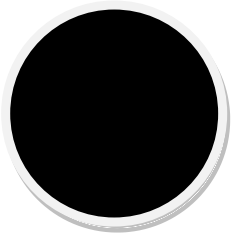
South East London

ENCLOSURE 8 – ENCLOSURE 22

NHS SOUTH EAST LONDON PCT/ CARE TRUST BOARDS

Thursday 19th May 2011, 3.00pm-6.00pm

Council Chambers,
Lewisham Town Hall,
1 Catford Road,
London SE6 4RU



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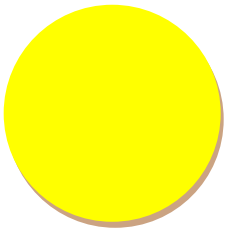

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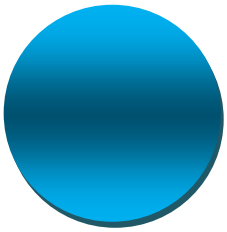

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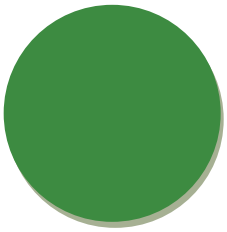

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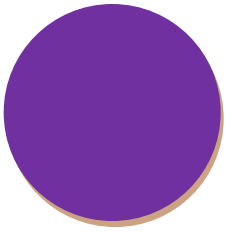

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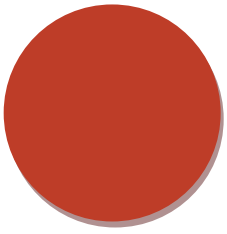

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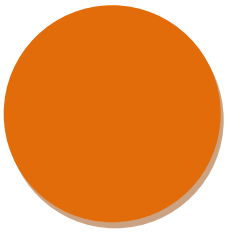

Southwark (Orange)

TAB COLOUR INDEX

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

A meeting in Public, of the Boards of Bexley Care Trust, Bromley Primary Care Trust, Greenwich Teaching Primary Care Trust, Lambeth Primary Care Trust, Lewisham Primary Care Trust and Southwark Primary Care Trust will take place on **Thursday 19th May 2011, 3.00pm-6.00pm at the Council Chambers, Lewisham Town Hall, 1 Catford Road, London SE6 4RU.**

Board members are requested to send questions or clarification requests to the Board Secretary by 12.00pm on Monday 16th May 2011. Answers to these questions will be provided to Board members the evening before the meeting via e-mail and will be tabled at the meeting and appended to the minutes.

The public are asked to indicate to the Board Secretary any points of enquiry or questions they would wish to address with the Boards, three days before the meeting, please contact Jane Walker on 020 3049 4335 or via e-mail at jane.walker11@nhs.net.

Chair: Caroline Hewitt

AGENDA

AGENDA

	Time	Item	Papers	Presented by
BM/001/11	3.00	**Welcome & Introductions**		Caroline Hewitt
BM/002/11	3.05	**Apologies for Absence**		Caroline Hewitt
BM/003/11		**Declaration of Interests*** *Members should discuss any potential conflicts of interest with the Chair prior to the meeting*		All
BM/004/11	3.10	**Matters Arising not on the agenda**		Caroline Hewitt
SET-UP				
ACTION BY: All Boards				
BM/005/11	3.15	**Governance** • Governance Framework - Joint Committees - Standing Orders/Standing Financial Instructions/Scheme of Delegation • Adoption of the Principles of Public Life • Adoption of NHS SEL Boards' Contract • Adoption of lead officer roles • Indicative Corporate Risk Register	ENC 1 ENC 2 ENC 3 ENC 4 ENC 5	Simon Robbins

BM/006/11	3.30	**NHS SEL Business Plan & Corporate Objectives** To agree the Corporate Objectives and the NHS SEL Business Plan	ENC 6	Gill Galliano
BM/007/11	3.40	**Integrated Plan** To approve the integrated plan (full document available at http://www.selondonsector.nhs.uk/documents/608.pdf) and receive an executive summary identifying key risks and way forward	ENC 7	Gill Galliano
BM/008/11	3.55	**Emergency Planning & Business Continuity Policy** To agree the NHS SEL Emergency Planning & Business Continuity Policy	ENC 8	Dr Ann-Marie Connelly
SET-UP				
INDIVIDUAL ACTION BY: Bexley Care Trust, Bromley Primary Care Trust, Greenwich Teaching Primary Care Trust, Lambeth Primary Care Trust, Lewisham Primary Care Trust and Southwark Primary Care Trust				
BM/009/11	4.05	**Minutes of previous PCT Board meetings** To agree the minutes and action sheets from the previous Board meetings of: • Bexley Care Trust • Bromley PCT • Greenwich Teaching PCT • Lambeth PCT • Lewisham PCT • Southwark PCT	ENC 9	Dr Joanne Medhurst/ Pamela Creaven Dr Angela Bhan Annabel Burn Andrew Eyres Martin Wilkinson Andrew Bland
BM/010/11	4.15	**Pathfinder Development & Delegation** To agree the proposal for delegation to Local Clinical Commissioning Committees	ENC 10	Gill Galliano
BM/011/11	4.35	**Local Clinical Commissioning Committees** To agree the Terms of Reference of the Local Clinical Commissioning Committees (LCCC): • Bexley • Bromley • Greenwich • Lambeth • Lewisham • Southwark	(See ENC 1)	Dr Howard Stoate Dr Andrew Parson Dr Hany Wahba Dr Adrian McLachlan Dr Helen Tattersfield Dr Amr Zeineldine

AGENDA

10/11 YEAR END				
ACTION BY: All Boards				
BM/012/11	4.45	**Performance & Quality** To note the 2010/11 outturn performance position	ENC 11	Jane Schofield
11/12 ISSUES				
ACTION BY: All Boards				
BM/013/11	4.55	**Finance Report** To note the 2010/11 financial position, agree overall cluster budget, note impact of acute contract settlements, use of 2% non recurrent funding and QIPP programme. To delegate authority to the audit committee for adoption of accounts and sign off to Chair, Chief Executive and Director of Finance	ENC 12	Marie Farrell
BM/014/11	5.05	**Quality Report** To receive an update on key quality issues to be prioritised in 2011/12	ENC13	Dr Jane Fryer
BM/015/11	5.15	**London Review of Cancer Services** To receive an update on actions to be taken and any decisions to be made	ENC 14	Andrew Eyres
BM/016/11	5.25	**Pharmaceutical Applications Panel** To approve a proposal to establish a Pharmaceutical Applications Panel	ENC 15	David Sturgeon
11/12 ISSUES				
INDIVIDUAL ACTION BY: Bexley Care Trust, Bromley Primary Care Trust, Greenwich Teaching Primary Care Trust, Lambeth Primary Care Trust, Lewisham Primary Care Trust and Southwark Primary Care Trust				
11/12 ISSUES – FOR DISCUSSION				
BM/017/11	5.30	**BEXLEY CARE TRUST** To discuss progress on the QMS Campus Outline Proposal	ENC 16	Dr Joanne Medhurst/ Pamela Creaven
11/12 ISSUES – TO RATIFY CHAIR'S ACTION				
BM/018/11	5.45	**BEXLEY CARE TRUST** To ratify Chair's Action for the business case and transfer of £2.4 million to the Local Authority for social care	ENC 17	Dr Joanne Medhurst/ Pamela Creaven

BM/019/11	5.45	**LAMBETH PRIMARY CARE TRUST** To ratify Chair's Action for Lambeth PCT & Southwark PCT Community Services Integration with GSTT	ENC 18	Andrew Eyres
BM/020/11	5.45	**BROMLEY PRIMARY CARE TRUST** To ratify Chair's Action for Local Pharmaceutical Service Continuation of Designation	ENC 19	Dr Angela Bhan
ITEMS FOR INFORMATION ONLY The following items are for information only and will not be the subject of discussion at the meeting unless members indicate otherwise three working days before the meeting. Please contact Jane Walker on 020 3049 4335 or e-mail **jane.walker11@nhs.net**				
ACTION BY: All Boards				
BM/021/11		**Chair's Report**	ENC 20	Caroline Hewitt
BM/022/11		**Chief Executive's Report**	ENC 21	Simon Robbins
BM/023/11		**Director of Public Health Briefing**	ENC 22	Dr Ann-Marie Connolly
ANY OTHER BUSINESS				
BM/024/11	5.50	Any other business		
BM/025/11	5.50	To receive questions from the public (if time allows)		Caroline Hewitt
DATE OF NEXT MEETING				
BM/026/11		Thursday 21st July 2011, PART I 3.00pm-6.00pm, PART II 6.10pm-7.00pm, Venue to be confirmed		
BM/027/11		To consider a motion that the public should be excluded from the meeting while the remaining business is under consideration, as publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted.		Caroline Hewitt

*All Board members and senior employees of NHS SEL have the legal obligation to act in the best interests of each of the SEL PCTs and Care Trusts. Public service values matter in the NHS and those working in it have a duty to conduct NHS business with probity. All board members and senior employees are therefore expected to declare any personal or business interest which may influence, or may be perceived to influence, their judgement. This should include as a minimum, personal, direct or indirect financial interests.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 8

ENCLOSURE 8

EMERGENCY PLANNING (EP) & BUSINESS CONTINUITY (BC) POLICY

DIRECTOR RESPONSIBLE: Dr Ann Marie Connolly – Director of Public Health

AUTHOR: Mr Nick Vincent, Emergency Planning Manager

TO BE CONSIDERED BY: All

SUMMARY:
As the organisations have been through extensive re-organisation, with movement of provider arms and downsizing of staff, there has been a need to revise the approach to emergency planning and to providing a 24 hour on-call rota. In March a shortlived Joint Emergency Planning group came together and coordinated work on the establishment of a new cluster wide Director on-call rota with associated supporting material and induction. This was the first phase of action on the transition of responsibilities and new postholders.

However there is a programme of work required to ensure as the PCTs continue to be Category 1 responders under the Civil Contingencies Act. It is important that the statutory responsibilities are fulfilled and can be demonstrated to be fulfilled.

The approval of this policy contributes to the assurance process and completion of assurance returns to NHS London to demonstrate that the new organisation is compliant with its statutory responsibilities.

An appendix to the policy document sets out the Terms of Reference for a new Emergency Planning and Resilience Steering Group. It is proposed that Group will report to the Quality and Safety Committee of the Board

At the beginning of April each London cluster was asked to complete an assurance template about emergency planning and business continuity. This was completed for NHS SEL and submitted by the relevant date at the end of April 2011. To support the NHS SEL submission the attached policy was completed to out line progress so far and planned actions. It was

submitted with the caveat that it was subject to Board approval.

KEY ISSUES:
Prior to April 2011 PCTs provided an out of hours rota to respond to the management queries and also any major incidents. With the changed structures and loss of many staff, this has meant that much of the planning and preparation has become out of date. A cluster wide approach has been implemented to secure a sector wide system that supports BSUs to fulfil their local responsibilities.

The actions so far and the proposed approach will put in places systems to assist with managing risks of being faced with incidents and issues that require an immediate response. It assists the Joint boards to be assured that their responsibilities are fulfilled.

The approach that has been taken is to work within existing resources with a small non-pay contingency fund. It is not possible to identify the financial impact of a major incident as it will depend on the type of major event.

INVOLVEMENT:
- This paper has been reviewed by the Cluster Management Board

RECOMMENDATIONS:
The board (s) is asked to:-
- Approve the policy
- to note the actions taken so far and approve the planned actions to secure robust emergency planning and resilience arrangements for the Joint Boards

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E-Mail: nick.vincent@southwarkpct.nhs.uk
Telephone: 020 7525 0292

South East London

Emergency Planning (EP) & Business Continuity (BC) Policy
May 2011

ENCLOSURE 8

Executive Summary

Emergency preparedness is a vital element which should underpin all NHS activity. NHS South East London is a transition body, but is composed of legally constituted public bodies with statutory duties to have emergency and business continuity plans in place.

This policy paper updates the Joint South East London PCT/Care Trust Boards regarding work that has taken place to date. It examines roles and responsibilities and governance arrangements around emergency planning and recommends the adoption of national standards for emergency planning.

There is a need to review all the emergency plans to ensure they are consistent with the new arrangements; this includes generic plans as well as threat-specific plans. The threat-specific plans will be derived from a risk assessment process and ensure that the organisation is prepared for those risks and hazards deemed to be serious in terms of likelihood versus impact.

The organisational changes have resulted in the need for a root and branch review of business continuity plans across the Cluster; this policy paper gives a summary of an action plan (within a timeframe) to put revised business continuity plans for corporate cluster activity in place within six months.

Finally, this paper discusses the need for a process to ensure the organisation and its component parts are ready for the challenges that the London Olympics will bring next year.

1. Introduction

The NHS in London is currently in a period of major change following the publishing of the White Paper “Liberating the NHS”, and the requirement of NHS London to substantially reduce management costs. The substantial changes to the architecture of the NHS have significant implications for the well-established processes that make up health emergency planning and response in London. Additionally, because health emergency planning is integrated into London’s major incident planning and response, the changes have consequences beyond health; all of London’s responder’s will need to consider the changes and their impact at all levels.

Throughout this period, the threat to the country from an act of terrorism remains “severe”, i.e. an attack is highly likely. The threat from cyber terrorism has also, over the last decade, increased exponentially. Last winter demonstrated the challenges that severe weather can bring in the context of climate change; whilst the expectations surrounding the Olympic Games in terms of resilience bring added

impetus to the emergency planning and business continuity requirements of the CCA 2004.

During the consultation period, consideration was given by emergency planning managers across South East London as to the likely consequences for emergency planning, response and the possible need to revise the executive on-call arrangements.

In mid-March, a decision was made to form a short-life working group to analyse these issues and form an operational plan. This group, which continues to meet, is chaired by Dr Ann Marie Connolly and members are drawn from emergency planning, public health managers and now newly appointed senior managers from some BSUs from across the area with admin support from the cluster. Emergency Planning Network Managers from NHS London have also attended all meetings to date and have fully contributed to this process.

To date, the group has established,

- A successful transition from the PCT on-call arrangements to a first and second-on call Executive Director for the cluster
- An on-call rota completed up to mid-July
- An on-call handbook (drawing on the best bits from of all the existing handbooks)
- Review of Emergency Control Rooms across the six PCT and subsequent identification of a Cluster Primary and Secondary emergency control room at Lower marsh and Bexley respectively.
- Training – a rolling programme of 1-2-1 sessions for directors before they go on call
- A Draft Cluster Major Incident Plan, based on the best elements of the existing PCT plans. To be validated during planned training and table top exercise for end of May and beginning of June.
- The commencement of threat-specific Cluster Incident Plans, starting with a Heat Wave Plan
- The Development of a Cluster Emergency Planning and Business Continuity Policy, Strategy and Action Plan

The Cluster has had to submit evidence of preparedness to NHS London as part of a National Emergency Preparedness Assurance Process. As an organisation in transition this has proved to be challenging. However, one of the aims of this policy is to lay down a clear direction towards maintaining a state of emergency preparedness.

2. Scope

These proposed changes will require a dynamic review of the Cluster and BSU emergency preparedness arrangements. This Policy applies to:

- NHS South East London, incorporating:
- Bromley BSU
- Bexley Care Trust
- Greenwich BSU
- Lambeth BSU
- Lewisham BSU
- Southwark BSU

The Policy aims to:

- Identify responsible officers for emergency planning and business continuity
- Formally acknowledge that EP and BC is a corporate function of the Cluster and BSUs
- Proposes the adoption of nationally established standards for emergency planning and business continuity
- Proposes emergency planning and business continuity corporate structures and governance arrangements
- Sets out the Business Continuity Management Process as it applies to the Cluster and BSUs
- Explains the EP and BC training and exercise schedule.

3. General principles

3.1 Ownership and Governance

The six PCTs continue to legally exist with the corresponding statutory duties imposed by the Civil Contingencies Act 2004; this includes a duty to put systems in place for planning, implementing and reviewing responses to a range of potentially disruptive incidents.

The NHS Resilience and Business Continuity Management Guidance 2008

a) Gives each Chief Executive Officer responsibility for ensuring that their organisation implements a process that will ensure effective business continuity; and
b) Expects all NHS organisations to prepare, maintain and review business continuity plans to enable them to maintain critical services for at least seven days.

Guidance to the Act states that Category 1 Responders can collaborate in order to discharge their statutory functions and this policy is drafted with that context.

The executive lead for emergency planning is the Director for Public Health, Dr Ann-Marie Connolly.

Responsibility for detailed planning, coordination of training and exercising and liaison with other stakeholders with regard to EP & BC is delegated to members of the Emergency Planning and Resilience Steering Group which is comprised of:

- Emergency Planning Managers and emergency planning and business continuity leads drawn from all six BSUs – see below
- Cluster Estates EP Lead
- Cluster ICT EP Lead
- Greenwich BSU Olympic Lead
- Cluster Primary Care Commissioning EP Lead
- Cluster Communications EP Lead
- South East London Health Protection Unit

The Steering Group is accountable to the Cluster Board and reports via the Quality and Safety Committee. Terms of Reference are included in Appendix A.

The Emergency Planning and Resilience Steering Group will submit an annual report on emergency planning to the Board which will cover both each individual BSU and Cluster emergency preparedness.

Managers and staff have a responsibility to ensure they are familiar with emergency planning and response arrangements and attend training sessions and exercises appropriate to their position in the organisation.

3.2 Healthcare Resilience

A Publicly Available Specification was published in October 2010 (PAS 2015) by the British Standards Institute, sponsored by the Department of Health. The purpose of this document is to build upon the guidance issued in BS 25999 and NHS BS 25999 (Business Continuity Management). The PAS defines healthcare resilience as,

"the ability of an organisation to adapt and respond to disruptions, whether internal or external, to deliver organisationally agreed critical services"

It provides a generic framework on which NHS South East London can develop a resilience framework by incorporating the Integrated Emergency Management (IEM) model (*see Figure 1*). This is the UK national model, adopted by the Department of Health which defines a common set of words and processes. By adopting common ground it provides for effective cooperation with other organisations and external agencies.

For these reasons, NHS South East London adopts the IEM as the basis for its emergency planning and business continuity processes. The intention is that emergency planning and business continuity processes and outcomes will be aligned with BS 25999 and PAS 2015

Additionally, all major incident and business continuity plans will be reviewed against the London Olympic Regional Planning Assumptions (LORPA) and enhanced if necessary to ensure they are "Olympic Resilient".

Figure 1 – Integrated Emergency Planning Model

The elements of the IEM with examples of actions and applications are outlined below.

Element	Explanation	Application – examples
Anticipate	Sometimes called horizon scanning, gaining awareness of new hazards and threats	Internal and external intelligence, emergency planning meetings, communications, media
Assess	Hazards and threats as identified are assessed against the likelihood of occurrence and the impact if it did occur.	Use of community risk register and internal risk management processes.
Prevent	Application of a range of actions to mitigate either the likelihood of occurrence or impact.	Actions may be technical, practical, procedural or organisational.
Prepare	Maintain planning arrangements and effective management structures	Maintain plans, training and exercising. IGC and Board to be kept appraised of current developments via reports. External liaison processes.
Respond	Manage the immediate consequences of an emergency.	Maintain Emergency Control Room functions. Robust and resilient C3 capabilities.
Recover	Manage the longer term consequences and get back to “normal” ASAP	Ensure BC plans detail criticality of functions and recovery strategies

4. Emergency Planning structures across BSUs, NHS South East London and other stakeholders

Emergency Planning and Business Continuity is required at the local BSU level and at the Cluster level. Certain areas of planning need to be fully integrated at the local level and aligned with borough council and social care activity. However, because the command and control structures are based upon the Cluster’s Senior Management Team and assurance processes directed at the Cluster, a common framework approach (based on templates) is to be adopted.
This will ensure a consistency of approach and assist local managers in drawing up their plans.

4.1 Roles and Responsibilities – see also organisational chart in Appendix B

BSU

- Local champions to be nominated with responsibility for local emergency planning and business continuity, and:
- Should be of sufficient seniority to represent to the BSU at external meetings
- Supported by Emergency Planning Managers
- Are members of the NHSSEL Emergency Planning Steering Group
- Attend the Borough (Council) Emergency Planning Forum in their area
- Attend as required NHS London EP Network meetings
- Attend Provider Emergency Planning Committees if required, e.g. acute trusts
- Drafts plans to deal with specific threats that require local liaison, e.g. Heatwave and Flood Planning.
- Drafts Business Continuity Plans for the BSU supported by the Emergency Planning Managers
- Liaises with local Public Health Department in respect of Pandemic Planning
- Coordinates data aggregation within the BSU for incident Situation Reporting, e.g. primary care activity

Public Health Department

- Leads work on Pandemic Preparedness and Mass Outbreak Plans
- Supports BSU EP & BC Champion where that person is not in the Public Health Department
- Liaises with the South East London Health Protection Unit and the BSU Champion in respect of other health protection issues that may arise.

NHS South East London

- Emergency Planning Managers coordinate BSU plans and provides planning frameworks and templates
- Hosts and supports the work of the Emergency Planning Steering Group through the administrator based at Lower Marsh.
- Develops and maintains major incident response capabilities**,** including communication, command and control, e.g. Emergency Control Rooms.
- Coordinates Assurance Processes received from external bodies
- Leads on training and exercising
- Develops and maintain threat specific emergency plans where the threat is across South East London, e.g. Major Incident Plan, fuel disruption, adverse weather
- Develops and maintains a corporate business continuity plan.
- An Emergency Planning Manager will attend NHS London Emergency Planning Network meetings on behalf of the cluster.
- Maintains an emergency planning and business continuity page on the NHS South East London intranet and public website.
- Ensures arrangements and senior staff members participation in the out-of-hours rota for the cluster
- Ensures preparedness and business continuity plans for primary care contractors are in place across SEL

5. Emergency Planning

Emergency planning is defined as,
"[The] development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of a civil emergency"
British Standard BS NHS 25999 (2009)

The six PCTs had well-established major incident plans that have been reviewed on an annual basis and externally assessed through the NHS London Assurance Process.

The reorganisation has removed much of the local applications and emergency planning must now take at the Cluster level where command and control now sits.

Much work has been done in respect of a generic Major Incident Plan which has been distributed to the executive On-Call Team in draft form. This will be subjected to a table top exercise in June before formal ratification by the Management Board and Joint South East London PCT/Care Trust Boards

Threat-specific planning will take place using a standard Impact v. Likelihood risk assessment matrix. However, there are a number of nationally acknowledged risks where plans are expected to be in place. These are:

- Pandemic Plan – consistent with the new national Pandemic Strategy (2011)
- Heatwave Plans
- Mass Casualty Plans
- Chemical, Biological, Radiological, Nuclear and Explosion Plans (CBRN-E)
- Road Fuel Disruption Plan
- Lockdown Plans
- Evacuation Plans

It is the intention to rapidly develop these plans over the remainder of 2011 so as to be prepared for 2012. A number of plans already exist across the Cluster and it is the intention to extract the best elements to formulate these plans so that they can apply across the cluster and be made locally applicable for each BSU/local borough.

