SC highlighted that non-executive directors would have been sighted on the development of improvement plans and contracts as they had been presented at governing body meetings. The committee noted that much progress has been made to ensure the STP is working more closely to a plan and to common ambitions. It was noted that although the lay member forum was not currently looking to move to a joint forum with providers, it may be appropriate to meet jointly a few times a year at key points. RW suggested it might be helpful to discuss with RG on how to best use the lay members forum to support this - Action CW

Based on her experience, NK felt that governing bodies were not fully appraised of the plans which could be a potential risk to the successful delivery of the system transformation. RW assured the committee that a risk is being tracked on the System Reform Delivery Group’s BAF around effective engagement and communication and a specific workstream has been established to implement engagement plans. Further assurance was provided that the engagement plan is on track and further details on the system reform will be communicated once they are finalised.

The committee noted the planning stocktake.

South East London IG&P Board Assurance Framework – April 2019

Members reviewed the SEL BAF and noted the current risk position.
The committee noted the BAF, acknowledging the comments made at the start of the meeting.

10. **Any Other Business**

CW highlighted to the committee that a single diligent system is available across SEL. For future meetings, papers will be uploaded to diligent, circulated via email and only a couple of printed copies will be provided. Access to this system for all members needed to be confirmed – **Action OAR**

11. **Date of next meeting:** Friday 10 May 2019, 3.00 - 5.00pm.
South East London
Integrated Governance & Performance Committee

Minutes

10 May 2019

Present

Ray Warburton (RW) Independent Lay Member & Meeting Chair
Andrew Bland (AB) Accountable Officer, SEL Commissioning Alliance (SELCA) ¹
Andrew Eyres (AE) Accountable Officer, Lambeth CCG
Simon MacKenzie (SM) Secondary Care Doctor, Lewisham CCG
Martin Wilkinson (MW) Managing Director, Lewisham CCG
Christina Windle (CW) Director of Commissioning Operations, SELCA
Angela Bhan (ABh) Managing Director, Bromley CCG
Harvey Guntrip (HG) Lay Member, Bromley CCG
Sarah Cottingham (SC) Director ICDT, SELCA
Ross Graves (RGr) Managing Director, Southwark CCG
Neil Kennett-Brown (NKB) Managing Director, Greenwich CCG
Richard Gibbs (RG) Lay Member, Southwark CCG
Kieran Swann (KSw) SEL Assurance Team, SELCA
Keith Wood (KW) Lay Member, Bexley CCG
Adrian McLachlan (AM) Chair, Lambeth CCG
Sue Gallagher (SG) Lay Member, Lambeth CCG
Yvonneke Roe (YR) Clinical Lead, Southwark CCG
Jacqueline McLeod (JM) Clinical Lead, Lewisham CCG
Malcolm Hines (MH) Director of Finance, Southwark, Bromley & Bexley CCGs
Krishna Subbarayan (KS) Chair, Greenwich CCG

Apologies

Siddharth Deshmukh (SD) Chair, Bexley CCG
Usman Niazi (UN) Chief Financial Officer, SEL Commissioning Alliance (SELCA)
Christine Caton (CC) Chief Financial Officer, Lambeth CCG
Amana Humayun (AH) Lay Member, Greenwich CCG
Andrew Parson (AP) Chair, Bromley CCG
David Maloney (DM) Chief Financial Officer, Greenwich & Lewisham CCGs

¹ (Bromley, Bexley, Lewisham, Greenwich and Southwark CCGs)
1. Introductions, apologies and declarations of interest

RW welcomed members to the meeting. Apologies were noted as above.

No interests conflicting with the business of the meeting or changes to existing interests were declared.

2. Minutes of the last meeting – 5 April 2019

The minutes were approved as an accurate record.

CW updated the committee with the plan for the emergent Single CCG / ICS Board to receive the committee's minutes and recommendations in future. CW and RG shared their views on the proposal for lay members and trust NEDs establishing a regular meeting. It was noted a meeting was not planned to happen imminently.