6. Business Continuity Planning

Business continuity is the responsibility of all managers who should ensure their service has a continuity plan. The Emergency Planning Managers are available to assist in this process and give advice.
Additionally, commissioners should ensure that providers have robust and tested business continuity arrangements in place to recover to Business as Usual after an incident. This requirement should be included in contracts and SLAs.

As a new organisation, NHS South East London will develop, maintain and exercise a corporate business continuity plan to ensure the commissioning service is resilient and that it can continue to coordinate a response to an incident.

A summary and timeframe to achieve this is outlined below. This applies to the corporate activities of the Cluster.

Area	Comment	By when
Command and control	• On-Call arrangements (SEL1 & SEL2) • Emergency Control Rooms • On-Call Handbook – version 1 • Training package	Completed April 2011
Business Impact Assessment (BIA)	• Determine and document the impact of an incident on key activities and services • Identify critical activities • Establish Maximum Tolerable Period of Disruption of each activity • Identify interdependent activities and assets • Determine continuity requirements	June 2011
Risk assessment	Exercise to consider and document which risks are most disruptive to the organisation, e.g. staff unavailability, severe weather, industrial action.	July 2011
Strategy formation	Consideration of strategic options for critical activities for the following resources: • People • Premises • Technology • Information • Supplies • Stakeholders	August 2011
Plan Development	Plan to include: • Invocation methodology • Roles and Responsibilities • Incident Management Team • Communications • Recovery Strategies • Debriefing and staff welfare considerations	September 2011
Training and Exercising	Training and exercising planned for May and June 2011 Schedule of ongoing training and exercising to be drafted proportionate to the risks surrounding the London Olympics. Current planned dates: • 3rd October 2011 • 8th December 2011 • 17-20th April 2012 (Pan-London)	Ongoing

6. London 2012

NHS South East London will have a key coordinating role in ensuring that emergency plans and business continuity plans across the NHS have a high level of inter-operability. London and the NHS are well versed in incident management; the

challenge the Olympic Games brings is the sustained period of activity whilst the world's media is watching.

The expressed intention from NHS London is that the Games should be "business as usual" but all plans should be tried, tested and "Olympic-Resilient". All plans should be reviewed against the London Olympic Regional Planning Assumptions (LORPA) and enhanced where necessary.

As Greenwich BSU is an Olympic Borough, the focus is likely to be there, but also in the South Bank areas of Lambeth and Southwark. The Emergency Planning and Resilience Steering Group will support and assist these areas and develop risk-appropriate plans to meet there challenges.

7. Conclusion

The coming year is likely to bring new developments as the a greater understanding of the future emerges, particularly with reference to the role of Public Health Departments, local authorities and the respective functions of Public Health England and the NHS Commissioning Board.

Additionally, the Cabinet Office is currently reviewing the Civil Contingencies Act 2004. The Enhancement Programme will contribute to revised legislation to take into account national changes in Responder status and the application of the CCA in London.

The Emergency Planning and Resilience Steering Group will keep the Management Board and Joint South East London PCT/Care Trust Boards informed of such developments and their impact on a regular basis.

It is recommended that the Joint South East London PCT/Care Trust Boards adopts this policy as the basis for emergency planning and business continuity processes.

Appendix A
Emergency Planning and Resilience Steering Group
Terms of Reference

Emergency Planning and Resilience Steering Group
Joint South East London PCT/Care Trust Boards

Terms of Reference

Aims

To provide strategic coordination of all aspects of Emergency Planning and Resilience for the Joint South East London PCT/Care Trust Boards, on behalf of the NHS SEL London Joint Board.

Objectives

1. Devise appropriate systems across BSUs, public health departments, local authorities and the Boards directorates to ensure resilience for all parts of the PCTs.

2. To develop a work program and oversee its implementation to develop and deliver the emergency planning and resilience functions of all 6 PCTs/Cluster.

3. To assess sector wide emergency planning requirements in relation to local risks, report and provide and provide assurance to the NHS SEL Joint Board.

4. To foster a collaborative approach to NHS emergency planning across the Joint South East London PCT/Care Trusts, ensuring a high level of inter-operability between the plans of the acute, non acute Trusts, BSU's and the subsequently for GP Consortia.

5. To provide a forum to strengthen and build upon the close relationship with the SEL Health Protection Unit and to decide upon appropriate and effective interaction with the wider Health Protection Agency.

6. To ensure effective communications between NHS stakeholders in SEL.

7. To consider local, regional and national emergency planning requirements to inform the work of the Emergency Planning Resilience Steering Group. (EPRSG)

8. To build on the collaborative approach within the NHS, fostering co-operative relationships with the SEL Boroughs and other multi agency partner organisations including Independent providers .

9. To share the findings of local emergency planning groups in order to:

   - Encourage learning.
   - Identify common issues.
   - Identify and share good practice.
   - Prevent duplication of work streams.
   - Contribute to the development of emergency planning across the wider NHS.

10. To establish short lived working groups as appropriate to deal with specific elements of the SEL ERP responsibilities and development of plans.

11. To contribute to the process of emergency planning training, exercising and post incident review across the NHS in SEL.

12. To develop and improve understanding of the SEL NHS Command and Control model.

13. To receive direction from, and provide advice to, the SEL Cluster Board on Resilience and Emergency Planning.

14. To work towards ensuring fully compliant and resilient GP Consortia.

Membership

- Director of Public Health (Chair)
- SEL NHS Emergency Planning Managers
- SEL Health Protection Unit emergency planning lead.
- Other NHS staff and appropriate representatives from external organisations, as identified by existing members.
- BSU EP Representatives
- Appropriate representative from the Cluster communications team
- Member from Greenwich BSU leading on Olympic Preparedness
- Co-opted members, agreed by existing members, for issues requiring specialist support.
- Health Emergency Planning Adviser (HEPA)

- Directorate of Primary Care Senior Representative

Accountability

The group is accountable to the NHS SEL Quality and Safety Committee . The group recognises that it has material devolved autonomy to develop policy, practices and relationships.

Timeframes, Reporting

The group will meet initially on a monthly basis and any reports will be submitted to the SEL NHS Joint Boards at that time.

It is the responsibility of all members to ensure that they advise the chair if unable to attend any given meeting and where possible provide an alternate.

Review

The work achieved by this group will be reviewed on a yearly basis and a decision taken on the need to continue or to adapt the arrangement.

Quorate

50% representation of BSU
1 Emergency Planning Manager
1 Chair

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 9

MINUTES OF PREVIOUS BOARD MEETINGS

DIRECTOR RESPONSIBLE: Gill Galliano, covering the role of Director of Development

AUTHOR: Ben Vinter, Integrated Governance Manager

TO BE CONSIDERED BY:
The Joint Boards are asked to receive and adopt as a record the appended minutes

SUMMARY:
The Joint Boards are asked to receive the minutes of each of the last meetings from 2010/11 of South East London PCTs and Bexley Care Trust, noting actions taken since the last meeting.

KEY ISSUES:
The Board minutes should be adopted for accuracy with the following actions having been taken or outstanding since each meeting;

Bexley

Agenda Item No	Agenda Item	Action requested	Status
031/11	Approval of the Diabetes Business Case	The Board approved the Business Case subject to satisfactory key performance indicators being agreed	Confirmation email sent to NEDs on 16.3.11.
032/11	PBC Kitemark 2011-12	The Board agreed the 2011-12 Kitemark and allocation of £1.5m subject to the details being amended to ensure it was aligned with the QOF.	Confirmation email sent to NEDs on 23.3.11.

ENCLOSURE 9

033/11	Joint Commissioning Strategy – Living Well with Dementia A Local Strategy for Implementation and Development	The Board approved the Strategy subject to satisfactory outcomes being approved by the Clinical Cabinet.	Clinical Cabinet will approve satisfactory outcomes and monitor the strategy.
037/11	Shadow Health Partnership Board Update	£2.4m for re-enablement and alleviation of winter pressures to Local Authority.	Chair's Action completed – see Sector Board Meeting 19.5.11 item BM 0115 Chair's Action for 2011-12 NHS Funding for Social Care

Bromley

Item No/Page	Action	Status
39/11 Pages 3/4	- Finalisation of the Cluster Governance arrangements and notification of Board agreement (Jim Gunner's email of 22 March to Caroline Hewitt refers)	On agenda 19/5/11 Joint Boards meeting .
39/11 Pages 3/4	- confirmation of appointment of Jim Gunner (Vice Chair) as a governor of Bromley Healthcare and of PCT involvement in the appointment of the Bromley Healthcare Chief Executive	On agenda 19/5/11 Joint Boards meeting
40/11 Pages 4/5	- Amendment of the report on Transitional Public Health Directorate Arrangements as proposed at the Board meeting and provision of legal support for the Section 75 agreement.	
44/11 Pages 7/8	- confirmation of the sign off of the indicative summary budgets following outcome of the SLA settlements	On agenda 19/5/11 Joint Boards meeting
13 – page 7	- development of assurance framework for the Joint Board	On agenda 19/5/11 Joint Boards meeting
27 – page 11	- development of the business case for the proposed Penge Primary Care Centre	

Greenwich

No outstanding Actions (see minutes attached).

Lambeth

Item No/Page	Action	Status
4 – page 2	**Matters Arising** **- Living Well Collaborative Mental Health Programme** HCM agreed to circulate to Board members a copy of the presentation on the LWC Mental Health programme due to be presented to the Health and Adult Services Scrutiny Committee later that evening.	Actioned.
7 – page 3	**Governance** AE to give consideration to the request of the Council to have a co-opted member of the LCCCB.	Being considered by the LCCCB, LB Lambeth formally invited to attend.
8 – page 4	**Annual Public Health Report (APHR)** JT and SG to discuss any final wording suggestions to the response of the Annual Public Health Report with AE prior to submission.	Completed, no material change required.
11 – page 5	**Integrated Plan 2011/12 (IP)** Board members to direct any outstanding questions to MM. MM to then provide a collective response and circulate to Board members for final approval with any final amendments to the Integrated Plan clearly outlined.	No further comments received from Board. Integrated Plan (IP and supporting financial framework) submitted to NHS London March 2011.
13 – page 7	**South East London Integrated Care Pilot** AE to suggest to Programme Board inclusion of Public Health input into the pilot. Update on pilot to be provided to the Cluster to share learning.	Actioned To be addressed in Forward Agenda planning
27 – page 11	**Message to Staff** Formal message of thanks to be sent on behalf of all the NEDs acknowledging staff for their hard work and to wish them success in the future	Message emailed to staff on 25.03.2011

Lewisham

Item No/Page	Action	Status
11/31	Section 75 - arrangements for an overarching Section 75 for Public Health, Children's Services and Mental Health would be taken forward.	To be discussed at Mayor and Cabinet in May
11/32	Assurance was requested that there would be improvement in the quality of maternity services provided at Lewisham Hospital.	Local Quality and Safety working group to review on forward planner along with Cluster contracting team and public health.

ENCLOSURE 9

11/36	A report requested from NHS London on how many staff had left with a redundancy payment and then rejoined the NHS.	
36.2	A request for an induction pack for NEDs for each new Committee to be produced.	

Southwark

Item No/Page	Item	Action
1055/11	**Governance Arrangements** The Board approved the use of Chairs Action as appropriate to approve final proposals in order to allow implementation of the governance structures by 1st April 2011.	Chairs action was taken to agree the Terms of Reference for the Clinical Commissioning committee, and sub groups for QIPP Delivery, Engagement and PALS, and Integrated Governance.
1060/11	**Transfer of Community services to GSTT Foundation Trust** Approved the use of Chair's action to agree the Transfer agreement, on behalf of the PCT, subject to approval by NHS London. Agreed to support Chair's Action in the unlikely event that outstanding issues in relation to the Transfer agreement cannot be resolved within sufficient time to allow the transfer to take place on 1st April 2011, and it becomes necessary to establish an interim management Agreement with Guy's & St Thomas NHS Foundation Trust.	The Chair and Board members were appraised of the final discussions and negotiations between Lambeth, Southwark and GSTT Trust. Approval was given to the signing of the Transfer Agreement and Contract, which took effect from 1 April 2011.

INVOLVEMENT:

COMMITTEE INVOLVEMENT:

- The matters raised relate to the business of each Board

PUBLIC AND USER INVOLVEMENT:

- n/a

IMPACT ASSEESMENT:

- Boards to be advised by BSU MDS

RECOMMENDATIONS:

The board (s) is asked to:-

1. RECEIVE verbal updates from BSU MDs on any outstanding actions

2. AGREE the minutes

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ENCLOSURE 9

ENCLOSURE
Board Meeting
Date
Agenda Item

BEXLEY CARE TRUST BOARD

Minutes of the Meeting held on Tuesday 15 March 2011
In Danson Youth Centre, Brampton Road, Bexleyheath at 9.30 a.m.

Present:

Ms Barbara Scott	**Chair**
Mr Chris Ball	**Non Executive Director**
Mr Keith Wood	**Non Executive Director**
Mr Paul Cutler	**Non Executive Director**
Cllr John Davey	**Non Executive Director**
Cllr Eileen Pallen	**Non Executive Director**
Dr Joanne Medhurst	**Director of Clinical Redesign & Governance**
Mr David Parkins	**PEC Chair**
Ms Pam Creaven	**Borough Director**
Mrs Theresa Osborne	**Director of Finance & Resources**

In attendance:

Mr James Westbury	**Interim Director of Strategy and System Development**
Dr William Cotter	**Clinical Cabinet General Practitioner**
Ms Emma Gennard	**Mental Health Commissioning Manager**
Mr Jon Hanlon	**Communications Manager (for item 012/11)**
Ms Khushbu Lalwani	**Public Health Development Manager**
Mr Martin Murphy	**Joint Head of Mental Health Commissioning**
Mr Colin Nash	**Minute taker**
Dr Howard Stoate	**Chair of the Clinical Cabinet**
Mrs Mary Stoneham	**Corporate Business Manager**

There were 12 people present in the audience.

026/11 WELCOME AND APOLOGIES FOR ABSENCE

26.1 Barbara Scott welcomed the Board and members of the Public to the meeting.

26.2 Board members were reminded that any conflict of interest with regard to items on the agenda, needed to be declared before discussion commenced.

26.3 Apologies were received from Anthony McKeever and Sue Gower.

027/11 MINUTES OF MEETING

27.1 The minutes of the Bexley Care Trust Board Meetings held on 25 January and 15 February 2011 were **AGREED.**

028/11 MATTERS ARISING FROM THE MINUTES

28.1 **13/11 Amendment to Revised Standing Orders**
Dr Howard Stoate reported that the Bexley Clinical Cabinet Terms of Reference formed part of the Standing Orders approved by the Board on 25 January. Since then the Business Support Unit structure had been finalised and the Bexley Clinical Cabinet (enhanced) Terms of Reference produced to reflect this. The Board considered the revised Terms of Reference.

28.2 With regard to membership, Dr Stoate confirmed that only the 5 elected practising GPs and 3 executive members appointed by virtue of their roles within the Business Support Unit would be voting members of the Clinical Cabinet.

28.3 The Board **APPROVED** the amendment to the Revised Standing Orders.

029/11 DECLARATIONS OF INTEREST

29.1 The Board considered the updated Declaration of Interests. The NHS Code of Accountability required Board members to declare relevant and material interests for the Register of Interests to be regularly updated.

29.2 Cllr John Davey, noted that his amendment to his entry had not yet been incorporated into the Register. Mrs Stoneham agreed to ensure that the necessary amendment was made.

29.3 The Board **NOTED** the interests declared by the Board and Professional Executive Committee members as recorded in enclosure B.

STRATEGIC ISSUES

030/11 BEXLEY GP COMMISSIONING – A PROSPECTUS

30.1 Dr Joanne Medhurst summarised the Prospectus which had been written to capture the aspiration and ambition of Bexley GPs to respond to the White Paper – Equity and Excellence: Liberating the NHS. It was drafted following wide consultation with GPs and others and reflected their comments.

30.2 In the coming financial year the GP Led Consortium will concentrate on improving services for those with long term conditions, the elderly and those needing unscheduled care. In delivering this vision most effort will be concentrated on delivering the service redesigns for these three groups of patients, delivering the quality and cost improvements planned for these groups and in other areas and to make changes to the Queen Marys Sidcup Campus development.

30.3 Following a question from Keith Wood (Non-Executive Director), Dr Medhurst confirmed that the Prospectus was a high level document intended to increase the understanding of GPs about the Consortium's aims. She emphasised that more detailed strategy documents underpinned each aspect.

30.4 Theresa Osborne, Director of Finance, noted that the document would be revised to take account of the new BSU structure.

30.5 Barbara Scott asked about the plans backing up the ambitions expressed in the prospectus. Dr Medhurst replied that the Clinical Cabinet had developed a programme of work that focused upon the development of the QMS Campus and QIPP. Dr Stoate added that unscheduled care, currently the highest single risk to the Consortium, would also be a priority.

30.6 The Chair enquired how the Consortium would work differently to the Care Trust. Dr Stoate replied that the Consortium would work closely with GP colleagues to generate new ideas to improve services. He also believed the Consortium would be in a stronger position than the Care Trust to bring pressure to bear on GP practices to improve their individual performance.

30.7 Ms Scott noted that with the new Sector arrangements, the Consortium would not have direct control over the commissioning of services. Dr Stoate replied that the Consortium would lobby hard to ensure local control was restored as soon as possible, preferably in time to negotiate contracts for 2012/13. Dr Medhurst added that the Consortium was in a strong position to influence GP referral patterns and this remained an important lever in ensuring activity was delivered in line with negotiated contracts.

30.8 In response to the Chair's question on demand management, Dr Medhurst replied that if financial benefits related to community services they would accrue to the Consortium.

30.9 Chris Ball (Non-Executive Director) enquired how the Consortium would ensure it engaged with the public and what its plans were if commissioning did not return to local control. Dr Stoate replied that public engagement would be delivered primarily through the Membership Scheme and the Health and Wellbeing Board. He reiterated his view that whilst the Consortium would have some influence over commissioning under a regime governed by payment by results, it was extremely important that commissioning did return to local control.

30.10 Cllr Davey emphasised that unless the Consortium gained control over commissioning its ability to manage its finances would be compromised.

30.11 Paul Cutler (Non-Executive Director) enquired whether the Consortium believed it had the resources to invest in the tools and technology necessary to support the achievement of its vision. Dr Medhurst replied that the Consortium was currently undertaking a pilot with Oxleas NHS Foundation Trust to see if such options were cost effective. If it was shown that they were, a business case would be put forward. The Chair enquired if a rigorous cost benefit analysis was being undertaken. Dr Medhurst replied that whilst the BSU had no additional resources for this, but that the business case process had recently been made more robust and would be lead by Theresa Osbourne, Director of Finance.

30.12 The Board **NOTED** the contents of the Prospectus and **ENDORSED** the strategic direction set out within it.

031/11 APPROVAL OF THE DIABETES BUSINESS CASE

31.1 Theresa Osborne referred the Board to the Executive Summary attached to the Business Case, noting that it had been approved by the Resources Committee subject to the five provisions described.

31.2 Board members expressed concern that the outcomes expected from the Business Case were not sufficiently well described to allow its success or failure to be assessed at a later date.

31.3 Keith Wood (Non-Executive Director) noted that the Care Trust was a commissioner rather than provider of services and enquired who was responsible for project managing this service. Theresa Osborne explained that the Care Trust was currently responsible for project management and providing the training described in the Business Case, but that this matter would need to be resolved, possibly through a tendering process. Pam Creaven, Borough Director, added that it was possible this service may fall under the auspices of public health and become a local authority responsibility.

31.4 Dr Medhurst confirmed that John Grummitt, Project Manager would report to her.

31.5 The Board **APPROVED** the Business Case subject to satisfactory key performance indicators being agreed.

032/11 **PBC KITEMARK 2011-12**

32.1 Dr Bill Cotter referred to the paper which set out the 11 indicators that would form part of the 2011-12 Kitemark and how achievement would be assessed and payment made. The Kitemark incorporated a number of elements that were key to achieving Clinical Cabinet and Care Trust aims in 2011-12. He reported however that a letter regarding the Quality Outcomes Framework (QOF) had recently been received from the BMA and it was important that both the QOF and Kitemark were aligned.

32.2 David Parkins, PEC Chair, enquired who will determine the final Kitemark awards. Dr Cotter stated that the Clinical Executive would have this responsibility. Following discussions Dr Medhurst welcomed The Chair's offer of NED oversight of the process.

32.3 Cllr Pallen asked how the £1.5m allocation for the Kitemark was resourced. Dr Cotter explained that it was taken from the Freed up Resources budget.

32.4 In response to a question from Pam Creaven, Dr Cotter confirmed that the Kitemark was aligned with the GP Prospectus and QIPP schemes.

32.5 Pam Creaven noted that in future years the Kitemark indicators would need to include NHS Health Checks.

32.6 Barbara Scott noted that in previous years the Care Trust had had to adjust Kitemark requirements in year and this had reduced its credibility. Dr Cotter replied that this year tighter targets had been established and he did not expect this to arise again.

32.7 With regard to establishing the Kitemark in future years Dr Cotter undertook to involve Pam Creaven to ensure indicators took account to items not directly under the Care Trust's control.

32.8 The Board **AGREED** the 2011-12 Kitemark and allocation of £1.5m subject to the details being amended to ensure it was aligned with the QOF.

033/11 **JOINT COMMISSIONING STRATEGY – LIVING WELL WITH DEMENTIA A LOCAL STRATEGY FOR IMPLEMENTATION AND DEVELOPMENT**

33.1 Emma Gennard, Mental Health Commissioning Manager, referred to the paper and the fact that Bexley expects the numbers of patients accessing its memory service (currently 500) to rise by 28% by 2021. The Care Trust's response had been to create a local Dementia Board and develop a Joint Commissioning Strategy for the next five years (included with the Board papers) in partnership with Oxleas NHS Foundation Trust, the voluntary sector, patients and carers. The Strategy included a table of local priorities based on achieving a service in line with the National Dementia Strategy.

33.2 The Board discussed how achievement of the local priorities would be assessed and the need for any RAG rating to be based on objective criteria. Martin Murphy, Joint Head of Mental Health Commissioning, noted that some measurable improvement to services had already been observed such as the reduction in time to see a hospital psychiatrist from 9 months to 2 weeks. Barbara Scott added that the inclusion of measurable outcomes in the Strategy would assist the service to attract and retain the resources it would require from both health and other funding bodies. Martin Murphy reported that a GP now sat on the Dementia Steering Group.

33.3 David Parkins enquired if the service in Bexley had been benchmarked against other local services. Martin Murphy replied that this had not yet been done, but he was open to arranging external peer review if this would be helpful.

33.4 In response to a question from Barbara Scott, Theresa Osborne replied that the £411k quoted in the Strategy Document to enhance the memory service, was already incorporated into Care Trust budgets.

33.5 The Board **APPROVED** the Strategy subject to satisfactory outcomes being approved by the Clinical Cabinet.

034/11 BUSINESS CONTINUITY MANAGEMENT PLAN UPDATE

34.1 Pam Creaven informed the Board that the maintenance of robust business continuity plans was a statutory duty and an important element in the winter resilience planning. The Care Trust's plans had been updated to take account of the changes that had taken place since the original document had been approved in March 2009. Therefore individual service continuity plans had been completely revised and brought together into a single document.

34.2 Following a question from Chris Ball, Pam Creaven confirmed that there were links between the Care Trust's plans and those of the local authority. Joint emergency planning also took place in the Borough.

34.3 The Board **NOTED** and **APPROVED** the action taken to update the Care Trust's Corporate Business continuity Management Plan.

035/11 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2010-11. A PARTNERSHIP DOCUMENT BETWEEN BEXLEY CARE TRUST AND LONDON BOROUGH OF BEXLEY

35.1 Khushbu Lalwani informed the Board that the Local Authority and the Care Trust were required to produce a JSNA every two years. The JSNA was the means by which current and future health and wellbeing needs for the local population were identified. The information could then be used to identify commissioning priorities, strategies and plans to shape service provision. She highlighted the following points:-

35.2 The main gaps identified by the JSNA were in communications between organisations, men's health services, service provision in early years and services to assist parenting.

35.3 The Local Authority was currently reviewing the JSNA document and subject to their approval it would be released for public consultation in mid April.

35.4 Pam Creaven added that the process of developing this JSNA, with much greater engagement and consultation, was much more useful for commissioners than the previous iteration.

35.5 David Parkins commended the document as a powerful data base to inform the provision of future service provision.

35.6 Paul Cutler enquired whether the development of the JSNA had revealed any unexpected results. Ms Lalwani replied that no great surprises had been identified but the importance of developing measurable outcomes for service provision and the importance of identifying priorities for the whole Borough had been reinforced.

35.7 The Board **NOTED** the report.

036/11 HEALTH AND WELLBEING CAMPUS AT QUEEN MARYS SIDCUP (QMS)

36.1 Dr Joanne Medhurst reminded the Board that A Picture of Health (APOH) plans had been signed off by the Department of Health on condition that a Health and Wellbeing Campus was developed on the QMS site. An outline proposal for a campus would be submitted to NHS London by the end of this month and this paper described the strategic direction.

36.2 Theresa Osborne noted that currently the overhead charges levied by SLHT, the site owners, were such as to make the development of a campus unaffordable and this issue would need to be resolved before the project could move forward.

36.3 Cllr John Davey enquired what the transition costs in moving to the campus were estimated to be. Dr Medhurst replied that when costings were made last year a £500k provision had been made.

36.4 Keith Wood emphasised that, as commissioners it was for service providers to price the service. He also added that the campus would only be affordable if the costs of acute care were reduced sufficiently to release the necessary resources.

36.5 Chris Ball commented that if successful the Campus would represent an exciting service development for Bexley patients.

36.7 The Board **NOTED** the contents of the report and **ENDORSED** the strategic direction of the Campus Proposal.

037/11 SHADOW HEALTH PARTNERSHIP BOARD UPDATE

37.1 Pam Creaven, Borough Director, reported that the main issues discussed were the QMS Campus and the transfer of public health services to the Local Authority. She noted that Bromley were looking to affect an early transfer. Bexley were looking to identify what services should be included before deciding whether an early transfer was appropriate.

37.2 A high level report on public health finances was scheduled for the next meeting of the Bexley Overview and Scrutiny Committee (OSC).

37.3 The Care Trust had a sum of £2.4m for re-ablement and alleviation of winter pressures and was working with the local authority to identify what services it should be used to support. Theresa Osborne added that it had been made clear that no monies could be transferred until robust business cases had been approved by the Sector Board.

038/11 PERFORMANCE ISSUES

38.1 **FINANCIAL PERFORMANCE UPDATE AS AT MONTH 10 2010/11 (JANUARY)**

38.2 Theresa Osborne summarised the Board report and highlighted page 3 of the report.

38.3 The Care Trust had reported a £1k surplus against a breakeven plan at month10. Control

totals had been agreed with Darent Valley and Guys and St Thomas's and discussions were still ongoing with King's.

38.4 Despite some improvement expected in month 11, it was expected that the Care Trust would not achieve the 15% reduction in commissioning management costs set by the Department of Health and NHSL. TO noted however that this target would not be measured in 2011-12 as the Department of Health would be monitoring full running costs.

38.5 The over performance on acute contracts was £3,327k at the end of month 10 with £5,096k extrapolated for the full year. This was without the SLHT over performance, for which budget had been transferred from reserves.

38.6 Full details on the above were contained within the report, with RAG rated risks to the position described on pages 26 to 30.

38.7 With regard to Management costs Keith Wood noted that the target would have been achieved if the costs associated with CSL and SELACU were excluded. Theresa Osborne replied that she had raised this point with NHSL and SELACU on a number of occasions.

38.8

The Board **DISCUSSED & NOTED** the Month 10 (January) financial position and forecast outturn detailed in this report;
The Board **DISCUSSED & NOTED** the key risks & cost pressures identified to achieving a breakeven position in 2010/11 and the management actions being taken to address and mitigate these risks;
The Board **NOTED** the revenue and capital resources available to the Care Trust;
The Board **NOTED** the progress against approval of 2010/11 Operating Plan initiatives;
The Board **DISCUSSED** the forecast reduction in management costs and the need for further actions if 15% reduction is to be achieved in 10/11;
The Board **NOTED** the month 10 forecast performance against the key national finance targets.

38.9 **APPROVAL OF THE 2011-12 DRAFT ANNUAL CARE TRUST BUDGETS**

38.10 Further to the presentation of the budget planning assumptions to the January Board, Theresa Osborne referred to the paper setting out the initial 2011-12 budgets for commencement on 1 April. The DOH and NHSL required PCTs to include in their planning assumptions the top slicing set out on the first page of the substantive report and to make a 1% surplus in 2011-12. This equated to £20m and has resulted in £5.5m of unidentified QIPP being included in the budget.

38.11 The risks to the budget were described on page 7 of the substantive report. The most substantial risk was the loss of direct control over acute contracts and the unidentified QIPP.

38.12 It was possible that the Care Trust could submit a bid for use of the 2% non-recurrent funds to cover the balance of its historic deficit.

38.13 Keith Wood enquired about the current position with regard to the SLHT contract. Theresa Osborne replied that SLHT had not agreed to the Sector's proposal but as the Care Trust was not part of the contracting process the reasons for this were not clear. Sector was making preparations for an arbitration application. James Westbury added that the Care Trust had not yet concluded a contract with King's, but in that case it was clear where the differences between the two sides lay.

38.14 Barbara Scott noted that SLHT were behaving as they had in the previous year and a new approach was needed in order to shift their behaviour. The outcome of arbitration would indicate whether the health economy was prepared to enforce its stated contracting rules.

38.15 Dr Stoate emphasised the importance of Sector performance managing the acute contracts. Barbara Scott expressed concern that the new arrangement would not be robust enough and advised that the Care Trust concentrate their efforts on the remaining levers directly within their control.

38.15 The Board were concerned at the high degree of risk inherent in this budget.

38.16

The Board **NOTED** that the budgets were presented in accordance with national / London / Sector guidance, including the presentation of 1% surplus, but that the report presented by the Director of Finance highlighted a number of potential risks that could significantly impact the draft budgets and achievement of the Care Trust's statutory financial duties. At the time of the Board meeting, members were mindful of the difficulties experienced by the Sector Commissioning Team in negotiating settlements for 2011/12 SLAs with any providers and in particular the likelihood that the SLHT SLA would again be subject to NHS London arbitration, which in 2010/11 cost the Care Trust c£10m over and above budgets set. This risk is in addition to the other risks detailed within the report. The Board **APPROVED** the draft 2011/12 budgets, in recognition of the necessity to have operational budgets in place for 1st April 2011, on the understanding that they might be subject to substantial revision once the outcome of SLA negotiations was known.

039/11 COMMISSIONING PERFORMANCE FRAMEWORK EXCEPTION REPORT

39.1 Mr Westbury took the Board through the report showing where key indicators were below expectations and the remedial actions being taken. He noted that poor performance at SLHT had adversely affected number of indicators, for example cervical screening. Sector were now responsible for monitoring acute contract indicators and had initiated some follow up work , but not in all areas of poor performance, for example the 18 week target and the London Ambulance Service targets.

39.2 Barbara Scott enquired about the three safeguarding children training indicators currently rated red on the KPI table. James Westbury replied that the Care Trust was discussing improvements to training with Oxleas NHS Foundation Trust and the matter was being monitored by the Quality Group. He confirmed that the target was an NHS London responsibility.

39.3 In response to a further question from the Chair, Mr Westbury confirmed that the Care Trust were not directly penalised for failures in provider targets, but may be subject to increased scrutiny. Provider units were responsible for producing rectification plans. The importance of distinguishing commissioner and provider responsibilities in the exception report was emphasised.

39.4 James Westbury highlighted the Care Trust's success in meeting its dental access target. The Board congratulated all those involved.

39.5 With regard to QOF, James Westbury reported that a schedule of meetings to address outlying performance had been agreed with the relevant GP practice.

39.6 Pam Creaven informed the Board that responsibility for some of the immunisation and vaccination targets would be passing to the Local Authority.

39.7 The Board **NOTED** the report and the actions being taken to improve performance.

040/11 OPERATIONAL PERFORMANCE

40.1 **COMMISIONED SERVICES QUALITY REPORT QUARTERS 1 & 2 2010/11**

40.2 David Parkins referred to the report examining key quality domains (Patient Safety, Clinical Effectiveness and Patient Experience) relating to services commissioned by BCT which identified the quality assurance process that had been developed for monitoring these services. He noted that the Care Trust and fellow commissioners were working collaboratively with providers such as SLHT and a high degree of openness and trust characterised these contacts.

40.3 With regard to services provided by SLHT, David Parkins reported discharge arrangement needed further improvement and there was a need to reduce the numbers of pressure ulcers (the severity of ulcers had reduced). Consideration was being given to make this a CQUIN for SLHT. A&E performance had stabilised and there was now increased confidence in the data around this.

40.4 Dr Medhurst reported that with her change of role the BBG/SLHT Clinical Quality Group would in future be chaired by Dr Angela Bhan. David Parkins and Dr Santamaria would continue to be members.

40.5 Barbara Scott enquired whether the GP Clinical Cabinet had established a Risk Register. Dr Stoate replied that this was in development. The Board asked for a copy of this document.

40.6 David Parkins was also drafting terms of reference for the Quality Sub Committees that would report to the Sector Board. He was concerned that these groups would not receive as much detail about quality of services that had proved effective in monitoring services locally.

40.7 The Board **RECEIVED** the report and **NOTED** that the report had been received by the BCT Clinical Quality Governance Group who had agreed that the quality concerns identified in the report are, or have been actively addressed through the appropriate groups.

41/11 COMMUNICATIONS AND PATIENT IMPROVEMENT UPDATE

41.1 Jon Hanlon, Communications Manager, reported that the Care Trust had held a recent GP engagement event which attracted over 100 attendees. Information to GPs had been improved through Practices now having access to a secure section of the Care Trust's intranet. In addition an editorial committee for a GP Newsletter had been established.

41.2 Other developments since the last meeting included the launching of the Pharmacy Home Delivery Service and the Diabetes website.

41.3 Jon Hanlon also reported that Barbara Scott was the winner in the Not For Profit Category of the 2010 Non Executive Director Awards and had received coverage in the national press.

41.4 With regard to patient engagement, Jon Hanlon reported that a Community Health Older Peoples Panel had been established and the Care Trust had manned its regular Heath and

Wellbeing stand at the Broadway. The Care Trust had received 150 responses to its "mystery shopper" exercise. A report on the results was in preparation.

41.5 Noting that the JSNA had identified men's health as a key issue, Barbara Scott suggested linking with Charlton Football Club who had a track record of successfully engaging with the male community. Dr Stoate added that previous health campaigns in association with B&Q had also been successful.

41.6 **GOVERNANCE ISSUES**

42/11 BOARD ASSURANCE FRAMEWORK

42.1 Theresa Osborne referred to the updated Assurance Framework which followed the same style as those previously submitted to the Board. She also noted that it had been reviewed by the Care Trust's Internal Auditors who had concluded that it met the requirements of the 2010/2011 Statement of Internal control and provided "reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation to all its main business activities". The auditors recommended that the Trust's Risk Management Strategy be reviewed from April 2011 and that a user friendly version of the Board Assurance Framework be produced for clinical users from April 2011.

42.2 Dr Stoate was pleased to note that the risks associated with the Sector not carrying out its performance management duties adequately had been given an appropriately high rating.

42.3 The Board **NOTED** the contents of the report and the internal auditor's recommendations.

43/11 ANNUAL REPORTS

ANNUAL REPORT ON THE SAFER MANAGEMENT OF CONTROLLED DRUGS

43.1 Mr Parkins asked the Board to note the significant amount of work undertaken in relation to controlled drugs and that the Care Trust should be assured that it was fulfilling its responsibilities in relation to them.

43.2 The Board **RECEIVED** and **APPROVED** the annual report

44/11 ITEMS FOR INFORMATION

44.1 **CHAIRS ACTION**

44.2 Mrs Stoneham referred to the paper noting the Chairs agreement to proceed with the termination of the Primary Medical Care Services between Bexley care Trust and Access Medical Services as detailed in the paper.

44.3 The Board **RATIFIED** the chairs action

45/11 PEC CHAIRS ACTION

45.1 The Board **RATIFIED** the PEC Chairs action to approve the following:-

- Full list Policy
- GP Rent Protocol
- Local Dispute Resolution Procedure

46/11 USE OF THE BEXLEY CARE TRUST SEAL APRIL 2010 – MARCH 2011

46.1 On behalf of the Audit Governance Committee the Board **NOTED** the report on the use of the Seal.

47/11 WAIVER OF TENDER JANUARY 2010 – MARCH 2011

47.1 The Board **NOTED** the report on Tender Waivers and the reasons for them for the period to 15 March 2011.

48/11 QUARTERLY REPORTS FROM NON EXECUTIVE COMMITTEE CHAIRS

48.1 None.

49/11 SUB-COMMITTEES OF THE BOARD

49.1 The Board **RECEIVED** and **NOTED** the following minutes:-

- Audit and Governance Committee - 4/2/11
- Bexley Children's and young Peoples Trust - 13/10/10

50/11 PUBLIC QUESTION TIME

50.1 Ms Brenchley-King, Chair of the local branch of Diabetes UK expressed her view that the resources being used to support diabetic patients in Bexley were being well used. She was supportive of the Board wishing to ensure these services were supported by measurable outcomes.

CLOSING ITEMS

051/11 ANY OTHER BUSINESS

51.1 In response to a question from the Chair, James Westbury confirmed that the Care Trust had received five Expressions of Interest with regard to the Bursted Woods practice.

052/11 DATE AND TIME OF NEXT MEETING

52.1 Cluster Board on 19th May 2011

053/11 CLOSURE OF PART ONE

53.1 The Board **APPROVED** a motion that: representatives of the press and other members of the public be excluded from the remainder of this meeting having regard for the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
[Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

MINUTES OF THE MEETING
OF THE BOARD OF BROMLEY PRIMARY CARE TRUST
HELD IN PUBLIC ON THURSDAY 17 MARCH 2011
IN THE HARRY LYNE ROOM AT THE BECKENHAM BEACON

Present:	Jim Gunner	Chair
	Dr Angela Bhan	Joint Director of Public Health
	Bee Lean Chew	Non Executive Director
	Sarah Dowling	Non Executive Director
	Marie Farrell	Director of Finance
	Marcia Fry	Associate Non Executive Director
	Professor Ami David	Non Executive Director
	David Fletcher	Non Executive Director
	Harvey Guntrip	Non Executive Director
	Dr Nada Lemic	Joint Director of Public Health
	Clive Uren	Chief Executive

In Attendance:

Marcia Bryan	Strategic Manager, LD Services
Meredith Collins	Interim Director of Commissioning
Sonia Colwill	Director of Prescribing and Quality
Keith Fowler	Secretary to the PCT Board
Harry Goldingay	Associate Director, Risk
Diane Hedges	Acting Chief Executive, CPU
Mimi Morris-Cotterill	Director of Programme Delivery and Chief Information Officer
Dr Andrew Parson	GP Consortium
Terry Rich	Director of Adult and Community Services, LBB
Pat Wade	Bromley LINk
Jill Webb	Assistant Director of Primary Care
Adam Wickings	Director of Primary Care
Robert Williams	Associate Head of HR/OD

Members of the Public/Staff:
Jan Brunton (NHS Retirement Fellowship). H Hothi (Novartis), Elizabeth Roberts (NHS Retirement Fellowship), Patricia Weal (Bromley LINk).

Immediately preceding the meeting an opportunity was afforded to members of the public present to put questions to the PCT Board. The PCT Board Secretary read out a question received from Mrs Sue Sulis, who was not at the meeting, about the Fresh Start Scheme. The PCT Board undertook to provide a written reply to Mrs Sulis following the meeting.

ENCLOSURE 9

Answers to previous questions and responses are available on the PCT's website www.bromley.nhs.uk or can be obtained from the Secretary to the PCT Board.

33/11 **APOLOGIES FOR ABSENCE, ANNOUNCEMENTS AND DECLARATIONS OF INTEREST**

There were no apologies.

34/11 **MINUTES OF THE PREVIOUS MEETINGS**

The minutes of the PCT Board Meeting held on 27 January 2011 were agreed to be a correct record and were signed by the Chair after including an amendment with regard to the Health and Well Being Board, first paragraph, page 4.

35/11 **MATTERS ARISING FROM THE MINUTES**

15/11 - Pharmaceutical Needs Assessment - Sonia Colwill explained that responsibility would in future lie with the Health and Well Being Board, as part of the Joint Strategic Needs Assessment. The South East London Cluster, and subsequently the National Commissioning Board would need to consider the provision of new pharmacies in South East London.

18/11 - Any Willing Provider - Adam Wickings said that a recent bidders event had been well attended and much interest shown with regard to proposals to invite bids for the community dermatology and community gynaecology services.

19/11 - South East London Treatment Access Policy - Nada Lemic said that subsequent to the PCT Board ratifying the reviewed policy at its previous meeting, further changes had been made with regard to bariatric surgery. She tabled a paper listing the changes. These had been seen and approved by the Healthcare Governance and Risk Sub Committee. The PCT Board ratified the proposed changes as presented.

24/11 - Joint Strategic Needs Assessment - The PCT Board received and noted the JSNA.

36/11 **URGENT BUSINESS**

There was none.

37/11 **CHAIRMAN'S REPORT**

Jim Gunner said that his report would be dealt with in connection with Item 39/11 below.

38/11 **CHIEF EXECUTIVE'S REPORT**

Clive Uren said that his report would also be covered in Item 39/11.

STRATEGY

39/11 **TRANSITIONAL MANAGEMENT ARRANGEMENTS**

Jim Gunner tabled a paper which set out the latest proposals of the governance arrangements for the six South East London PCTs from 1 April 2011. He said that discussions were still ongoing across the Sector. He summarised the main arrangements which included Joint Boards for the six PCTs sharing the same chair and seven non executive directors, chief executive, finance director, director of public health and operations director. Each PCT Board would also include its own Borough Support Unit (BSU) managing director and clinical lead. In each borough there would be a Local Clinical Commissioning Committee (LCCC) to oversee the transition to GP commissioning, and a Health and Well Being Board (HWB), managed by the local authority, to set the strategic direction of health service commissioning in the borough.

Sarah Dowling asked to see the terms of reference of the Health and Well Being Board when available. Marcia Fry asked which of these groups would meet in public. Clive Uren said that the Joint PCT Boards would meet in public and that the LCCC and HWB would have public representation included in their membership but were not required to meet in public. He also undertook to feed back to Sector a preference for the Joint Boards to rotate their meeting venues.

Clive Uren said that more discussion was required on the areas that each of these groups would cover, and that this was likely to be an evolutionary process. Andrew Parson said that agreement would be required on what items would be reserved for the PCT Joint Board and what would be devolved to the LCCC. Angela Bhan said that the tabled paper contained a framework for these issues which would need to be built upon when there was more clarity. A pragmatic approach would be necessary and a roadmap from the Sector on how the transitional arrangements were expected to perform was expected soon. This would shape the role of the BSU and set out how the GP commissioning role would take on more responsibility. Marie Farrell said that the arrangements would need to be kept fluid. Harvey Guntrip considered that the Sector level arrangements would need to keep a high level view and would require good feedback from the BSU and commissioning clusters.

In response to concern expressed by representatives of the Bromley LINk who were present, Jim Gunner said that the PCT would not be

allowed to lose sight of its main role; to maintain the provision of safe, high quality health services for the people of Bromley.

In response to a question from Terry Rich about membership of the Joint Board for Bromley it was noted that some appointments had been confirmed, including; Caroline Hewitt - Chair, Simon Robbins - Chief Executive, and Marie Farrell - Director of Finance. Angela Bhan had been appointed as interim Bromley BSU managing director. Clive Uren said that it was hoped to fill the remaining two director posts at the BSU shortly. He added that the future Sector and BSU structures were much smaller than the previous arrangements for six separate PCTs and there would be no spare capacity.

Sarah Dowling considered that it was difficult to be positive about the proposed changes. This was the last PCT Board meeting in the current format and she was very unclear about what would follow. She considered that an adjustment to the timetable under which the present arrangements would cease from 1 April would be required.

The PCT Board agreed proposals from the Chairman to let him have their comments on the tabled paper by Monday 21 March. They approved subsequent Chair's action to decide, based on their comments, the Board's response to Sector on the governance proposals. This would facilitate a timely decision in anticipation of the changes from 1 April 2011. PCT Board members asked for the response to Sector to be appended to the minutes of the meeting.

40/11 **TRANSITIONAL PUBLIC HEALTH DIRECTORATE ARRANGEMENTS**

Nada Lemic introduced a proposal to transfer the PCT's Public Health Department to the London Borough of Bromley under a Section 75 Agreement, from 1 June 2011. The report included a service specification for the provision of public health services. Provision for a Consultant in Public Health had been included.

David Fletcher asked about the financial implications of the transfer. Nada Lemic said that public health staff would be seconded under the same terms and conditions, and that the budget had yet to be decided. There would be no transfer of funding at this stage. Terry Rich said that it was proposed to introduce a "shadow" budget from 2012/13. In the first year the budget would remain with the PCT.