It was confirmed that KSw would pick up on the option to include an SPC based analysis of the performance position as part of the performance assurance report.

The committee reviewed the action log and noted all actions due for May 2019 as being complete.

3. Deep dive: Round up of 19/20 Operating Plan submissions

SC presented a summary of the 19/20 planning round for SEL. She reported that plans have been approved by the STP and submitted as part of the STP Operating Plan for 2019/20. She advised the committee that planning trajectories for the key performance standards were still being further developed in dialogue with NHSE on GSTT cancer performance on 62 day waits focussing on out-of-London flow; diagnostics at KCH and GSTT with a push from the regulator for trusts to recover their performance position more quickly; and additionally the trajectory for RTT backlog clearance which SC reported was being discussed with trusts and regional directors to work through the deliverability of the proposed trajectory.

SC noted that the target trajectories are underpinned by provider recovery plans and she explained the governance arrangements to be set-up or currently in place to oversee delivery of plans in-year.

SC highlighted the risk in delivery of trust trajectories, including workforce risks associated with operational delivery – both in terms of managerial and clinical capacity to deliver; and the challenges posed by vacancy rates and restructures. A further risk was highlighted relating to demand and capacity mismatches. SC described the mitigations to this risk as pathway changes and demand management actions together with short-term recovery actions including in-housing and outsourcing and work across trusts to manage and distribute demand between sites. SC flagged a specific challenge in trusts being able to rapidly react to changes in capacity (i.e. to cover unplanned clinical absences etc.). SC commented on risks associated with managing cultural change to support the uptake of new pathways and out-of-hospital responses.
SG asked whether SC had concerns around how trusts actions to promote a positive working culture and staff health and wellbeing were being undertaken. She also asked whether there was any concern related to issues associated with pension changes as had been highlighted in the press.

SC confirmed her assurance that GSTT respond effectively to their staff survey to ensure staff are effectively supported and their wellbeing considered. SC agreed to ask the trusts to comment on how their boards monitor staff wellbeing and issues related to staff morale – **Action SC**.

ABh explained some of the work being led by SEL STP on developing workforce to support recruitment and retention across a range of clinical professions.

RW added that the equality analyses underpinning, and the actual results of, the NHS Workforce Race Equality Standard (WRES) pointed to some trusts being difficult places for staff to deliver and thrive to their potential.

It was agreed to schedule a further ‘deep-dive’ on issues relating to workforce. **Action - KSw/RW** to schedule.

MH explained the pension changes that have recently come into effect. SG said her point was about the disincentives for consultants to undertake extra sessions. SM noted this is likely to be a risk for central London trusts.

YR asked how we might ensure surplus capacity is more efficiently used across the system (i.e. IUC centres) and how streaming initiatives work effectively to facilitate this. She also commented that patients often have a great insight into how things could improve, and asked SC how do trusts capture and use this intelligence?

SC commented on some of the work the team and trusts do in delivering streaming of patients attending A&E departments. She also gave some examples of how specific patient feedback is used and issues of concern addressed and escalated.

RG asked about the governance arrangements in place to oversee joint programmes of pathway change.

SC said that the overarching programme for both urgent and planned care was reported to the STP/Emergent ICS Board which included the chief executives of the trusts. She described some examples of outpatient transformation which had come out of the planned care boards and would be overseen by the STP / emergent ICS Board in future via the Acute Care Board.

AM asked about the research that had been completed into the nature of increased demand in both planned and unplanned care. AM also asked when SC anticipated seeing an acute impact of developments in primary care including the implementation of PCNs.

SC described some of the pathway changes and assumptions around a shift of capacity to out of hospital settings. She said this should be further analysed ahead of the next planning round. On the reasons for increased access, SC report on work being undertaken on demand and capacity analysis with the cancer network on diagnostic capacity.
SM asked about fluctuating patterns of urgent care performance at KCH. SM also asked about how increased e-RS use had increased waiting lists.