Sarah Dowling asked whether the proposals for monitoring quality were sufficient. Nada Lemic said that there was limited capacity for reviews and monitoring care pathway developments. It would be necessary to prioritise.

Ami David asked for more information about the Public Health input to commissioning community services. Nada Lemic said that Public Health

would need to feed into commissioning in the Sector, and that improving health services was about a third of the work. Sarah Dowling was concerned that proposals for the health improvement agenda were not as comprehensive as they had previously been. Whilst it was necessary to identify priorities, this should not exclude other areas. Nada Lemic said that this action was based on the areas identified in the Public Health White Paper for future development.

Terry Rich said that this work would be overseen by the Health and Well Being Board which would decide priorities arising from the community. Angela Bhan agreed and added that the independent role of Public Health should also be recognised and needed to be reflected in the report.

Meredith Collins said that some Public Health issues were fundamental to local commissioning and that this needed to be clearly reflected in the Service Level Agreement.

The PCT Board agreed that the draft report should be amended to reflect the points raised and noted that legal advice would be required before finalisation. Subject to this, the PCT Board agreed the proposed date of transfer (1 June 2011), the schedule of services, and that regular reports should be received by the Health and Well Being Board.

41/11 **BROMLEY HEALTHCARE**

Clive Uren introduced the report and invited the PCT Board to give its decision on the externalisation of the community provider unit as a social enterprise to be known as Bromley Healthcare. The final decision would be taken by the NHS London Capital Group at its meeting on 25 March. If approved, Bromley Healthcare would commence on 1 April 2011.

The PCT Board noted a general improvement in the risk assessment associated with the Due Diligence Report. It also noted that the governance rating had fallen back from green to amber as a result of the need to undertake a second Chief Executive appointment process. It noted that Diane Hedges had agreed to remain as Acting Chief Executive while recruitment took place. Work on the contract and business transfer agreement was in the final stages. More work was required in respect of the out of hours service. CQC registration was still awaited.

Harvey Guntrip said that Diane Hedges should be a member of the Bromley Healthcare Board for as long as she was Acting Chief Executive. He emphasised the need for PCT involvement in the chief executive appointment process, and suggested this should include the Vice Chair of Bromley PCT.

Jim Gunner congratulated the team on the progress achieved and the now favourable risk situation. The PCT Board agreed to approve the transition of the Bromley Community Provider Unit to a social enterprise known as Bromley Healthcare Community Interest Company from 1 April 2011, subject to the following conditions:

- signature of the Business Transfer agreement and provider services contract by the Chief Executive of the PCT.
- the availability of CQC registration in full or as part of the PCT cover arrangements
- resolution of the arrangements for the Out-of-Hours service
- the Chair of Bromley PCT to be a governor of Bromley Healthcare, and the other continuing Bromley PCT non executive to also be a governor, if permitted in the Articles of Association
- Diane Hedges to be retained as Acting Chief Executive and a Board member of Bromley Healthcare pending a substantive chief executive appointment
- Bromley PCT's participation in the appointment of a substantive chief executive of Bromley Healthcare

42/11 **COMMISSIONING SERVICES FOR LONDON (CSL) REVIEW**

The PCT Board formally noted that Chair's action had been taken on 25 February 2011 to approve recommendations, as set out in the report, to wind down CSL and amend its establishment agreement accordingly. Chair's action had been necessary to comply with the timescale set for agreement by all London PCT Boards. The PCT Board also noted that there would be no additional investment required in the current financial year, and that the maximum total investment from all London PCTs in 2011/12 had been reduced to £4.859 million.

OPERATING PLAN 2011/12

43/11 **BROMLEY QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN 2011/15**

Meredith Collins presented a draft plan for the delivery of QIPP within Bromley. Although still to be finalised, it identified the key areas of work in the coming year.

Jim Gunner asked whether there was adequate resource within the Borough Support Unit (BSU) structure to manage the plan. Meredith Collins said that not all the posts had yet been filled and that interim arrangements were being considered. Angela Bhan said that a programme management approach would be required, and that the Cluster Board would need to keep an overview although the BSU would be responsible for what was delivered in Bromley.

Andrew Parson said that there would need to be adequate monitoring and feedback. GP commissioners would need support from the BSU.

Pat Wade asked about external involvement in the communications and engagement plan and Mimi Morris-Cotterill said that it was draft at this stage and comments would be welcomed.

Marie Farrell confirmed that each borough would need to contribute to the Sector plan. Savings of c. £76 million were required in 2011/12 across the Sector, and following risk assessment a further £20 million still had to be identified. Achievement of the QIPP targets would underpin the financial plans of each PCT and be required for the delivery of financial balance. The Finance and QIPP Committee at Sector would be monitoring this.

The PCT Board received and noted the report.

44/11 **INDICATIVE BUDGETS 2011/12**

Marie Farrell presented the indicative summary budget for 2011/12. She said that it could not be finalised until contract negotiations had been concluded. The total funding for next year had increased from £490 m to £508 m. The Learning Disability budget (£8 m) would transfer to the London Borough of Bromley (LBB).

Key requirements of the Operating Plan for 2011/12 included a 1.5% tariff deflator, market forces factor changes, a 0.5% contingency and the achievement of a 1% surplus. A further 2% of the budget was to be retained by NHS London to be used for non recurrent purposes only. Bids would have to be made by the Cluster to NHS London for the use of these funds. The 2011/12 baseline would also have to fund the c. £3m reablement funding. As this was a significant sum it was essential to agree how these funds could best be applied across the Bromley health economy to benefit patients. The budget also included the funding released from accelerating the management cost savings into 2011/12. £2 per head of registered population (c. £600k) was available to support the commissioning development needs of GPs. Again, this money would be held centrally and accessed via the cluster bids from clinical leads. The budgets assumed delivery of QIPP, and failure to secure the programme would result in financial pressures. The budgets were indicative at this stage as acute contracts had yet to be agreed. This could have significant consequences. Furthermore, the Cluster budget needed to be finalised. This would not be possible until the recruitment process was complete and any consequences identified.

Harvey Guntrip asked whether, as Bromley had achieved its savings target in 2010/11, there would be any effect on Bromley from underachievement in other Boroughs. Marie Farrell said that each PCT would continue to be a statutory entity and would retain its own resource

limit, and that there were no plans to pool funding at this stage, nor any plans for the use of any surplus.

In response to a question from Sarah Dowling, Marie Farrell said that the Sector would work with the BSU to develop plans to bid against the 2% centrally held funding. Each bid would be individually negotiated.

The PCT Board noted the indicative summary budgets and agreed to delegate authority to the Director of Finance to sign them off when the outcome of the SLA settlements was known.

OPERATING PLAN 2010/11

45/11 **FINANCE REPORT**

Marie Farrell presented the finance report to the end of month 11 (February). The PCT Board noted an underspend of £244k, and a forecast outturn surplus of £5.9 m, increased in line with the position reported to NHS London. The £1m increase in the surplus was due to the CQUIN outturn at South London Healthcare NHS Trust (SLHT). There were plans for a forecast £600k surplus within the community provider unit to be carried forward into Bromley Healthcare if possible.

There had been no significant changes in individual budget lines since the previous report. The contingency had been released to address pressures which included prescribing for the first time this year. An increased uplift would be required for prescribing next year.

The cost improvement programme for 2010/11 had been overachieved. 15% management costs target for 2010/11 was on course for achievement. Marie Farrell therefore reported that the PCT was likely to achieve all three of its statutory financial objectives on 2010/11.

The PCT Board noted the situation and Jim Gunner congratulated Marie Farrell and her team for the excellent outcome.

46/11 **QUALITY REPORT**

SLHT Monitoring - Sonia Colwill recognised the work done by the Clinical Quality Review Group over the year, especially with regard to A & E services and Maternity services. The Group would continue into the next year with increased GP participation. SLHT had achieved well with regard to Infection Control where there had been only one reported incident to date. Reports had now been received on CQUINS, and the PCT was working with the Trust to agree some stretch targets for 2011/12.

Angela Bhan said that a gateway review at the end of January had shown that the closures at Queen Mary's Hospital, Sidcup (QMS) had

been well handled and implemented. There had been improvements in paediatric services at the Princess Royal University Hospital (PRUH). Consideration was being given to improved use of urgent care centres across the Trust. Admissions avoidance was linked to the QIPP programme. She also reported that there were some 50 delayed discharges daily at the PRUH and Queen Elizabeth Hospital, Greenwich (QEH). These were due to a number of reasons including meeting the care choices of patients. A work programme to address the issues was being undertaken.

Oxleas NHS Foundation Trust - After a strong performance earlier in the year achievement of CQUINs had fallen back in the 3rd and 4th quarters, especially with regard to the physical health of patients. This issue would become a focus in next years CQUINs. Another focus would be the transition from the CAMHS service to adult services.

Community Provider Unit (CPU) - Angela Bhan reported significant progress on quality, including the achievement of all the CPU's CQUIN areas in 2010/11. Detailed work had begun on CQUINs for the coming year which would include pressure sores, and improving patient experience. CPU outcome measures would also be costed.

The PCT Board received and noted the report.

47/11 **PROVIDER PERFORMANCE REPORT**

Meredith Collins reported a deterioration of performance against the 4 hour A & E waiting target at SLHT during the winter. This had improved towards 95% in February. There had been a significant drop in the number of patients admitted within 18 weeks in the last 3 months, leading to a significant backlog. Discussions were being held with SLHT about this.

There were still some fundamental issues hindering progress on the contract with SLHT for 2011/12, and arbitration looked likely. The risks to Bromley from this were lower than those for the other PCTs. The Trust would be taking a significant financial problem into the coming year in addition to the cost savings required from all Trusts. They would also need to progress towards Foundation Trust status.

The PCT Board received and noted the report. They also noted that in future the report would be considered by the Local Clinical Commissioning Committee of the BSU, and the Quality and Performance Committee of the Cluster Board.

48/11 **WORKFORCE KPIs**

Robert Williams reported falling staff in post figures due to the MARS and Voluntary Redundancy Schemes. There had been a small increase in

expenditure on bank staff and a significant decrease in agency staff. There had been an increase in sickness absence after earlier improvements, but, overall, the profile was similar to the previous year. There had been a 4% decrease in the number of staff appraisals carried out, but submission of personal development plans had increased. There was a rise in staff turnover but it was still in line with the overall rate.

The PCT Board received and noted the report.

49/11 **ASSURANCE FRAMEWORK**

Harry Goldingay said that the transitional management arrangements remained a significant concern for the capacity of the organisation. The risks were centred around recruitment and the handover process. Work was being undertaken to ensure business continuity.

The PCT Board received and noted the report. Harvey Guntrip thanked Harry Goldingay for all the work that he had done to develop the Assurance Framework for the Board. He hoped that the quality of the reports would be maintained through the transition. Clive Uren said that there would be a governance role for this in the BSU, and there would need to be links into the Cluster arrangements.

50/11 **PENGE PRIMARY CARE CENTRE - BUSINESS CASE**

Adam Wickings introduced a draft business case. He said that the condition of the primary care estate was a long standing issue for the PCT. The draft proposals would help to address inequalities in the relatively deprived area of Penge. Local GPs had found a partner to address these issues in a plan that would provide new accommodation for five Penge practices. Three of the practices were fully signed up to the proposals and the remaining two were still in discussion. There would be a key meeting with NHS London next week to approve the capital. Board endorsement was now being sought on the direction of travel.

The Board considered the likelihood of the two remaining practices joining the project and the consequences if they did not. It was felt that new premises with community provider unit staff also on site would bring considerable advantages for all patients that the practices could not ignore.

Marcia Fry asked about accessibility to the new centre. Adam Wickings said that there were good public transport links.

In reply to a question about affordability, Adam Wickings said that the GPs would not be required to make a capital contribution to the project and that there was a complex formula for rent reimbursement that was

not based solely on the cost to GPs. Costs had been reduced from original proposals by the use of shared reception areas etc.

The PCT Board endorsed the proposals in principle, and agreed that work should continue to finalise the business case. It should demonstrate real benefits to patients.

51/11 **LEARNING DISABILITY SERVICES**

Terry Rich introduced an update report. The Board noted that completion with regard to the Cheyne site had now slipped to October/November 2011. All other schemes were on site, and due to slippage resulting from adverse weather, would be completed in June. The Cheyne delays would mean longer occupation of the Bassetts/Tugmutton site. The PCT would remain statutorily responsible for these patients until they could transfer. There was a delay with implementing the proposals for the respite care centre resulting from the capital value of the buildings for transfer. Clive Uren said that all estate issues now had to be dealt with by NHS London, and that Marie Farrell was dealing on the PCT's behalf. Terry Rich said that a new site had been identified for the community learning disabilities team, and that the funding situation was being dealt with. The expectation was now that the Bassetts site would be cleared by November 2011.

The financial risks had been taken into account. There would be no transition grant from the Department of Health in the coming financial year. The plan was to carry some of the grant forward from the current year and to use other Department of Health funding sources. Terry Rich said that the Health and Well Being Board would oversee the service in future, but that the current BSU and PCT Board arrangements would need to continue through the final stage of transition.

Harry Goldingay confirmed that Serious Incident reporting for the service would continue through the BSU.

The PCT Board received and noted the report.

52/11 **PATIENTS REFERRAL CENTRE**

Angela Bhan reported that an investigation had been led by an independent consultant who had prepared a long report helpfully summarised for the Board by Harry Goldingay. It included a draft action plan. The root causes of the build up of referrals in the Centre had included team issues, the training and induction for new staff, the introduction of the MSK pathway too soon after the previous reinstatement of the service, and the standard of operating procedures, monitoring and assurance.

Key recommendations included the recruitment of a senior project manager to oversee the service, the provision of new operating procedures, broader clinical engagement and remodelled capacity and monitoring procedures. It was intended that in future the focus would be on a number of care pathways, but not all. Andrew Parson said that GPs were considering the strategic direction of the Centre and the contribution it could make to QIPP. They were also considering the triage pathways it could provide to services in the community. They were reviewing the technology that would be required.

The PCT Board received and noted the report and that the Project Manager post would report to the BSU managing director.

53/11 **NEW AND REVIEWED WRITTEN CONTROL DOCUMENTS**

The PCT Board ratified the reviewed Policy and Procedure for Domestic Abuse.

ITEMS FOR INFORMATION

54/11 **REPORTS FROM THE COMMITTEES OF THE BOARD**

The PCT Board received and noted the minutes of the meeting of the Audit Committee held on 8 February 2011, and the meeting of the Community Provider Unit Board held on 24 November 2010.

55/11 **ANY OTHER BUSINESS**

There was none.

56/11 **DATE OF THE NEXT MEETING**

To be confirmed under the cluster arrangements.

Jim Gunner thanked Clive Uren who was attending his last meeting of the Board for all his work over the past 10 years at the PCT. Clive Uren wished good luck to all colleagues whether they were staying with the PCT or moving on.

…….. CHAIR

Greenwich NHS
Teaching Primary Care Trust

ENCLOSURE A
Business Public Meeting
Date:
Item: 3.0

GREENWICH TEACHING PRIMARY CARE TRUST

Minutes of the Business Meeting of the Greenwich Teaching Primary Care Trust Board held at 6.30 p.m. Wednesday, 23rd March 2011 in the Grand Salon, Charlton House

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PRESENT

Board Members:

Rev Jeremy Fraser	- Chairman - Non-Executive Director
Mr Ade Adeagbo	- Non-Executive Director
Dr Vijay Bajpai	- PEC Member
Mr Michael Chuter	- Non-Executive Director
Mr Graham Elvy	- Executive Director of Finance
Ms Susan Free	- Non-Executive Director
Ms Diane French	- Non-Executive Director
Dr Hilary Guite	- Executive Director of Public Health and Well-being
Mr Steve James	- Non-Executive Director
Ms Jane Schofield	- Chief Executive

In Attendance:

Cllr Peter Kotz	- LBG, Associate Board Member
Ms Annabel Burn	- Deputy Chief Executive, Director of Quality & Performance
Ms Lesley Strong	- GCHS Managing Director
Ms Sheila Freeman	- Chair, Greenwich LiNK
Mr David Sturgeon	- Executive Director of Primary Care and Community Transformation
Mr Tony Read	- Executive Director of Strategic Planning and Commissioning
Dr Niraj Patel	- GP Consortium Board Member
Mr Jay Stickland	- Senior Assistant Director, Transforming Adult Social Services and Personalisation (for Mr John Nawrockyi)
Mr Colin Nash	- Minute taker

There were eight members of the public present.

202/2011 WELCOME

Rev Fraser welcomed the Board, officers and members of the public to probably the last meeting of the PCT Board in its current format.

203/2011 ADDITIONAL ITEM – RECEIPT OF PETITION

The Chair read out and **RECEIVED** a petition of 1100 signatures. The Chair agreed to meet representatives of the petitioners outside the meeting to discuss how their representations should be taken forward.

204/2011 APOLOGIES FOR ABSENCE

Apologies were received from Cllr Jackie Smith.

Opening Business

205/2011 MINUTES OF THE PUBLIC BUSINESS MEETING

The minutes of the meeting held on 19th January 2011 were **APPROVED** subject to the inclusion of Ms Free and Ms Strong in the list of those present.

206/2011 MATTERS ARISING NOT ON THE AGENDA

None.

207/2011 DECLARATIONS OF INTEREST

Mr James declared that from 1 April 2011 he would take up the position of Lay Advisor on the Oxleas NHS Foundation Trust Board. To avoid any conflict of interest, it was **AGREED** that Mr James would not vote on agenda item 213/2011, the 2011/12 Budget.

208/2011 DELIVERY OF LONDONWIDE COMMISSIONING SUPPORT FOR PCTs AND CLUSTERS

The Board considered two papers headed Delivery of London wide Commissioning Support for PCTs and Cluster: a review of the service provided by CSL and an Annex headed Winding Down CSL Functions. Ms Burn took the Board through the papers and highlighted that relatively little use had been made of Commissioning Support for London's (CSL) informatics products by SEL PCTs. With the winding down of CSL data warehousing, claims management and acute data benchmarking would need to be managed locally. Capacity would continue to be in place to undertake each of these functions, partly through the Sector Acute contracting Team, partly through contracts such as Bexley's Mede System and also through use of tools and websites such as SUS, Unify, HES Online and NHS Comparators.

In answer to a question from Rev Fraser, Ms Schofield replied that a report on the costs of CSL to PCTs would be received by the appropriate body under the new transitional governance arrangements.

With the Chair's permission, Mrs Hook registered her concern that this represented a

diminution of local control over local health services. She enquired whether, under the transitional arrangements, PCT Board meetings would continue to be open to the public. Rev Fraser replied that he had been given this undertaking. He added that, in order to ensure a smooth handover of responsibilities by April 2013, NHS Greenwich had decided that GP Consortium Board meetings, would be held at the same time as PCT Board meetings so that both groups shared the same information about local health services.

The Board **APPROVED** the recommendations set out on page 1 of the paper Delivery of London wide commissioning Support for PCTs and Clusters: A Review of the services provided by CSL.

Quality

MATTERS FOR INFORMATION

209/2011 CONTROLLED DRUGS REPORT

Ms Burn referred the Board to the RAG rated Report from October 2009 to September 2010. Mr Sturgeon added that the single amber item in the report identified as "Ensures a formal controlled drugs review is carried out once a year of each primary care provider in contract with the PCT", was now green.

The Board **RECEIVED** the Controlled Drugs Report.

210/2011 DIGNITY IN CARE STRATEGY

Ms Burn referred to the joint strategy "Embedding dignity in Greenwich" produced by the London Borough of Greenwich, Greenwich Community Health Services, Oxleas NHS Foundation Trust and NHS Greenwich. This was an important piece of work aimed at ensuring dignity was respected across all care services.

The Board **APPROVED** the Strategy.

211/2011 QUALITY SUB-COMMITTEE

Dr Windsor reported that the Committee had meet earlier in the day and ensured that all outstanding items were handed over to the GP Consortium so they could be taken forward.

The Board **NOTED** the verbal report.

PERFORMANCE

MATTERS FOR CONSIDERATION

212/2011 GREENWICH QIPP 2011/12 – 2014/15

Mr Read highlighted the following points in the Greenwich QIPP plan. The plan set out to close the QIPP funding gap by improving the efficiency of services whilst maintaining their quality. The financial implications were set out on page 29 of the plan. This would be

achieved by improving the efficiency of providers, redesigning care and referral pathways, shifting healthcare delivery closer to home and ensuring that the healthcare delivered was necessary and based on clinical evidence.

Mr Read emphasized the local clinical ownership of the QIPP plan and the importance of the Greenwich BSU supporting the Greenwich GP Consortium to achieve the net savings target. Mr Read informed the Board that the budget paper, to be considered next on the agenda, had revised the net saving target from £11.5m to £14.8m in 2011/12.

In response to a request from the Chair, Mr Read agreed to ensure a report on the position with regard to the Greenwich QIPP contribution be presented to an early meeting of the Cluster.

With the Chair's permission Mrs Hook asked how Greenwich residents would be able to keep track of local QIPP schemes. Rev Fraser replied that the Greenwich element of QIPP would continue to be considered by the Board which would remain open to the public.

In response to a concern expressed by Dr Guite that corporate memory must be retained under the new arrangements, Mr Read agreed to include within the report submitted to the Cluster a position statement with regard to public health initiatives in Greenwich.

The Board **RECEIVED** the report on the Greenwich QIPP Plan.

213/2011 <u>2011/2012 BUDGET</u>

Mr Elvy referred to the 2011/12 Budget Setting and Operating Plan Detailed Assumptions paper which summarised the following:-

- anticipated revenue allocations and income,
- revenue allocations and income on a Source of Funds basis (net changes in resources compared with 2010/11) and
- expenditure commitments on an Application of Funds basis (the PCTs planned changes in expenditure compared with 2010/11).

The Budget included the requirement that PCTs should make a 1% surplus during the year and savings associated with achieving the QIPP target.

Rev Fraser noted that the PCT had achieved its financial targets in each of the last 10 years and asked whether it would do so again. Mr Elvy cautioned that formal contracts with all providers had not yet been signed off but provided the projected outturn did not change significantly as a result of unforeseen matters, he expected it to do so.

Dr Guite enquired about the significance of the red rated items in the QIPP Programme Risk Assessment, Attachment 1 to the report. Ms Schofield replied some were the result of contracts not yet being signed or schemes not as yet progressed far enough. These were expected to change to green in future. For those that remained red, where the judgment had been taken that they would not deliver the savings attributed to them, an alternative scheme would need to be identified.

With the Chair's permission Mrs Hook enquired how the PCT would respond if the health needs in a particular area proved to be greater than that anticipate in the budget. Rev Fraser replied that the reserves maintained by PCT were intended to address such matters.

Ms Schofield added that if a particular issue peculiar to Greenwich emerged, that could not be managed within existing resources, it would be for the PCT to argue its case for more funds with the Sector and NHS London. She cited prison health as a potential example.

The Board **APPROVED** the 2011/12 Budget on the basis set out in section 6 on page 9 of Mr Elvy's paper.

214/2011 2010/2011 ANNUAL ACCOUNTS

Mr Elvy referred to his paper proposing in section 3, that in the event that Board arrangements for 2011 do not provide for a Board date shortly before the 10th June 2010 Accounts deadline the Board should appoint a special committee, as set out in the paper, to approve them on its behalf.

The Board **AGREED** the proposal to establish a Special Committee to be convened to meet by the required deadline, if required.

215/2011 PERFOMANCE MONITORING REPORT

Ms Burn took the board through the report which included all available performance information as at Month 10, January 2011. Although World Class Commissioning had been withdrawn as a framework for assessing commissioners, the report used the WCC metrics as they were the most significant for the people of Greenwich and covered the areas of greatest concern to the Board. The areas of concern described in the report were all known to the Board.

Ms Schofield added that the performance with regard to the 4 hour waiting time target in A&E had improved significantly recently, although the 18 week waiting time indicator remained a concern and would continue to be monitored.

With regard to the immunisations indicators Mr Sturgeon reported that the PCT had now achieved three quarters of good performance. All GP practices were submitting data and a data cleansing exercise had been completed. He particularly mentioned that MMR performance had risen to 82%, the fifth best performance in London.

In response to a question from Rev Fraser, Mr Sturgeon agreed that the introduction of shadow key performance indicators had helped practices focus on the areas that required improvement.

Ms Burn also noted that a combination of investment and partnership working had allowed the PCT to improve the support offered to those who wished to die at home.

The Board **NOTED** the report.

216/2011 PERFOMANCE INDICATOR FRAMEWORK 2011-12

The Board **RECEIVED** the Performance Indicator Framework.

217/2011 FINANCE REPORT – MONTH 11

Mr Elvy took the board through the executive summary set out on the first page of the report. The overall position at Month 11 was an overspend of £14.96m for NHS Greenwich and an underspend of £0.525m for Greenwich Community Health Services. This cumulative deficit of £14.4m had been covered by the release of reserves allowing the PCT to report a surplus of £4.8m at Month 11, as planned.

With the Chair's permission a member of the public enquired how budget expenditure would be monitored under the transitional governance arrangements. Rev Fraser replied that local PCTs would continue to be statutory bodies until April 2013. The Greenwich Board would therefore continue to monitor local budgets. As PCTs would share some senior executives, it was probable that they would meet simultaneously with other PCTs, but the governance arrangements would still allow for the Greenwich budget to be appropriately monitored in public meetings. Rev Fraser had been given an undertaking by the Sector Chief Executive that the concept of subsidiary would apply, so that matters applicable to a particular PCT would be determined at the most local level consistent with the transitional governance arrangements. Rev Fraser also emphasised that the PCT bodies would work pragmatically with new GP consortia to ensure tight control over finance was maintained during the transitional period.

Ms Schofield confirmed that the Director of Finance for the Sector would be Ms Marie Farrell, currently Director of Finance at Bromley PCT.

The Board **NOTED** the Finance Report.

MATTERS FOR INFORMATION

218/2011 ANNUAL AUDIT LETTER 2009/10

The Board **NOTED** the key messages in the Annual Audit Letter from the PCT's external auditor.

219/2011 PERFORMANCE SUB COMMITTEE

There was no further update on this Committee.

MARKET MANAGEMENT AND PROCUREMENT

MATTERS FOR INFORMATION

220/2011 MARKET MANAGEMENT AND PROCUREMENT SUB COMMITTEE

Mr James reported that the Learning Disability Service had been successfully tendered and the people of Greenwich would benefit from better learning disability services as a result. This had been a joint procurement exercise between the Local Authority and the PCT and he congratulated all those involved.

Mr Sturgeon reported that the joint business case with Oxleas NHS Foundation Trust for the transfer of community services had been approved by the Investment Committee. He also understood that it had been approved by the Foundation Trust regulator, Monitor. Financial matters had been resolved with the exception of one issue which would be the

subject of discussed between the two Chief Executives of GTPCT and Oxleas. He did not foresee anything that would prevent the transfer of services on from 1st April 2011.

The Board **RECEIVED** the verbal update.

GREENWICH COMMUNITY HEALTH SERVICES

221/2011 GREENWICH COMMUNITY HEALTH SERVICES BOARD (GCHSB) POLICIES FOR APPROVAL

- **Annual Leave Policy**
- **Dignity in the Workplace Policy**
- **Maternity Policy**
- **Overpayment Policy**
- **Protection Policy**
- **Relocation and Associated Expenses Policy**

Mr James reported that all the above policies had been seen and approved by all appropriate parties. They would help to ensure the rights of staff were protected in any successor organisation.

On behalf of the Board Rev Fraser thanked all the PCT staff who had continued to discharge their duties in a professional manner at a time of great personal uncertainty for many of them.

The Board **APPROVED** the policies.

INTERGRATED GOVERNANCE

MATTERS FOR INFORMATION

222/2011 INTERIM JOINT HEALTH AND WELLBEING STRATEGY FOR GREENWICH

Dr Guite drew the Board's attention to the report summary. The Strategy had been developed jointly with Greenwich Council and a range of other partners and was the first that sought to improve health and well being across the two organisations. Both the Health and Wellbeing and Children's Trust Boards were supportive of the approach taken. The Strategy had also been considered by the Shadow GP Commissioning Consortia who would be key stakeholders in its future implementation. Because the national policy environment had shifted considerably since the strategy was first developed, it has been renamed an interim strategy. Implementation would be overseen by the new Health and Wellbeing Board to be established shortly. She commended the strategy was a good basis for moving forward in this area.

The Board **NOTED** the interim strategy.

MATTERS FOR CONSIDERATION

223/2011 PROPSED GOVERNANCE ARRANGEMENTS

- **Revised Governance Arrangements**
- **Greenwich Clinical Commissioning Committee Terms of Reference**

Ms Burn took the Board through the paper describing the transitional governance arrangements and the terms of reference of the Greenwich Clinical Commissioning Committee. She highlighted the following points.

The NHS Greenwich Board had engaged with colleagues in the six South East London PCTs to develop transitional governance arrangements. Two options were under consideration, one with Bexley Care Trust formally as part of the Joint Board and one where they remain separate (the preferred option). The final arrangements would be agreed once a decision had been taken on Bexley's level of participation.

The governance arrangements set out in the paper aimed to ensure the ongoing delivery of high quality safe services over the transitional period to April 2013 and to support and enable the development of a new commissioning system with GP consortia taking responsibility for healthcare and Local Authorities for Health and Wellbeing improvement.

In South East London it was proposed that whilst individual PCT Boards remain the statutory bodies responsible for commissioning health services they would share elements of common membership including a common Chair and Chief Executive. The arrangements were set out in detail in the paper.

In response to a question from Mr Adeagbo, Ms Burn confirmed that robust handover arrangements between executives were in place to ensure no hiatus in responsibilities.

Dr Guite noted that responsibility for public health would remain with local boards. The arrangements described in paragraph 3.1.2 of the Transitional PCT Governance Arrangements stated that further discussion was necessary to determine how public health advice from the six PCTs to the joint Board would be achieved through a single public health representative. Ms Schofield added that this matter was still under discussion.

Under the transitional governance arrangements it was for individual PCTs to determine the terms of reference of their own Clinical Commissioning Sub-committee to support the Joint Board. Ms Burn referred directors to the terms of reference for the Greenwich Clinical Commissioning Committee. This committee would take on the role currently undertaken by the PEC. A final decision on the nurse representative was still under discussion.

The Board **SUPPORTED** the proposed approach to PCT Board arrangements as set out in the paper and was content for Chairs Action to be used to approve the final agreement by 1 April 2011.

The Board **APPROVED** the establishment of the Greenwich Clinical commissioning Committee and the terms of reference as set out in the paper.

224/2011 INTEGRATED GOVERNANCE COMMITTEE (IGC)

Ms Free reported that the IGC had focused on reviewing risk so that an up to date risk register, highlighting Greenwich specific issues could be passed on to the Cluster. The Risk Register had been shared with the GP Consortium.

The Board **RECEIVED** the report.

225/2011 ASSURANCE FRAMEWORK

The Board **NOTED** the updated Assurance Framework.

226/2011 RISK REGISTER

The Board **NOTED** the updates Risk Register.

227/2011 IG TOOLKIT

Ms Burn referred to the paper summarising the self-assessment scores approved by the Information Governance Steering Group. The report also identified the gaps in assurance and the work being undertaken to address these prior to submission of the toolkit assessment on 31 March 2011. Ms Burn informed the Board that even with this additional work it was likely the PCT's score would be 57% against its target of 66%. This was however a good score given the organisational change affecting the PCT.

The Board **NOTED** the current position and **AUTHORISED** the Chair and Chief Executive to sign off the toolkit submission prior to 31 March 2011, once the additional assurance work described in the report had been completed.

The Board also **NOTED** that Ms Burn was carrying out the roles of Caldicott Guardian and Senior Information Risk Owner (SIRO) as set out in the report.

Closing Items

228/2011 ANY OTHER BUSINESS

Mr Elvy reported Chairs' Action had been taken approving payments to the London Borough of Greenwich under section 256/7. These were in five key areas of joint strategy and development: Improving the health and well-being of children and young people, tackling health inequalities and improving the health of adults and older people, winter planning and capacity implementation, mental health strategy & implementation, and community services strategy and development.

Mr Elvy also reported a Chairs' Action on the NHS London Director of Finance and Investment had approved the PCTs business case to acquire 4 new 125-year leasehold flats in Greenwich for accommodation for people with learning difficulties. This had been included in the PCTs capital programme towards the end of last year with agreement of the sector as a reserve scheme to utilise slippage in other parts of the PCTs programme.

Mr James commented that this was very good news for this client group, which will help take forward the joint strategy for people with learning difficulties. It will allow 4 people currently placed outside the Borough to return to existing supported accommodation in Greenwich, save the NHS money, and it will also give another 4 people in the same client group an improved standard of accommodation.

In addition, the final Chairs' Action had been taken approving the NHS Greenwich Sustainable Development Action Plan 2010.

The **Board NOTED and RATIFIED** all three (3) Chairs' Actions.

229/2011 PUBLIC QUESTIONS

1. Mrs Smith asked about the differences between GP PMS and GMS contracts. Mr Sturgeon replied that General Medical Services (GMS) contracts were based on national contract provisions whereas Personal Medical Service (PMS) contracts were locally defined by PCTs.

2. Mrs Smith enquired how the PCT saw its contracts with Evolution Health developing in Greenwich. Mr Sturgeon replied that the practice in Charlton and Kidbrooke had 1500 registered patients and was looking to expand. In Thamesmead, Evolution ran a GP lead health centre currently serving 3000 registered and 4000 walk in patients. The high number of walk in patients indicated that the health centre was meeting a previously unmet health need. A third GP lead health centre was scheduled to open in General Gordon Square, Woolwich.

3. A question was asked about the urgent care centre at Queen Elizabeth Hospital. Mr Sturgeon replied that the UCC currently saw about 30% of people who would otherwise have attended A&E. It was planned to put the service out to tender in the future.

230/2011 DATE OF NEXT MEETING

This was the last scheduled meeting of the Greenwich Teaching Primary Care Trust Board.

231/2011 EXCLUSION OF THE PRESS AND PUBLIC

The Board **APPROVED** the following motion, in accordance with section 1(2) of the Public Bodies Admissions to Meetings Act 1960; that members of the press and other members of the public now be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

NHS Lambeth

Board Meeting Agenda
Thursday 17th March 2011
1.00pm - 4.00pm
Canteen Area, 4th Floor, 1 Lower Marsh, SE1 7NT

Minutes of the Meeting

Present	Caroline Hewitt	Chair	CH
	Andrew Eyres	Interim Chief Executive	AE
	Nicholas Campbell Watts	Non Executive Director	NCW
	Christine Caton	Interim Director of Finance	CC
	Helen Charlesworth-May	Executive Director of Integrated Commissioning	HCM
	Una Dalton	Executive Director, HR and Corporate Affairs	UD
	Evelyn Dunwoody	Non Executive Director	CE
	Carolyn Emanuel	PEC Board Member	
	Frances Wedgwood	Interim Medical Director	FW
	Sue Gallagher	Non Executive Director	SG
	Graham Laylee	Non Executive Director	GL
	Moira McGrath	Director of Primary Care	MM
	Girda Niles	Non-Executive Director	GN
	Ash Soni	Co-Chair of the Clinical Board	AS
	James Toohill	Non Executive Director	JT
	Ruth Wallis	Executive Director, Public Health	RW
	Jo Cleary	London Borough of Lambeth, Executive Director - Adults' and Community Services	JC
In Attendance	Tania Barnett	Interim Corporate Business Manager	TB
	Marion Shipman	Assistant Director, Clinical Quality and Governance	MS
	Hiten Dodhia (item 8)	Consultant in Public Health Medicine	HD
	Heather Blake	Operations Director, Lambeth Community Health	HB
	Les Elliot	Lambeth LINk	
	Janet Buchanan	Member of the Public	

Item No	
1.	**Welcome & Introductions**
	CH welcomed Board members, partners, staff and members of the public to the meeting and noted that this was the last NHS Lambeth Board meeting in its current format with the present membership. CH thanked those members of the public that had been regular attendees to NHS Lambeth board meetings. CH noted that Michael English, member of the LINk was unable to attend today's meeting and recognised the loyalty and contribution shown to NHS Lambeth over the years.
2.	**Apologies**
	There were no apologies.
3.	**Action Log and Minutes of the Board meeting of 27th January 2011**
	The minutes were accepted as a true account of the meeting.
4.	**Matters arising not on the agenda**
	Safer Lambeth partnership refreshed/annual plan AE confirmed that the priorities had been circulated in the Board mailout. **Children's Safeguarding** RW confirmed that a briefing on variation in training had been circulated. **Living Well Collaborative Mental Health Programme** HCM reported that an up-to-date presentation of the programme would be presented to the Health and Adult Services Scrutiny Committee at the meeting later that evening and agreed to circulate a copy of the presentation to Board members. **Action: HCM**
5.	**Chair's Action**
	The Board ratified the following Chair's action taken since the Board meeting held on 27th January 2011 to: ▪ Approve the recommendations on the future of CSL as discussed at the Board Seminar on 17th February 2011.
	Items For Presentation
6.	**Looking Back – Looking Forward**
	The Board was asked to receive a presentation on NHS Lambeth achievements and priorities looking forward for the health of Lambeth communities. CH, AE and AS provided the meeting with an overview of NHS Lambeth's achievements including: ▪ Improvement of complex local issues including teenage pregnancy, sexual health and

	HIV ▪ Strong reputation in financial management ▪ Reducing health inequalities ▪ Improvements in Long Term Conditions and Mental Health services ▪ Lambeth Community Health and Primary Care services CH also formally recognised Graham Laylee's contribution to work on sustainability. CH acknowledged that the future would be challenging but also exciting and full of opportunities, and enriched by the leadership of clinicians going forward. Quality partnerships were essential for success and CH stressed the importance of focusing on the future. CH, AE and AS took the opportunity to collectively thank all staff, Board members, volunteers and those from partner organisations for the successes achieved by NHS Lambeth. AE presented CH with a bouquet of flowers to formally thank her for her work and dedication as Chair of NHS Lambeth and to wish her well in her new role as Chair Designate of the South East London Cluster Board.
	Items For Decision - Transition
7.	**Governance**
	CH gave an overview on the proposals for governance arrangements across the six South East London PCT Boards. Proposals have been developed to ensure that PCTs assure the ongoing delivery of service quality and safety over the transition period to April 2013 and to support GP Consortia in the development of a new commissioning system. CH reported that in advance of the final agreement, Chair's Action will be sought to approve the final submission by 31st March 2011. AE provided an overview of the proposals to establish the Lambeth Clinical Commissioning Collaborative Board (LCCCB) from 1st April 2011. In November 2010, the Clinical Board replaced the PEC to take Clinical Commissioning forward. The next step is the transition of the Clinical Board to the LCCCB. AE reported that the Clinical Board have reviewed and provided input into draft papers. JC expressed a preference that the Council have a co-opted member on the LCCCB as opposed to a representative of the Council being invited as an attendee. AE confirmed that full consideration would be given to this request. **Action: AE** The Board: ▪ Received an update on proposed governance arrangements for the PCT Board and agreed to the use of Chair's Action to approve final proposals. ▪ Approved the establishment of the Lambeth Clinical Commissioning Collaborative Board and the proposed terms of reference to replace the Clinical Board.

8.	**Annual Public Health Report (APHR)**
	RW distributed bound copies of the Annual Public Health Report. AE gave an overview of the recommendations to continue investment in health improvement and reduce health inequalities, following RW's presentation at the NHS Lambeth Board meeting on 27th January 2011. AE asked Board members to review the recommendations. Board members discussed the future of Public Health and concerns were raised about the lack of clarity over those components of Public Health that will remain. RW assured the Board that joint working in Lambeth was historically very good and well supported, with a clear focus on what needs to be done. JC assured the Board that the Local Authority supported the proposals and recognised the importance of Public Health. HCM's joint appointment and the development of the Health and Wellbeing Board are integral to taking Public Health forward. It was agreed that JT and SG would discuss any final wording suggestions to the response with AE. **Action: JT, SG and AE** CH thanked RW and the Public Health team for all their work carried out on behalf of the people of Lambeth. The Board: ▪ Formally received the Annual Report of the Department of Public Health and considered its findings and recommendations. ▪ Considered the draft proposed response from the Board to the recommendations made and approved the final response in principle subject to amendments made by JT, SG and AE.
9.	**Community Services Integration – Transfer of Lambeth Community Health to Guy's and St Thomas' NHS Foundation Trust**
	AE updated on progress to transfer Lambeth Community Health and Southwark Provider Services to GSTT from 1st April 2011. AE reported that good progress was being made on the physical transfer and legal arrangements were being finalised. Further to the recent JCPCT meeting, a couple of outstanding issues within the Transfer Agreement are being addressed including finalising elements within the contract and ownership of risk in terms of cost. Board members discussed a number of items including: ▪ Continuation of the Transformation Partnership Board to oversee the development of Community Services post-transfer. ▪ The achievability of timescales for the transfer to take place by 31st March 2011. ▪ How the continuation of services will be managed. The Board: ▪ Noted progress in relation to the transfer of Lambeth Community Health services to Guy's and St Thomas' NHS Foundation Trust, on behalf of King's Health Partners.

	▪ Approved the use of Chair's Action to agree the Transfer Agreement on behalf of the PCT, subject to approval by NHS London. ▪ Agreed to support Chair's Action in the unlikely event that the outstanding issues in relation to the Transfer Agreement cannot be resolved with sufficient time to allow the transfer to take place on 1st April 2011, and it becomes necessary to establish an interim Management Agreement with Guy's and St Thomas' NHS Foundation Trust.
10.	**Integrated Plan 2011/12 (IP)**
	MM gave headlines of the NHS Lambeth input into the NHS South East London Cluster Integrated Plan, including: ▪ Priorities for 2011/12 ▪ Supporting financial framework and performance expectations ▪ NHS Lambeth start budgets including the approach to PBC budget setting ▪ Termination of the learning disabilities pooled fund ▪ Approach of NHS Lambeth to the delivery of QIPP ▪ Governance and programme management arrangements to support implementation and oversight of the plan ▪ The issues and risks that remain outstanding at this point MM outlined that four core programmes are proposed for 2011/12and work is currently being developed around these: ▪ Planned Care ▪ Unplanned Care ▪ Mental Health ▪ Staying Healthy Board members discussed a number of items including: ▪ Allowances in Integrated Plan for contracts and systems sustainability and levels of risk ▪ Population and incidents growth in start budgets ▪ How the Integrated Plan will improve services for local residents ▪ Impact on acute services and assumptions around emergency readmissions ▪ Assurance around financial and project issues and contingency plans ▪ The use of the 2% non recurrent funding ▪ The importance of working with GPs to determine access to care MM and CC outlined the next steps, confirming that: ▪ An enhanced risk assessment is to be completed once the final plan is signed off including approaches to mitigating risk and submitted to the LCCCB in May 2011. ▪ The final version of the plan and update to the PCT's Medium Term Financial Strategy is to be submitted to the LCCCB in May 2011 for final approval once the Integrated Plan has been approved by NHS London. GL thanked MM and CC and their teams for the enormous amount of work gone into developing this plan to date. It was agreed that if Board members have any outstanding questions, to direct them to MM. MM to then provide a collective response and circulate to Board members for final approval with any final amendments to the Integrated Plan clearly outlined. **Action: All**

	and MM The Board: ▪ Approved the 2011/12 NHS Lambeth Start Budgets in line with the proposed 2011/12 Operating Plan and our Strategic Plan subject to any agreed amendments. ▪ Noted the remaining financial risks facing NHS Lambeth in 2011/12. ▪ Approved the termination of the Learning Disabilities Section 75 Pooled Fund arrangement in line with the implementation of the Valuing People Transfer. ▪ Noted the approach being taken to Practice Based Commissioning Budget Setting for 2011/12.
11.	**Integrated Commissioning between NHS Lambeth and Lambeth Council – Partnership Agreement**
	HCM gave headlines of the partnership agreement for integrated commissioning between NHS Lambeth and Lambeth Council including key principles, aims, benefits and intended outcomes for a range of health and social care commissioning functions, and a framework for the approach. During the process, both parties have sought independent legal advice. NHS Lambeth has been advised by Capsticks Solicitors in drawing up the integrated agreement. HCM outlined her position as The Executive Director of Integrated Commissioning which is jointly accountable to the interim Chief Executive of NHS Lambeth and the Executive Director of Adults' and Community Services. The Board approved for signature the Integrated Commissioning and Management Agreement between NHS Lambeth and Lambeth Council.
	Items For Update
12.	**Transition and Organisational Change Update**
	UD gave headlines on: ▪ managing transition to secure delivery and enable change and ▪ delivery of Management Cost savings and organisational change. UD gave an update on the appointments to the Lambeth BSU, development plans for LCCCB members including the planned LCCCB away session and the transfer of LCH to GSTT including the transfer of staff. CH and AE formally recognised the enormously difficult task to ensure arrangements were in place during this transition period and thanked UD and her team for their hard work to achieve this. The Board noted the progress in transitional arrangements.
13.	**South East London Integrated Care Pilot**
	Sue Gallagher declared an interest in this item as a Trustee of the Charity, providing funding for the pilot.