SC commented that these may be associated with challenges around the trust’s operational management control; demand and capacity planning; and the trust having several partners having previously worked with it advising on resolution plans. ABh also noted the changes in recording practice of type 3 patients from June 2018, which caused a drop in performance at PRUH. SC commented on the e-RS referral growth was from non-local CCG areas with enhanced visibility of services to referring clinicians in these areas. She highlighted the agreement of some referral restrictions for non-local patients.

KS suggested that a combination of community and secondary care clinicians could play a useful role in overseeing and enabling the implementation of ambulatory care pathway changes. SC described some of the work in place and the groups set-up below the high-level governance structure that supported the pathway changes. She talked about examples of where local trusts have acted to successfully to ensure pathway changes are delivered.

JM commented on the variety of pathways available and suggested a resource to support accurate signposting so clinicians and patients can access the right service. She also asked whether the total opportunity for acute activity reduction has been realised - **Action SC** to provide further information to the committee on the possibility of resources to support better signposting and also the total opportunity of reducing demand through full use of the alternative pathways included in operating plans.

**The committee noted the update.**

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4. **SEL CCG Performance Assurance Report**

KS introduced the updated Assurance Report. He informed members that these changes were designed in response to feedback received from committee members including that provided as part of the recent survey on the committee’s pilot phase.

KS explained that the over-arching aim of the changed format was to better equip the committee to undertake its assurance role as an overseer of the SEL CCGs acute performance improvement and contract management processes. He said that the new format additionally attempts help the committee to hold CCG members to account for their contributions to performance improvement.

HG proposed that the reference to BAF in the assurance report should include a review date. Other than that, the Committee welcomed the format and thanked KSw and colleagues for responding so well to the concerns of members.

With regard to the content of the report, SC highlighted the inclusion of LAS and 111 data and reported that KCH had achieved its 52-week wait trajectory at March 2019.

RW asked for more details on the workforce issues experienced by the 111 service. HG commented that it appeared that there was a risk of a potential that professionals might not be set-up to work in the service for the long-term and that a targeted approach to recruitment, retention and development of post-holders should be considered. ABh explained some of the workforce challenges relating to 111 and she described some of the challenges recruiting...
senior clinicians and mentioned a model of rotational posts for ANPs and GPs which is being trialed in the clinical advisory service. She commented on the graph of page 16 which shows the Impact of the IUC service reducing demand on urgent care services.

RW asked for further comments on how mental health patients are managed by the service. SC mentioned the agreed routing of patients to Oxleas and SLAM. She further noted the funding of winter pressures monies that were used to support mental health reduction in 12-hour breaches and support for mental health in urgent care department and advised the committee that this investment has been mainstreamed in 19/20 contracts.

SM asked whether trusts undertook a learning process from the RCAs in cancer and then made changes to practice. SC explained the RCA process and highlighted the main factors in cancer as being complexity of cases; administrative issues and patient choice. She explained some of the work in place to address this and noted the process of challenge around response to RCAs.

SG asked about whether data was available to show how each SEL CCG was delivering their commitments to support a community response to urgent care demand. SC highlighted some of the challenges in this and noted this was work in progress. She described issues related to access to comparative data from community providers. SC noted the CCGs have been asked to set out their individual responses to out-of-hospital actions to reduce demand.

SC responded to a point raised in the previous minutes about cancer performance at LGT. She flagged the managerial and cancer data team vacancy rates; and issues with diagnostic access. She reported this has been escalated with the trusts and she has received an action plan from the trust within the last few days. **Action – SC** to update the next committee on progress against delivery of this action plan as part of the performance assurance report.

JM asked about Transforming Care and for some further explanation on why adults and children didn’t have a CTR in place within 14 and 28 days respectively. NKB explained the logistical process for establishing CTRs with the right membership. He noted that this has been addressed by NHS England and it was expected to improve over the course of the year.