	AE updated Board members on the development of the Integrated Care Pilot including progress to date of the key priorities emerging through discussions with partners and the next steps in the project. AE outlined the enabling workstreams and integration along the pathways and reported that HCM and MM are key members of the Programme Board. AE confirmed that the next step is the development of a more detailed business case for funders which will be developed during the spring and early summer. SG advised that the Charity has strict funding guidelines and suggested when preparing the business case that it demonstrates: ▪ Innovative working ▪ Refers to learning from similar work elsewhere. ▪ Transparency of Clinical Governance Indicators. RW suggested that the pilot might benefit from input from Public Health and AE agreed to take this back to the Programme Board. **Action: AE** Board members discussed the importance of being clear on shared outcomes and having a high level of commitment to delivery. CH suggested that it might be useful to provide an update to the Cluster to share learning. **Action: AE** The Board noted the background and progress in the Integrated Care Pilot led by King's Health Partners.
Regular Reports	
14.	**Board Assurance Framework**
	UD updated Board members on the key elements of the Board Assurance Framework and noted the following: ▪ Out of Hospital Care has moved to a RAG rating of red ▪ Progress is being made in the areas of Children and Young People, and Staying Healthy. The Board: • Agreed the Board Assurance Framework for 2010/11 as at 09/03/2011 • Noted identified patient safety and reputational risks as at 09/03/2011
15.	**Chair's Report**
	CH presented the Chair's report and Board members discussed concerns about a report from the Patient Experience Group highlighting serious concerns with customer services within GSTT. SG reported that GSTT had provided feedback stating that some of these issues are longstanding and make take some time to resolve. The Board received the Chair's report for the period 21st January – 10th March 2011.

16.	**Chief Executive's Report**
	AE presented the Chief Executive's report and highlighted work on the development of a strategy for cancer care. Board members discussed the Local Area Agreement and sought assurance that going forward partnerships would continue. AE assured the Board that the Health and Wellbeing Board would ensure engagement with local areas and continue to develop partnerships. The Board received the Chief Executive's report for the period 26th January – 10th March 2011.
17.	**Clinical Board Co-Chair's Report**
	AS presented the Clinical Board Co-Chair's report and updated on the All Practice GP event that took place on 26th January 2011, where GPs had demonstrated a strong commitment to Commissioning in Lambeth. The Board received the Clinical Board Co-Chairs' Report.
18.	**Director of Public Health Report**
	RW presented the Director of Public Health report and CH noted the significance of the work carried out within the Public Health team over the last period. The Board noted the report of the Director of Public Health.
19.	**Director of Finance and Information**
	Finance Report CC provided headlines on the financial position as at month 10 and reported that the month 11 forecast had now been finalised and that NHS Lambeth is on target to deliver its target 1% surplus £6.2million. CC confirmed that she would be presenting the month 11 Finance Report to the PCT Audit Committee in more detail on 25th March 2011. Board members discussed the composition of the new Cluster Audit and Risk Committee. It is anticipated that one NED from each existing PCT Audit Committee would be a member of the Cluster Audit and Risk Committee. Handover arrangements were discussed and internal audit are preparing a risk assessment for each PCT as part of this work. The Board: • Noted the 2010/11 financial position at month 10 and the change to NHS Lambeth's 2010/11 Resource Limit since month 8. • Noted the latest performance against NHS Lambeth's 2010/11 Cash Management strategy. • Approved the proposal for the Cluster Audit and Risk Committee to have delegated responsibility to sign off the draft and final accounts on behalf of the PCT Board, if required.

20.	**Performance Report**
	AE gave the headlines of the Performance Report and reported that good progress is being made in a difficult climate. CH thanked GN for her Chairmanship of the Performance Committee. The Board noted: • the draft minutes of the 7th March 2011 Performance Committee. • the NHS Lambeth March 2011 Performance Report, using the latest available data.
21.	**Capital Report**
	AE provided headlines of the Capital Report and reported that construction is underway at Akerman Road. Progress has been made with the carbon footprint reduction for NHS Lambeth and LCH. AE confirmed that with regards to the transfer of LCH to GSTT and asset transfer, GSTT will operate assets on lease from the PCT, as assets cannot be transferred. The Board: • Noted the process for the approval of the Strategic Capital Development Programme for 2010/11, set against overarching investment priorities for 2010/11, as approved at the March 2010 Board. • Noted progress in the development of Neighbourhood Resource Centres/Hubs across Lambeth and of the Lambeth, Southwark and Lewisham LIFT initiative, (including Akerman Road and the Lambeth Council-led Norwood Hall scheme). • Noted progress in the implementation of both the Sustainable Development Management Plan and the Travel Plan, and in the development of the Commissioner Investment Asset Management Strategy (CIAMs). • Noted work being undertaken on estate issues to progress the integration of community services with GSST.
22.	**Lambeth Community Health**
	GL recognised the enormous work carried out by Heather Blake, Operations Director at LCH and her team to ensure business continuity during the transfer period to GSTT. CH also noted the outstanding results achieved in the staff survey and thanked all involved in this work, highlighting the need to learn from this information. The Board noted the activities and progress being made by Lambeth Community Health.
23.	**Workforce Report**
	UD updated Board members on the key elements of the Workforce Report and noted most operational work had been overtaken by transformational change and transfer arrangements at this time.

	The Board received an update on the level of workforce activity for the third quarter.
	Items For Information
24.	**The Board received for information the following minutes:**
	▪ Clinical Board – 5th January 2011
	▪ Clinical Board – 2nd February 2011
	▪ Quality and Governance Committee meeting – 6th December 2010
	▪ Joint NHS Lambeth and NHS Southwark JCPCT Meeting – 4th January 2011
	▪ JCPCT Sector – 10th November 2010
	▪ JCPCT Sector (draft) – 12th January 2011
	▪ Lambeth First Meeting (draft) – 20th January 2011
	▪ Safer Lambeth Partnership – 19th October 2010
	▪ Safer Lambeth Partnership (draft) – 25th January 2011
	▪ CYPSP (draft) – 19th January 2011
	▪ Joint NHS Lambeth and Lambeth Community Health Audit Committee Meeting (draft) – 21st January 2011
25.	**Register of Sealed Documents**
	The Board noted and accepted the current register of sealed documents.
26.	**Register of Members interests**
	The Board noted and accepted the current register of interest of Board and Clinical Board members.
	Closing Items
27.	**Any Other Business**
	Message to Staff JT acknowledged that as this is the last Board meeting, it was important to recognise the tremendous contribution from all staff in the successes achieved at NHS Lambeth. The Board agreed that a formal message of thanks should be sent on behalf of all the NEDs acknowledging staff for their hard work and to wish them success in the future. **Action: TB**. **Message of thanks from the Chair of the Board** CH expressed her sincere thanks for having the privilege of Chairing the NHS Lambeth Board. CH acknowledged and thanked all those who have been involved in the work of the organisation and particularly those who will not form membership of the new Board post 1st April 2011. CH acknowledged particular thanks to: ▪ TB for her support in servicing the Board meetings over the last year. ▪ AS for his contribution as Chair of the PEC and Clinical Leader. ▪ CE for her clinical input. ▪ The Executive Team for going above and beyond to deliver whilst showing integrity

	during difficult challenges. ▪ AE for his flexibility, calm and confidence as the leader of the organisation. ▪ All the NEDs, particularly for their skills and ability around the Board table which has made a huge impact on patient care in Lambeth. ▪ HCM for joining the NHS Lambeth Management Team at a difficult time of change. CH acknowledged that the contribution of all will leave a strong and lasting legacy for the development of Clinical Commissioning in Lambeth.

Minutes of the eighty second NHS Lewisham Board meeting held at Cantilever House, Eltham Road, Lee, London SE12 8RG on 23 March 2011

Present:	Mr Michael Richardson CB	Chairman
	Mr Steven Corbishley	Non-Executive Director
	Ms Gill Galliano	Chief Executive
	Ms Magda Moorey	Joint Chair, CCEC/Interim Dir. of Governance and Engagement
	Ms Rona Nicholson	Non-Executive Director
	Mr Geoff Price	Acting Director of Finance
	Dr Danny Ruta	Joint Director of Public Health
	Dr Helen Tattersfield	Chair of the Federation, Joint Chair of CCEC and GP
	Mr David Whiting	Non-Executive Director
	Mr Martin Wilkinson	Director of Strategy and System Management
In Attendance:	*From the PCT:*	
	Ms Lesley Aitken	Board Secretary (minute taker)
	Ms Dee Carlin	Head of Joint Commissioning
	Mr Mike Hellier	Head of Performance and External Assurance
	Dr Faruk Majid	GP and member of CCEC
	Mr Charles Malcolm-Smith	Deputy Director, HR & OD
From outside the PCT	Ms Natalie Burrell	Pharmaceutical Representative
Apologies:	Ms Susan Johnson	Non-Executive Director

LEW 11/28 Welcome and Introductions

Mr Richardson welcomed all to the last meeting of the PCT in its current form.

REGULAR ITEMS

LEW 11/29 Minutes of the meeting held on 2 March 2011 and Action Log

The minutes of the meeting held on 3 February 2011 were approved as an accurate record subject to 11/23 *The Federation were in the process of appointing an Executive team who would sit on the Clinical Commissioning Executive Committee in the future. The Chair of the Executive Team would need approval by the PCT Chair as Joint member for the PCT.*

LEW 11/30 Matters arising

Mr Wilkinson would replace Ms Moorey as the Senior Information Risk Officer (SIRO), as Ms Moorey currently holds the post of Caldicott Guardian and would be unable to hold both posts.

ENCLOSURE 9

LEW 11/31 Chief Executive's Report

Ms Galliano presented the Chief Executive report to the Board and highlighted the following:

Staff Survey – there had been a positive improvement in responses to the staff survey especially in communications. The review would be fed into the work going forward.

Section 75 – a meeting with Lewisham Council had been held with agreement that a Section 75 for Public Health would be taken forward. Arrangements for mental health and children's services would be incorporated into the document. Dr Ruta, Ms Galliano and Ms Carlin would take forward with the council.

ACTION: Ms Galliano/Ms Carlin/Dr Ruta

The transfer of Stop Smoking and Health Development services to Lewisham Healthcare Trust (LHT) was **APPROVED.** A total of nineteen staff would be affected. The first legal agreement relating to the transfer of the Lewisham Community Health Services to LHT on 1 August 2010 would be amended to incorporate the arrangement.

ACTION: Chairman's action would be taken to sign off the contract

The Board NOTED the report.

LEW 11/32 Report from the Joint Chairs of the Clinical Commissioning Executive Committee (CCEC)

Ms Moorey reported that the next CCEC meeting would be held the following day.

At the last CCEC meeting the committee has asked for further detail on the mental health CQUIN objective. A report would come back to the Committee.

Regarding maternity services it was agreed that no further additional investment would be made until sound assurance was given that previous investment had achieved improvements in patient experience and additional staff were provided.

Ms Nicholson said that LHT had to improve customer satisfaction in their maternity services. The Board's disappointment with LHT was noted and requested assurance that there would be an improvement in the quality of maternity services provided. Mr Wilkinson would take this further.

ACTION: Martin Wilkinson

Ms Moorey tabled a paper *Review and Transition Planning Workshop Outcomes* She outlined what the members that attended the meeting on 25 February thought they had done well, what they needed to do more of, what was needed to be done in the future and discussed the legal requirements for the local CCEC/Clinical Board. The Committee were to look at their membership in line with fulfilling statutory requirements

It was noted that Mr Richardson had written to CCEC members regarding transfer from the Professional Executive Committee (PEC) from June 2010 to April 2013.

The Board NOTED the report

LEW 11/33 Report from the Chairman of the Audit and Risk Committee

Mr Corbishley reported that the Audit and Risk Committee had at its meeting that morning and looked at documents such as the Statement on Internal Control and the Corporate Governance Framework, which would be handed over to the new Audit Committee. Residual outstanding risks around issues such as payroll had been discussed along with taking Internal Audit arrangement into the Cluster.

The Committee were assured that a sound legacy document with actions was being compiled for consideration by the new Audit Committee.

The Board thanked Ms Moorey and Dr Tattersfield for their chairmanship of PEC and CCEC and to Mr Corbishley for the Audit and Risk Committee.

LEW 11/34 Performance Reports

34.1 Resource Framework and Financial Position 2010/11

Mr Price, Acting Director of Finance presented the report. A similar report had been presented to the PCT Finance Committee.

The PCT's actual surplus at the end of February 2011 was £4.561m. This was an improvement on the shortfall reported in January which was mainly due to the recording a proportion of the potential profit on the sale of Wardall's Grove.

Subject to the sale being completed by end of March 2011 and acute performance not exceeding the projected £10.1m overspend and no further cost pressures being identified, for example any further overspend on prescribing, it was expected that the PCT would achieve the planned year end surplus of £5.1m. Mr Price was leading on the sale of Wardall's Grove and would be pressing for completion before 31 March 2011.

Mr Richardson thanked all concerned for the achievement of the year end surplus but expressed regret that the PCT had again incurred a significant overspend on acute services. The Board expressed a view that the new Cluster arrangements would need to ensure appropriate oversight of the acute sector was maintained to help avoid this risk manifesting itself over the next few years.

The Board NOTED the report.

34.2 Performance Report

Mr Hellier presented the report which detailed the handover of performance indicators and strategic initiatives in line with the new organisational structure from 1 April 2011. Following a review at SMT it was noted that IAPT and Dementia future leads would be changed to Joint Commissioning.

The document was looking at where new indicators would go, for example A&E indicators would be managed at the Cluster. Mr Hellier reported that Choose and Book had a new measure in the Operating Plan. It was acknowledged that there was no local appetite for the system because of technology flaws and the time required to use the system. Though it was noted that choice was high on the Governments agenda.

Mr Richardson said that there had been a great improvement in the way data had been presented to the Board, he thanked Ms Moorey, Mr Hellier and Ms Bradley for their contribution. NHS Lewisham was one of the top performing PCTs in London which was a tribute to PCT staff.

The Board NOTED the report

34.3 Board Assurance Framework and Heat Map

Ms Moorey reported that the top four risks presented were transitional risks.

She explained the clustering of risks in boxes 8 (unlikely x major) and 12 (possible x major) would remain vertically static as the assessed Impact level would be unchanged but that further actions currently in place would focus on reducing the likelihood of these risks materialising thereby producing a horizontal reduction in the Likelihood score.

The Board NOTED the report

ITEMS FOR DECISION

LEW 11/35 Operating Plan and Budget 2011/12

Mr Price presented the final version of the 2011/12 Operating Plan and Budget which had been fully discussed at the Finance Committee earlier in the day. Previous versions had been presented to the Board.

Since the last report to the Board there had been changes made to:

- Acute services; the budget had increased to reflect the current position on contract negotiations with the adjustment made to QIPP savings figures.
- Prescribing; the budget had been increased to better reflect 2011 outturn
- Mental Health – to reflect an allocation adjustment though the overall effect was neutral.

Mr Price stated there was likely to be some movement between budget headings as detailed budgets were completed and responsibilities change due to restructuring but these would be within the overall budget envelope.

The Board APPROVED the PCT's 2011/12 Operating Plan and Budget

ITEMS FOR DISCUSSION

LEW 11/36 Transition Update

Ms Galliano reported that there would be fewer redundancies than expected. It was agreed, at Ms Nicholson's request, to obtain a report on redundancies across the Sector and where staff had moved to in the new arrangements. Mr Corbishley also asked for a report from NHS London on how many staff had left with a redundancy payment and then rejoined the NHS; this was requested in order to justify the spending of public money. This should go to the new Joint Remuneration Committee.

ACTION: Ms Galliano

36.1 Transitional PCT Governance arrangements for South East London PCTs and Bexley Care Trust

Ms Moorey introduced the report and enforced that whilst PCTs/Care Trust would continue to be statutory organisations there was to be a consolidation of management capacity, with a single management team managing a cluster of PCTs. This approach would be consistent across London. It was acknowledged that there were still issues to be resolved with Bexley Care Trust.

The Business Support Unit (BSU) would be overseen by a Clinical Commissioning Committee. The composition of the local committee would be for local decision, though there was an expectation that it would be chaired by a Clinical GP Commissioner lead. Terms of Reference were being determined.

As the Appointments Commission would not have appointed the required Non Executive Directors by 31 March 2011 PCT Boards would retain legal responsibility until the joint Board was in place. Mr Richardson's term of office ceases on 31 March and therefore a Vice Chair for the PCT would need to be appointed to provide Chair's action where necessary. **The Board AGREED that Mr Corbishley would undertake this role.**

It was confirmed that there would now be two pools of six NEDs with one pool serving Lewisham, Lambeth and Southwark and the other Bexley, Bromley and Greenwich. This arrangement would ensure that each PCT/Care Trust would retain two NEDs.

The Board SUPPORTED the proposed approach to PCT Board arrangements.
The Board APPROVED the establishment of the Lewisham Clinical Commissioning Committee and the proposed Terms of Reference and membership

36.2 Legacy Documents

Ms Moorey introduced the Legacy Document for the Board. The document would provide high level assurance of where management arrangements would be covered. There would be further documentation completed by each member of staff which would indicate where duties would be handed on to.

It had been agreed that for each Committee the NEDs and EDs would receive an induction pack of patch information.

ACTION: Cluster Corporate Affairs Team

The Board NOTED the Legacy Document

LEW 11/37 Response to Public Health White Paper

Dr Ruta gave a verbal update. There was to be an intended joint response to the White Paper from Public Health and the Council. One area of contention in the response produced by Public Health had been the strength and statutory powers given to the Health and Well Being Board. As the Council required a political mandate to cover this area it had been decided to remove it from the response. Once there was a redrafted response from the Council it would be passed to the Vice Chair, Mr Corbishley, to take forward.

ACTION: Danny Ruta

ENCLOSURE 9

LEW 11/38 Any Other Business

Ms Galliano formally thanked Mr Richardson for all he had done for the PCT and residents of Lewisham.

Mr Richardson responded that it been a fascinating four years and that he had enjoyed working with all his PCT colleagues.

LEW 11/39 Next Meeting

The first NHS South East London joint Board meeting would be held on 19 May 2011 at 3pm in the Council Chambers, Lewisham Town Hall.

A

Southwark NHS
Primary Care Trust

Approved as accurate minutes
By Mee Ling Ng, Chair of
Southwark Primary Care Trust
Signed _____

Date _____

The minutes of the forty second meeting of the Southwark Primary Care Trust Board Meeting held on Thursday 24th March 2011 at 160 Tooley Street.

Present

Mee Ling Ng	Chair
Richard Gibbs	vice Chair & Non Executive Director
Peta Caine	Non Executive Director & Chair of Audit Committee
Anne Montgomery	Non Executive Director
Robert Park	Non-Executive Director
Dr Olufemi Osonuga	Chair Professional Executive Committee
Susanna White	Chief Executive
Malcolm Hines	Deputy Chief Executive & Director of Resources
Dr Ann-Marie Connolly	Director of Public Health
In attendance	
Andrew Bland	Director of Primary Care Development
Dr Jane Fryer	Medical Director
Donna Kinnair	DBE Director of Commissioning & Nursing
Adrian Ward	Head of Performance
Vicky Bradding	Corporate Secretary

1051/2011	**Apologies for absence** Edward Robinson Non Executive Director
1052/2011	The minutes of the meeting held on 27TH January 2011 were approved as a correct record.
1053/2011	**Chief Executive's Report** **The Board endorsed the decisions made by the Finance & Performance Committee in declaring St. Olave's and Ann Moss way sites surplus to requirements.** **The Board endorsed the revised accounting treatment for Dulwich Hospital, following the discussions that had taken place with the Finance and Performance Committee.**

ENCLOSURE 9

	The Board noted the items for information regarding the developments in GP Commissioning and the information governance update.
1054/2011	**Opening Budgets** MH reported that the 2011/12 contract position is still under negotiation. He outlined the budgetary framework and stated that the deadline for contract completion is 28th March for non Foundation Trusts. There is an outstanding arbitration issue regarding Lewisham Hospital that may be referred to NHS London but MH reassured the Board that this is an insignificant risk to SPCT. The deadline for contract completion with the Foundation Trusts is 21st May and work is progressing through LSL Alliance to complete contracts by this date for Guys & St. Thomas', King's and SLAM. Various other work is also ongoing mainly around corporate budgets and MH highlighted the uncertainty about recharges. In conclusion, MH stated that the PCT is at a similar position as this time last year. The final position will be reported to the Clinical Commissioning Committee in May. In answer to a question from RG, MH stated that a new issue with the Foundation Trusts this year is the 30day readmission penalty. New guidance is also awaited re Payment by Results and this uncertainty is shared nationally. In answer to a question from RP, MH confirmed that earmarked budgets contain general reserves and that the level of reserves has improved in terms of the overall starting position. PC enquired what conditions have been attached to the reserves held by the Strategic Health Authority. MH replied that these have not yet been defined. He has been requested to detail how the reserves will be spent but has been told that they will not be released until the half year. SW added that this had also been discussed at Health Overview & Scrutiny and advised that the situation is kept under close review. **The Board approved the revenue and capital Start Budgets 2011/12 and the financial risks and risk management arrangements. A full update of the final position including such recommendations that are necessary to maintain a balanced budget position for 2011/12 will be reported to the Clinical Commissioning Committee in May and to the next meeting of the PCT Board.** **The Board also agreed the overall QIPP savings programme.**
1055/2011	**Governance Arrangements**

	SW outlined the report. The process for recruiting new non executive directors has commenced. Existing non executive directors will stay until the end of April and RG will be the PCT Chair as MLN's contract cannot be extended again for a further period. RG stated that the governance structure has now been updated and recommended that the Board consider the review to ensure that it is fit for purpose. He also suggested that the governance structure be reviewed every six months. Discussion ensued and AB highlighted that SPCT do not have a PEC nurse. He also queried the number of PEC nurses on the proposed Board membership. Comments would be welcome on how the PEC nurse input can be incorporated. Nursing input into the Clinical Commissioning Committee also needs to be developed. However, he would not envisage six PEC nurse representatives on the joint PCT Board. He also highlighted that the responsibilities of the PEC Chair and the Chair of the Clinical Commissioning Committee have been incorporated into one role and that there is now public representation on the local Clinical Commissioning Board. PC emphasised the need to consider this report alongside the Scheme of Delegation. She also highlighted that changes that had been agreed previously have not been reflected in the report. The move to subsidiarity locally must be supported by the scheme of delegation and it is important that the timescale for approval of the scheme of delegation is clarified so that it can support the move to subsidiarity. RG reassured the Board that the draft governance structure reflects the scheme of delegation but he agreed that the final version needs to be available alongside the governance structures. Only approval of the approach in setting governance structures has been requested and the detail still needs to be finalised. . The Overview and Scrutiny Committee have been appraised of the situation **The Board supported the proposed approach to future governance arrangements as set at Appendix A in the report in advance of final agreement subject to the site of scheme of delegation** **The Board approved the use of Chairs Action as appropriate to approve final proposals in order to allow implementation of the governance structures by 1st April 2011.** **The Board also supported the establishment of the Southwark Clinical Commissioning Committee as part of these arrangements and approved the proposed and draft Terms of Reference (including membership) as set out in Appendix B. Nurse representation will be reviewed.**
1056/2011	**Transition Risk report and Board Assurance Framework**

	The Board noted the Transition Risk Report and Board Assurance Framework.
1057/2011	**Risk Management Strategy** **The Board approved the Risk management Strategy. A new strategy is required for 2011/12.**
1058/2011	**Statement of Internal Control** MH stated that Audit Commission Guidance has now been received and the final version of the SIC will be agreed at the April Audit Committee meeting. Discussions around the final version will be sector led. Process and responsibilities for 2010/11 financial statements have still to be finalised PC reported that an Audit position statement will be presented to the Audit Committee meeting in April. **The Board noted the draft Statement of Internal Control for 2010/11.**
1059/2011	**Counter Fraud & Corruption Policy** **The Board approved the Counter Fraud and Corruption Policy**
1060/2011	**Transfer of Community services to GSTT Foundation trust** MH reported that agreement has been reached with NHS London and also GSTT but is still required by the London Investment Capital Committee meeting tomorrow. A contingency position may be required as detailed in the report MH stated that the transfer will commence as a three year contract and it is recommended that approximately 20%of the contract will be market tested within the first few years. Twelve months notice will be given of the market testing arrangements. **The Board** • **Noted the progress in relation to the transfer of Southwark Community Health services to Guys & St. Thomas' NHS trust, on behalf of King's Health partners.** • **Approved the use of Chair's action to agree the Transfer agreement on behalf of the PCT, subject to approval by NHS London** • **Agreed to support Chair's Action in the unlikely event that outstanding issues in relation to the Transfer agreement cannot be**

	resolved within sufficient time to allow the transfer to take place on 1st April 2011, and it becomes necessary to establish an interim management Agreement with Guy's & St Thomas NHS Foundation Trust.
1061/2011	**Finance** **2010/11 Month 11 Financial Report-** MH outlined the main points of the report. The position is holding and improving with a projected under spend of £934K at year end. All key areas have been discussed with LSL Alliance. RG stated that this is very good news and had been discussed at the Finance & Performance Committee. SPCT overspend is the lowest in SE London and the efforts of GPs and the executive team in achieving this position must be acknowledged. In answer to a query from RG relating to Capital Charges, MH stated that previous guidance states that all assets remain but new guidance has been received stating that assets can be transferred. All transfers of assets will be reported. SW stated that this issue has been raised by other stakeholders. **The Board noted the month 11 Financial position detailed in the report and the mitigating actions and contingencies detailed in the report to ensure delivery of the Acute financial targets**.
1062/2011	**Performance** AW outlined the main points of the report. RG highlighted the need to publicise our achievements and link these to public health messages. He also highlighted the variation in GP referrals across the PCT and enquired whether this has been reviewed by GPs. AB stated that GPs need to review this huge growth of activity as soon as possible. DK stated that the capacity to challenge is limited at present and a whole stream of work is required. Discussions are currently on going with SLAM. **The Board noted** • **The PCT Performance report Month 10 and year end forecast** • **Southwark Provider Services Performance** • **Performance Report on Services provided by South London & the Maudlsey NHS FT[SLAM]**
1063/2011	**Items for Information** **The Board noted the following items of information:**

ENCLOSURE 9

	National NHS Staff Survey Results for NHS Southwark **Minutes from Board Committees** **Chair & Non Executive Director Activity report**
1064/2011	**Any other Business NONE**
1065/2011	**Date of next meeting To be confirmed**

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 10

PATHFINDER DEVELOPMENT AND DELEGATION

DIRECTOR RESPONSIBLE: Gill Galliano, covering role of Director of Transition

AUTHOR: Simon Hall, Interim Project Director - Transitional Development

TO BE CONSIDERED BY: All

SUMMARY:
The Board are asked to consider the proposal for delegating responsibilities to Pathfinders in south east London, through the Local Clinical Commissioning Committees (LCCCs) which are now sub-committees of the Board. The proposals require each Pathfinder to submit a Pathfinder Development Plan, and the paper outlines what this should entail in order to provide assurance both to the Board and to NHS London.

Within the recommendations (below) the Board should note that it is expected that a number of the Pathfinder Development Plans will be expected in late May or during June. In view of the desire to enable Pathfinders to take on delegated responsibilites at their own pace, it is proposed that these are scrutinised via the Cluster Management Board and Chief Executive with the Chair taking action to sign them off.

There is considerable enthusiasm for taking on devolved responsibilities for commissioning across the Pathfinders, and this report has therefore been brought to the Board at the earliest possible opportunity to enable Pathfinders to build on this enthusiasm, which will be placed at risk if no decision is made.
This report outlines how the journey from mobilisation through Pathfinder to full authorisation will happen for the GP consortia in south east London by April 2013. It looks at how consortia will gain the confidence and experience of the entire commissioning cycle utilising development support available to them, and establishes clear principles that will underpin the process of accreditation leading up to the shadow year from April 2012.

The report proposes utilising the Local Clinical Commissioning Committees for delegating responsibilities, with each Pathfinder agreeing a nominated Responsible Officer. The report also outlines a process for agreeing Pathfinder Delivery Plans, and outlines how these will be monitored and accredited.

KEY ISSUES:

One of the key elements of the White Paper, now encompassed in the Health Bill, is that the Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams, working in consortia. In November 2010 the Department of Health announced a national Pathfinder Programme to enable emerging GP Consortia to apply for Pathfinder status in order to undertake some of the preparation and development for the new system set out in the NHS White Paper, prior to legislation. With the exception of Greenwich, which is likely to be approved in June 2011, the other five shadow consortia in SE London have already been approved as Pathfinders.

The Cluster has been working with the local Pathfinders and NHS London to agree an approach to enable delegated responsibilities to be formalised as soon as practically possible locally. The proposed approach provides a framework that allows Pathfinder consortia to take on increasing levels of responsibility in a planned way and at the pace needed to enable them to be authorised by April 2013, whilst recognising that PCT Boards remain accountable for delivery until their abolition in April 2013. This approach also takes into account the priorities each Pathfinder outlined in its application to the Secretary of State, and the differences in development between local Pathfinders that will be reflected in the respective pace that they take on responsibilities at during 2011/12. It is designed to enable Pathfinders to take on commissioning responsibilities within existing legislative arrangements by building on existing governance and performance management arrangements. It enables each Pathfinder to take an overview of the totality of its commissioning portfolio, and to take on specific responsibilities at a pace appropriate to local circumstances.

The Pathfinder Delivery Plan has been designed in order to provide assurance to the Board and to NHS London, and to mitigate the risks that are inherent in any proposal for delegating responsibilities. This approach is similar to that adopted in inner and outer North East London, and draws upon learning from South West London.

Appendices 1 and 3 can be considered to be background information. Appendix 2 is essential for Board consideration, and outlines the detail of the Delivery Plan required and the assurance process.

INVOLVEMENT:
This report describes and addresses the principles for, and mechanism of, devolving commissioning responsibilities to Pathfinders in the period up to April 2013. There has been no patient and public engagement on this specific proposal, which is one to enable national policy to be enacted locally. Patients do attend the LCCCs that have been established, and these do meet at least four times a year in public.

The Cluster Management Board, and its Development Committee, have been involved in the thinking and drafting of this report. Each Pathfinder and all Borough Managing Directors were involved in a meeting on 4 May at which the thinking behind the proposals in this report was developed.

No health inequalities or equality impact assessment is appropriate for this report.

RECOMMENDATIONS:
The Board is asked to:

1. Note progress with the development and the achievement of Pathfinder status for all the emerging GP Consortia in South East London, the sources of development support through the London Pathfinder Development Programme and the development funding of £2 per head from April 2011.

2. To note the arrangements for delegation of non-acute commissioning, except for primary care, to BSU Managing Directors from April 2011 (as outlined in section 5.9).

3. To agree the proposed South East London approach to delegation of commissioning responsibilities to Pathfinder GP Consortia, as outlined in Section 5 and Appendix 2 of this Paper. Specifically the Boards are asked to agree the devolution of commissioning responsibilities for each of the Pathfinders via the Local Clinical Commissioning Committees.

4. To agree to receive Pathfinder Delivery Plans, as outlined in Appendix 2 to this report, as the means by which commissioning responsibilities will be delegated to each Pathfinder – subject to the NHS London assurance process.

5. To agree that delegation to Pathfinders should take place as soon as is practically possible across SE London, and to note that Bexley, Lambeth and Southwark are likely to be the first Pathfinders that put forward Delivery Plans for agreement.

6. To agree that Chair's action will be taken during May/June to approve any Delivery Plans from Pathfinders, subject to recommendation by the Cluster Management Board and Chief Executive. Details will then be reported back to the meeting of the Joint Boards in July 2011.

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PATHFINDER DEVELOPMENT AND DELEGATION
NHS SOUTH EAST LONDON – MAY 2011

1. Introduction

1.1 The NHS White Paper "Equity and excellence: Liberating the NHS", sets out the Government's long-term vision for the future of the NHS. The vision builds on the core values and principles of the NHS - a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how it is proposed to make changes in the NHS to:

- put patients at the heart of everything the NHS does;
- focus on continuously improving those things that really matter to patients;
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.

1.2 One of the key elements of the White Paper, now encompassed in the Health Bill, is that the Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams, working in consortia.

1.3 In November 2010 the Department of Health announced a national Pathfinder Programme to enable emerging GP Consortia to apply for Pathfinder status in order to undertake some of the preparation and development for the new system set out in the NHS White Paper, prior to legislation.

1.4 Subject to parliamentary approval, a prospective consortium will be able to apply to the NHS Commissioning Board to be established as a statutory body from April 2012 onwards, taking on its statutory commissioning functions from April 2013.

1.5 This report outlines how the journey from mobilisation through Pathfinder to full authorisation will happen in south east London by April 2013. It looks at how GP consortia will gain the confidence and experience of the entire commissioning cycle utilising development support available to them, and establishes clear principles that will underpin the process of accreditation leading up to the shadow year from April 2012.

2. Background: Clinically-Led Commissioning in South East London

2.1 In much of south east London there has been a tradition of clinically-led commissioning through previous initiatives such as Practice Based Commissioning (PBC). Clinically-led commissioning, where it has worked best, has ensured proactive care pathway service redesign and enabled the development of services, including supporting service change to improve quality, responsiveness, co-ordination and accessibility of services for the benefit of patients. The aspirations for south east London are to build on this further, to drive up quality provision through more patient-centred care pathways and to enable better use of resources. This is why the QIPP (Quality, Innovation, Productivity and Prevention) plans for each PCT area for 2011/12 have been developed by GP commissioners in conjunction with local commissioning teams.

2.2 The application process for Pathfinder status enabled each of the GP consortia to think about the ambition they wished to deliver through achieving

Pathfinder status, and the potential they have to drive clinically led commissioning locally. These aspirations were outlined in each of the Pathfinder applications.

2.3 There is a great deal of consensus between local GPs as to the advantages that the new system will bring:

- Ongoing engagement with health professionals and clinicians in general.
- Visible leadership in conjunction with management to ensure 'buy in' created at frontline level.
- Leading and supporting behavioural change in terms of culture and style of organisations.
- Creating a focus for fundamental change in working practice to enable the true benefits of clinically led commissioning to be experienced.
- Setting ground rules for system redefinition, service redesign and recommissioning.
- Adopting principles of strategic clinical leadership which sit alongside strategic management to deliver whole system change.
- Ensuring delivery of governance, efficiency and patient safety.
- Enabling real local accountability and responsiveness to patient need.
- Adopt a culture of continuous improvement.
- Patient centred with true patient feedback.
- Promote self care and well being.
- Trouble shooting/identification of obstacles in system.
- Sharing knowledge and promoting high quality practice.
- Working with local partnerships.

3. Establishment of GP Consortia in South East London

3.1 All of the emerging GP Consortia in south east London have been accepted onto the Pathfinder programme. There are six consortia (five of which have already been announced as Pathfinders) covering each of the south east London boroughs:

- Bexley;
- Bromley;
- Greenwich (expected to receive approval, June 2011);
- Lambeth;
- Lewisham; and
- Southwark.

3.2 Further details of the GP Pathfinders are shown in Appendix 1.

3.3 By the end of 2011/12 NHS South East London will have:

- Ensured that all consortia have the appropriate levels of responsibility and delegation to enable a shadow year in 2012/13 and authorisation in 2013/14.
- Ensured that energy and effort are focussed on outcomes and changes in delivery across the cluster, within current financial constraints.
- Ensured decisions are made in "different" ways reflecting the changing dynamic between Business Support Units/cluster teams and Pathfinder consortia.
- Provided clarity of outcomes which will be expected through the articulation of the vision in each Pathfinder application.

- Identified the relevant budgets and performance metrics from both the operating framework and local QiPP priorities.
- Devolved responsibility for acute contracting to clinically led management boards.
- Supported differences in the mix of scale and pace of delegation whilst maintaining system "grip" at cluster level, whilst maintaining the principle of subsidiarity for Pathfinders.

3.4 Achievement of these aims will be underpinned by these three stages in the development of local consortia:

Responsibility – The first step in this process will be to transfer responsibilities, establishing Board Committees which build on local arrangements, to enable Pathfinders to be at the centre of decision making across the commissioning agenda. All the Local Clinical Commissioning Committees will have been established by end May 2011.

Delegation – The Pathfinders will take on increasing levels of specific delegation for identified areas, including the associated outcome, finance and performance targets according to their pace of development. This will be outlined in each of the Pathfinders' Delivery Plans (see Appendix 2).

Authorisation – the Pathfinders will take on delegated responsibility across all areas in order to ensure a full shadow year and prepare for authorisation. This will happen by April 2012, but may happen earlier for some of the Pathfinders in SE London.

3.5 During this transition each Pathfinder will also address the development of Health and Well-being Board arrangements with local authorities, review the operation of client group and joint commissioning arrangements, and their approach to acute contracting support.

4. Development Support

4.1 London Pathfinder Development Programme

4.1.1 Eight of the early London Pathfinders (including the Southwark Consortium) have been working with the KPMG Partnership for Commissioning to develop a London Pathfinder Toolkit to support the transition to full authorisation, which includes a range of diagnostic tools and development approaches. Following a tendering process NHS London is in the process of putting in place a framework of providers to work with Pathfinders in using the Toolkit and to support their development.

4.1.2 NHS London has agreed a funding allocation for each Pathfinder, based on registered population, and the process for procuring a provider/providers from the framework has been designed to make this as simple and streamlined as possible. The Director of Workforce Development and the BSU Managing Directors are supporting Pathfinders in this process. An initial launch event, for all south east London Pathfinders, took place on 4 May 2011. At the event the process for accessing this Development Support, via a Statement of Works, was outlined, and Pathfinders initiated discussions as to which elements they may wish to draw down collectively in order to get the maximum benefit from this resource.

4.2 **Development funding of £2 per head**

4.2.1 From 1 April development funding equivalent £2 per head of registered population is available to each approved Pathfinder Consortium to enable them to take forward the establishment of their Consortium, and to start to undertake commissioning responsibilities. This will also be made available to the Greenwich Consortium from 1 May. The funding can be used in a number of ways including for organisational development not covered by the London Pathfinder Development Programme, backfill to enable clinicians to cover practice responsibilities whilst undertaking Consortium duties, and funding additional commissioning support capacity.

4.2.2 Each of the Pathfinders is now able to access this development funding, via their BSUs, once their plans have been given formal approval by the cluster Chief Executive. It is expected that plans for at least the first six months' funding will have been agreed by the end of May 2011.

4.3 **The Commissioning Cycle**

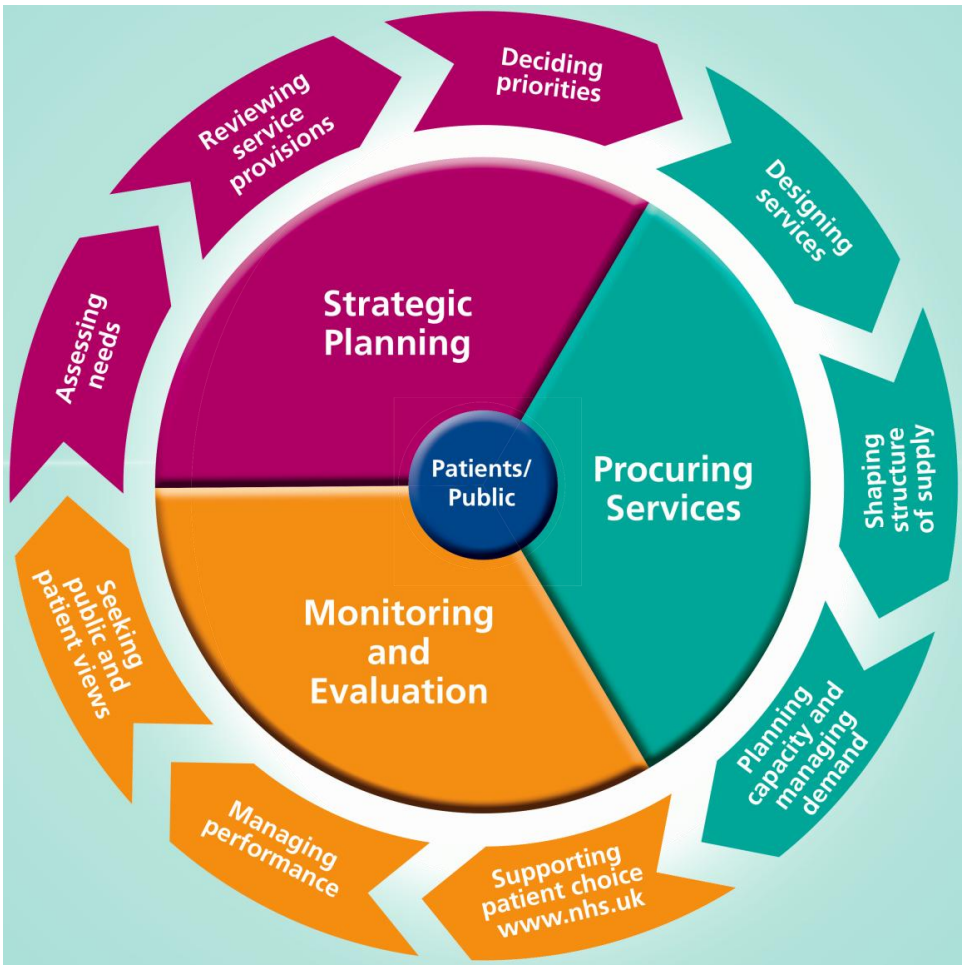

Diagram 1: The Commissioning Cycle (NHS Information Centre, 2008)

4.3.1 Diagram 1 (above) describes the commissioning cycle that PCTs have been working to over the past few years. It demonstrates the entirety of the activity of commissioning that has to be undertaken in order for it to be most effective, and the NHS London development support has been constructed to ensure that Pathfinders acquire skills across the entire commissioning cycle, with Statements of Works being constructed to reflect any gaps or priorities each determines locally.

4.3.2 In order to be most effective, our approach to delegation in south east London needs to be responsive to local circumstances (different areas have different needs and different levels of experience in clinically-led commissioning) and also needs to enable the new consortia to develop an in-depth understanding and skills across the whole commissioning cycle. This underpins our approach to delegation, and is fundamentally why we have proposed that the process of delegation is completely underpinned by supportive development as outlined above. The Statement of Works should meet each of the Pathfinders' assessment of the skills, support and training required to deliver their plans, but will not be seen as a condition for taking on additional responsibilities.

5. Delegation of Responsibilities

5.1 PCTs (working together in clusters) will continue to be accountable for commissioning, and overall governance arrangements, up to April 2013. However, it is important that they begin to devolve commissioning responsibilities to Pathfinder consortia, to enable them to start making a difference for their patients and to gain experience of commissioning in advance of authorisation. In announcing the national pathfinder programme the Secretary of State made clear his expectation that consortia will be supported to take on some commissioning responsibilities from April 2011 if they wish to do so.

5.2 NHS South East London has been working with the local Pathfinders and NHS London to agree an approach to enable this locally. The proposed approach provides a framework that allows pathfinder consortia to take on increasing levels of responsibility in a planned way and at the pace needed to enable them to be authorised by April 2013, whilst recognising that PCT Boards remain accountable for delivery until their abolition in April 2013. This approach also takes into account the priorities each Pathfinder outlined in its application to the Secretary of State, and the differences in development between local Pathfinders that will be reflected in the respective pace at which they take on responsibilities during 2011/12 with a view to running in shadow form for a full year from April 2012.

5.3 A more detailed paper outlining the approach is attached at Appendix 2. It uses the existing powers of PCT Boards and the Chief Executive as Accountable Officer to establish Board Committees and delegate functions with specific budget responsibilities: these are known as Local Clinical Commissioning Committees (LCCCs). It is designed to enable Pathfinders to take on commissioning responsibilities within existing legislative arrangements by building on existing governance and performance management arrangements. It enables each Pathfinder to take an overview of the totality of its commissioning portfolio, and to take on specific responsibilities at a pace appropriate to local circumstances.

5.4 A number of the Pathfinders in south east London have already indicated their wish to take on early delegated responsibility for the commissioning budgets of their PCT/Care Trust, and their PCT Boards have already established their LCCCs (or equivalent). At this Board meeting each of the Terms of Reference, having been subject to review by the cluster governance team, are to be approved (or have their revisions approved) in order that they can function as the means through which commissioning responsibilities can be delegated to the Pathfinders. The establishment of the LCCCs also enables each PCT/Care Trust to fulfil the statutory requirements of the Professional Executive Committee (PEC).

5.5 NHS London guidance sets out a process for approving delegation of responsibilities, with assessment of the plans through the Director of Development with input from finance, commissioning and performance. The assessment will include assurance that there is a shared understanding between Cluster and Pathfinder about the responsibilities to be delegated, the pace of delegation, and the support to be provided by the cluster with a joint meeting between NHS London, the particular Consortium and the cluster Chief Executive. The final decision is made by the Cluster Chief Executive as Accountable Officer, who then puts forward the proposal seeking formal approval to the relevant PCT/Care Trust Board.

5.6 NHS South East London is taking a similar approach to NHS South West London with respect to delegating responsibilities to its shadow GP consortia. NHS London have reviewed the NHS Kingston proposal (part of NHS South West London) and made comments which have been reflected in our approach. We have also taken into account the approach being taken to delegation in both inner and outer NE London, particularly the need for having a robust approach to assurance agreed that enables NHS London to hold the cluster to account for delivery of QIPP and financial balance.

5.7 It is proposed that the process outlined in Appendix 2 be adopted for all Pathfinders, in order to build on the considerable enthusiasm that exists amongst clinical leaders to take on these responsibilities as soon as is practically possible. It is recognised that the different Pathfinders are likely to want to take on different levels of delegated commissioning functions and budget responsibility through the local committees in the first instance, and the production of a “Pathfinder Delivery Plan” should enable this to happen. Practically it is also anticipated that there will be two “waves” of proposals, dependent upon the current readiness of the Pathfinders across the sector. As a minimum, it is anticipated that Bexley, Lambeth and Southwark will be in the first wave.