**The Committee noted the current performance position and registered its assurance that an adequate approach to remediation is in place and can reasonably be expected to deliver the necessary improvement.**

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<th>5. SEL CCGs Finance Update – M12 18/19</th>
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<td>MH presented the finance report and reported that KPMG were currently auditing final CCG accounts ahead of audit committees scheduled for May 2019.</td>
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<td>MH commented on the final year-end position for each CCG noting a net £6m deficit for the SEL CCGs against an original £3m planned surplus. He reported the delivery of QIPP at 86% of the original target of £105m. MH outlined the key areas of overspend as being in acute and continuing healthcare.</td>
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<td>KS asked about continuing healthcare spend across all CCGs, noting this was only not overspend in Bromley. MH and ABh said that this related to the way budgets had been set at the different CCGs. NKB noted the future risk around CHC spend.</td>
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The Committee noted the update and that regular SEL CCG finance reporting will begin in June 2019 based on M2 data.

South East London IG&P Board Assurance Framework – May 2019

RW thanked CW for this month’s BAF. He asked for questions and for comments on completeness of the BAF and the proposed risk scoring.

HG commented that the SEL BAF is well-aligned with local the local BAF in Bromley. He commented that the SEL BAF was rightly described at a high-level and focussed on providing assurance that actions were being undertaken to manage the risks with partners and providers.

The Committee discussed work in place to ensure patients are supported by services in advance of needing continuing healthcare. NKB explained some of the work underway in SEL to standardise and improve the clinical review process of patients; the setting-up of fast-track care packages for eligible patients leaving hospital; and the standardisation of continuing healthcare eligibility policies. AE commented on the changes in demographic prevalence of patients with CHC.

SM suggested that the team may wish to consider developing the content of the assurance column on the BAF so that these specify the actions being taken within the meetings noted in the current columns. CW proposed that the committee takes some further time to review risk assurances in further detail and it was agreed to do this for the June 2019 meeting – **Action CW / KSw.**

MW commented on the potential for slight variation in risk-ratings between CCG BAFs and SEL BAF and noted this would reflect local variation in risk appetite. SC commented on the lower risk-scores relating to a greater realism in start year trajectories when compared to previous years.

The Committee endorsed the BAF for May 2019 and accepted the proposed risk scores for each risk.

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<th>7. CCG Governing Body approvals of revised SEL IG&amp;P Terms of Reference</th>
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<td>RGr reported Southwark approved the updated ToRs for the SEL IG&amp;P and supported the direction of travel. He said that the Southwark Governing Body discussed changing the focus of the Southwark IG&amp;P in the context of the move to place-based system. He commented on the need for the committee to consider its future role and its relationship with CCGs on assurance relating to the quality of care commissioned by SEL CCGs.</td>
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<td>MW noted Lewisham’s approval of the ToRs at its 9 May 2019 Governing Body meeting.</td>
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<td>AM confirmed approval in Lambeth and highlighted the need to mirror changes in the business of the local IG&amp;Ps.</td>
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NKB confirmed agreement in both Bexley and Greenwich CCGs and said that a decision has been agreed to switch local IG&P to a bi-monthly cycle with an agenda that considered areas of business not covered at SEL level. He reflected that CCGs welcome early opportunity to receive and share papers in advance in order to get input from colleagues. KW commented on the learning curve for the Bexley GB in receiving reports from both local and SEL IG&P committees.

HG confirmed Bromley’s approval and noted their request that local committees propose items of business for the SEL committee to consider and act on.

It was proposed that meeting papers are made available to all CCG governing body members via Diligent – **Action KSw** to arrange with Jackie Peake.

The committee noted the update and RW thanked members for their work in colleague taking governing bodies through the proposed changes in the scope and delegation arrangements for the SEL IG&P.

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<th>8.</th>
<th><strong>Any other business</strong></th>
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<td></td>
<td>No items were raised.</td>
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| 9. | **Date of next meeting:** Friday 21 June 2019, 3.00 - 5.00pm. |