5.8 Although Pathfinder Delivery Plans are not complete for any of our Pathfinders at present, it is proposed that the Board agree to enabling delegation to take place as soon as is practically possible, using Chair’s action during May/June to approve any Delivery Plans from Pathfinders, subject to scrutiny by the Cluster Management Board and Chief Executive. Details will then be reported back to the meeting of the Joint Boards in July 2011. Any decisions on delegation made by the Joint Boards, or Chair’s action, will be subject to the NHS London assurance process.

5.9 During transition the SE London Chief Executive will remain the Accountable Officer. Responsibilities and budgets that are delegated will continue under the governance arrangements, Standing Orders and Standing Financial Instructions of SE London. Since April 2011 responsibility for all non-acute

commissioning (excluding primary care (all of SE London), and sexual health (Lambeth, Southwark & Lewisham only)) has been delegated to the Managing Directors of the Business Support Units. Delegation of responsibilites to Pathfinders is the next stage in this process.

5.10 The delegation arrangements proposed in Appendix 2 will continue to operate within the NHS South East London performance management and escalation arrangements in terms of accountability for financial management, QIPP delivery and quality performance standards, including through the established systems of performance management with NHS London (see Appendix 3). Progress will be monitored formally by the Chief Executive, Director of Finance and Director of Operations.

5.11 The proposals on delegation explicitly allow for a mix of both scale and pace across the cluster area. This will bring with it a particular set of challenges that need to be addressed by the cluster, and of which the PCT/Care Trust Boards need to be aware. In particular, care will need to be taken to ensure that any risks that might be created by this variability with respect to commissioning contracts that cover more than one borough, is mitigated at cluster level as part of performance management arrangements.

5.12 Risk management arrangements are being developed as part of the process of devolution of responsibility for financial management, and these will be co-ordinated through the Cluster Management Board. These include management of contingency reserves, contract levers to reduce financial risks and identifying areas where creation of risk pooling with other consortia may support the management of financial risk. NHS London have made it clear that they expect Clusters to scrutinise applications for delegated responsibility very closely where there is a significant financial gap in the local QIPP programme, and these areas are specifically covered in the Pathfinder Delivery Plans.

5.13 Clinical and other governance is an integral part of commissioning decisions and under the proposed approach appropriate working relationships will be established within the governance arrangements for delegated commissioning functions in such a way that also avoids duplication of functions or discussions.

5.14 It is recognised changes will be made to the arrangements as experience of working with delegated responsibilities emerges, and as further guidance is produced by the Department of Health following the “Listening Exercise” currently underway nationally.

6. Recommendation

6.1 To note progress with the development and the achievement of Pathfinder status for all the emerging GP Consortia in South East London, the sources of development support through the London Pathfinder Development Programme and the development funding of £2 per head from April 2011.

6.2 To note the arrangements for delegation of non-acute commissioning, except for primary care, to BSU Managing Directors from April 2011 (as outlined in section 5.9 above).

6.3 To agree the proposed South East London approach to delegation of commissioning responsibilities to Pathfinder GP Consortia, as outlined in Section 5 and Appendix 2 of this Paper. Specifically the Boards are asked to agree the devolution of commissioning responsibilities for each of the Pathfinders via the Local Clinical Commissioning Committees.

6.4 To agree to receive Pathfinder Delivery Plans, as outlined in Appendix 2 to this report, as the means by which commissioning responsibilities will be delegated to each Pathfinder – subject to the NHS London assurance process.

6.5 To agree that delegation to Pathfinders should take place as soon as is practically possible across SE London, and to note that Bexley, Lambeth and Southwark are likely to be the first Pathfinders that put forward Delivery Plans for agreement.

6.6 To agree that Chair's action will be taken during May/June to approve any Delivery Plans from Pathfinders, subject to recommendation by the Cluster Management Board and Chief Executive. Details will then be reported back to the meeting of the Joint Boards in July 2011.

APPENDIX 1
NHS SOUTH EAST LONDON
GP CONSORTIA PATHFINDERS

1st Pathfinder cohort

2nd Pathfinder cohort

3rd Pathfinder cohort

4th Pathfinder cohort

5th Pathfinder cohort
Submissions (Mar)

TBC

Bexley Clinical Cabinet
Number of practices: 29
Population size: 229,652

Bromley Clinical Commissioning Consortium
Number of practices: 49
Population size: 300,855

Greenwich Health
Expected announcement, June 2011

Lambeth Clinical Commissioning Collaborative
Number of practices: 52
Population size: 377,624

Lewisham Primary Care Federation
Number of practices: 48
Population size: 304,717

Southwark Health Consortium
Number of practices: 47
Population size: 319,127

APPENDIX 2
APPROACH TO DELEGATION

1. Local Clinical Commissioning Committees

1.1 The establishment of the Local Clinical Commissioning Committees (LCCCs) is the start of the process for delegating responsibilities to the new GP consortia. Some have already begun to meet in shadow form, and all the Terms of Reference have been reviewed so that the May 2011 meeting of the PCT/Care Trust Boards are assured in agreeing to delegate in this manner.

1.2 Whilst each of the LCCCs has been able to develop its own terms of reference to reflect local circumstances, each committee has to comply with the PCT's Standing Orders and Standing Financial Instructions and will operate within the legislative framework to which the PCT is subject. The LCCC is also required to comply with the PCT/Care Trust's commissioning policies as they currently exist. Any amendment to the PCT/Care Trust's policies has to be endorsed by the PCT/Care Trust Board.

1.3 Each Pathfinder will be expected to develop governance structures relating to all delegated responsibilities, including how the Pathfinder will work with its constituent practices, how it will operate in the transitional period through the LCCC, and how it will work within current cluster and BSU structures and processes. The Pathfinder will also be required to identify a Responsible Officer as the named individual accountable for the delivery of delegated responsibilities, and it is anticipated that this individual will be the Chair of the LCCC for the period of the transition, working with the support of borough Managing Directors. The Chief Executive of the cluster (as Chief Executive of each of the constituent PCTs/Care Trusts) remains the formal accountable officer until April 2013.

2. Fitness for Purpose

2.1 The key tests of the new arrangements as they are established will be:

- A clear vision and focus to articulate to practices and staff
- Ability to identify the metrics to track progress and ensure that the difference being made is tangible
- Pathfinders taking the lead with borough commissioning teams and managing directors supporting them
- Clear governance and decision making with real practice engagement and ownership
- Clarity of how the borough and cluster teams support the pathfinder work
- Engagement and transparency of vision and decisions for patients and public
- Engagement and transparency of vision and decisions for local authorities and Health & Well Being Boards

2.2 A Pathfinder will only deliver its commissioning responsibilities successfully if it has adequate development, management and infrastructure support. It is therefore also intended that they are required to describe each Consortium's leadership and engagement structure, governance and performance management arrangements together with their management and development support requirements

3. Accountability Agreement

3.1 During transition, the Cluster CEO will remain the Accountable Officer and the Pathfinders will take on delegated responsibility on behalf of the PCT Board. This means that commissioning functions for specified areas and budgets that are delegated will continue under the governance structures, Standing Orders and Standing Financial Instructions of NHS South East London.

3.2 There will be an agreement in place between the NHS South East London and the Pathfinder to set out the responsibilities for financial management, performance management and interventions in relation to the delegated responsibilities the consortia takes on. This will be included in the Accountability Agreement, which will be based upon a Pathfinder Delivery Plan.

4. The Pathfinder Delivery Plan

The plan will comprise four sections:

1. Leadership and engagement structure, including operating budget
2. Governance and performance management arrangements
3. Delegated responsibilities, trajectories and process
4. Support requirements
    - Development
    - Borough based commissioning support
    - Cluster commissioning/contracting support

Section 1 – Leadership and engagement structure

In this section the consortium should describe how they will use their operating budget to invest in a clinical leadership and engagement structure that will enable the delivery of their delegated responsibilities.

It should include:

- Consortium leadership team structure, roles, time commitments, remuneration;
- Clinical leads/director responsibilities for specific areas of delegated responsibility;
- An outline of how the leadership team engages Pathfinder/Consortium members to ensure delivery;
- A description of member/practice engagement and incentive schemes and how they will enable delivery.

Section 2 - Governance and performance monitoring arrangements

In this section the consortium should describe the governance and performance monitoring arrangements that they will establish to enable the delivery of their delegated responsibilities and how they will continue to assure the cluster.

It should include:

- A structure for managing delegated responsibilities including how the consortium reports to the PCT/Care Trust Board via the LCCC in order to fulfil statutory governance requirements;

- A description of the arrangements that will be established for performance monitoring the delivery of targets and measures aligned to delegated responsibilities.

Section 3 - Delegated responsibilities, trajectories and process

In this section the consortium should describe the delegated commissioning responsibilities that they increasingly wish to take on and at what point during 2011/12. This is with the aim that each consortium in SE London will be in a position to be able to take full shadow responsibility for all delegated commissioning responsibilities by April 2012.

The section should also describe the consortium's preferred process for taking delegated responsibilities, i.e. by QIPP project, contract, pathway, financial value/budget etc. All responsibilities should align to the cluster 2011/12 integrated plan.

It should include:

- Clearly defined and measurable quality, financial and activity outcomes for the activities the consortium wishes to take delegated responsibility for.
- A plan for how the consortium will achieve specific outcomes and in what areas (i.e. QIPP, vital signs, budgets etc), including how risks will be managed.
- A balanced financial plan.
- A timeline demonstrating what the consortium will take increasing responsibility for during 2011/12.
- A description of how the consortium will demonstrate capability to enable the cluster to increasingly approve additional delegated responsibilities so that the consortium can take full shadow delegated responsibilities for all commissioning budgets by April 2012.

Section 4 – Support Requirements

In this section the consortium should describe the support that they will need to deliver their plan. It should include a description of how they will use the leadership and organisational development support made available by NHS London together with the operational management support available from cluster commissioning support teams and their BSU.

It should include:

- A plan of how the consortium will use the Pathfinder leadership and organisational development providers commissioned by NHS London. This should, ideally, be the Statement of Works required by NHS London. (It is noted that the timescale for this development support has slipped due to procurement delays with the programme).
- A description of how the consortium will access the cluster commissioning support resources it needs to deliver delegated responsibilities.

5. Timeline

Diagram 2 shows how, over time, the movement from current arrangements to full and approved consortium commissioning will happen practically. For clarity, this has been broken down into three areas: (formal) accountability, (delegated) responsibility,

and operational management (i.e. who will actually do the commissioning on behalf of the responsible body). The "September 2011" heading is intended to show the situation as it is likely to be in September, as by then all of the Pathfinders in SE London will have begun to take on delegated responsibilities. It is entirely possible that for some Pathfinders the description for September 2011 could be applied from the end of May.

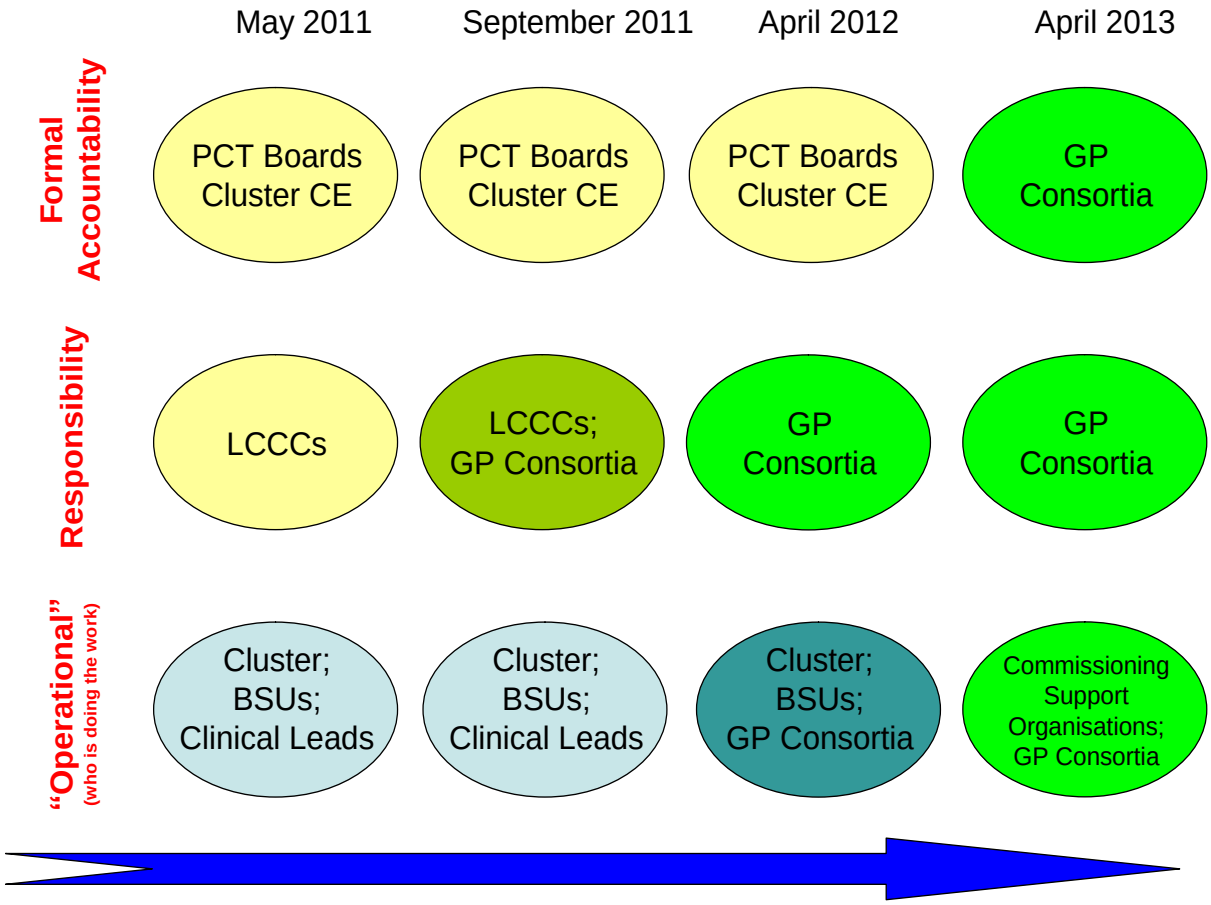

Diagram 2: Illustrative Timeline for Transition to Full Consortium Responsibility

6. Assurance Process

6.1 The process for accrediting each Pathfinder with delegated responsibilities will be simple, and follow the timetable outlined in each of the Pathfinder Delivery Plans. NHS London also have a role in assuring the cluster's process for enabling delegation, and their performance management principles are attached as Appendix 3.

6.2 Each of the Pathfinder Delivery Plans will also show an indicative timeline for the period up to April 2012, when each aspect of commissioning will be delegated to them. The Delivery Plan will also have explicit key performance indicators by which the Cluster Management Board will monitor progress, and provide assurance to the PCT/Care Trust Boards.

APPENDIX 3

Performance Management Principles for London

Maintaining financial stability and a strong grip on performance during this time of reform is vitally important. As the system for commissioning in London is changing, and accountability will sit with both clinical commissioners and PCT officers, it is felt that a set of principles for the way that performance management will be managed across London are required to ensure consistency in the approach used.

The following principles have been developed for the use of consortia and clusters in the development of plans for delegating responsibilities, and the signing of an accountability agreement between the Consortia Lead and Cluster Chief Executive. The development of the principles of performance management has included dialogue between colleagues across NHS London, the Associate Medical Directors for Primary & Community Care, and the NWL, SWL, & INEL clusters.

It is proposed that during Transition the following principles should apply:

1. The GP Consortia and cluster management team should ensure they work closely to identify and jointly plan the commissioned services the pathfinder wishes to take delegated responsibility for.

2. Plans will include relevant performance standards i.e. QIPP, Headline and Supporting measures from the NHS Operating Framework[i], existing public health measures and locally agreed standards, agreeing roles and responsibilities, and commissioning support. This will also likely include reference to CQUIN[ii], and other framework standards such as the NHS Outcomes Framework[iii] which is expected to have a baseline assessment in 2011/12 in preparation for go live 2012/13.

   NHS Operating Framework 2011/12

   
   NHS Operating Framework 1112.pdf

   NHS Outcomes Framework 2011/12

   
   NHS Outcomes Framework 1112.pdf

3. The cluster and borough teams will support consortia to take on their responsibilities including managing their own performance. This will include access to relevant performance data sources.

4. The SHA will hold the Cluster CEO to account as the accountable officer and therefore they will be responsible for holding commissioners (Cluster or GP Consortia) to account for the delivery of outcomes and targets, such as QIPP.

5. The approach to how the Cluster CEO will hold the local system to account for delivery will be defined locally. This will build on current performance management arrangements and processes. Critical to this will be appointing a named person accountable for the delivery of each commissioned service at cluster or consortia level.

6. The current financial monitoring arrangements of commissioners and providers will continue in 2011/12 as set out in the NHS Financial Manual[iv], with detail in the NHS Operating Framework 2011/12. How commissioners manage the financial performance of budgets delegated to GP Consortia during 2011/12 should be determined locally, and in most cases follow the PCT's existing monitoring and governance arrangements.

7. Standing Orders and Standing Financial Instructions will continue to apply under these delegated arrangements.

8. Performance Management arrangements must include explicit plans for managing financial and operational performance including:

    - Identification of clinical and financial outcome metrics for monitoring both national and locally agreed contracts and standards

    - Identification of the clinical and financial information required for performance management; an understanding of the level to which it needs to be disaggregated (pathfinder, locality, practice) and a plan for how this information will be obtained.

    - A plan for monitoring and reporting arrangements with providers and how remedial action will be taken

    - A plan for performance management, reporting and improvement that tracks information at the pathfinder, locality and practice level

    - An understanding of how pathfinders will be performance managed by the Cluster for the responsibilities delegated to them and alignment with the SHA Performance Framework for 2011/12, which is in development and incorporates requirements from the NHS Operating Framework, and existing reporting processes to DH.

    - A plan for intervening when necessary to address performance issues

Consortia will be required to participate in the regional and national performance monitoring processes required by NHS London and the Department of Health. It will be for local agreement how this is delivered.

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[i] NHS Operating Framework
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[ii] Commissioning for Quality and Innovation (CQUIN)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

[iii] NHS Outcomes Framework
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123138.pdf

[iv] NHS Financial Manual
http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/DH_4015846

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 11

2010/11 OUTTURN PERFORMANCE REPORT

DIRECTOR RESPONSIBLE: Jane Schofield, Covering the role of Director of Operations

AUTHOR: Sean Morgan, Director of Performance

TO BE CONSIDERED BY: All

SUMMARY:
This is the 2010/11 outturn performance report. The outturn report gives the final, or in some cases provisional, data for 2010/11 for the main Vital Signs and Existing Commitments as set out in last year's Operating Framework.

Final outturn data is included for healthcare associated infections (i.e. MRSA and C. diff.) Provisional March data is available for RTT waits (final data will be published on 19 May). Provisional A&E outturn data is included (as the Q4 data will be published on 13 May). However, Q4 data is not yet available for indicators such as childhood immunisation and the Report is based on the latest available data with an estimate made of the projected outturn.

The report summarises the headline performance, notes any specific issues relating to individual organisations within SEL and identifies key learning points to be taken forward in 2011/12.

The Report covers all the main access targets and public health priorities. The report contains some references to arrangements covering the LSL or BBG areas, which was the basis on which certain services were managed last year, future reports will of course reflect the position from 2011/12 moving forwards.

KEY ISSUES:
The main headline messages are:

The A&E 4-hour wait standard has been met by all Trusts for the year (measured from Q2-

Q4), with performance above 95%. SLHT has met its recovery trajectory despite high levels of demand over the Winter.

RTT performance deteriorated in January and February, and has remained below the standards at GSTT and SLHT, although performance has recovered partially at LHT. King's has continued to meet all the performance thresholds through the Winter. Both GSTT and SLHT have received support from the national Intensive Support Team and additional activity will be commissioned in 2011/12 in addition to action to improve operational productivity at both providers.

All the cancer wait standards are being met in aggregate across SEL, with the exception of the new measure on waiting time for subsequent treatment with radiotherapy which came into effect fro 1 January. However, Guy's & St Thomas' is not meeting either the 31-day or 62-day Cancer Wait targets in the year to date to end January, although an improvement is expected by end March.

SEL in aggregate achieved the healthcare associated infections (MRSA and C. diff.) trajectories. However, King's has failed its MRSA trajectory, partly due to the number of bacteraemias associated with a specialist soft tissue diabetes service. Guy's & St Thomas' has failed its C. diff. trajectory, partly due to additional cases being detected by a more effective two stage test introduced from September.

The report also gives some analysis of the public health Vital Signs indicators, focusing on issues where there is a specific performance issue, such as relatively high male all-age all-cause mortality in Greenwich and below target performance in reducing teenage conceptions. The latest position and action on childhood obesity is also described, as this is a key priority for improving health.

The one Vital Sign measure where performance is lower than target and the national average across the whole of SEL is childhood immunisation. The report describes the action being taken in each area, noting the considerable progress made over the last 2-3 years.

The Report notes the key learning from the year just ended which will be taken into account in managing performance in the current year.

Finance considerations - *no specific issues with budget implications*

Legal considerations - *none*

Staffing & Equalities considerations – there are no staffing issues. Variations in performance are highlighted, which mostly relate to either organisational issues or for the public health indicators to the local demography and levels of relative deprivation.

South East London

Appendices - an SEL aggregate level performance dashboard is appended. Future performance reports will contain dashboards with organisation-specific performance on the new headline and supporting measures as well as the existing public health measures.
INVOLVEMENT: • This report went to the Cluster Management Board on 3 May.
RECOMMENDATIONS: The board (s) is asked to:- • Note the contents of the Outturn Performance Report for 2010/11.
DIRECTORS CONTACT: Name: Jane Schofield E-Mail: jane.schofield@greenwichpct.nhs.uk Telephone: 020 3049 4066
AUTHOR CONTACT: Name: Sean Morgan E-Mail: sean.morgan@southwarkpct.nhs.uk Telephone: 020 3049 4483

NHS

South East London

2010/11 Outturn Performance Report

1. Referral to Treatment Time (RTT)

Reduction in waits for elective care is a tier 1 priority for the NHS, as set out in the 2010/11 NHS Operating Framework. The initial aim was for the percentage of patients whose referral to treatment time to be less than 18 weeks, with standards of 90% for admitted and 95% for non-admitted patients.

Throughout 2010/11 Kings Healthcare FT has been able to achieve these standards Guy's & St Thomas FT, Lewisham Healthcare and South London Trust have all fallen below either standard most notably since November/December. Even when the overall standard for admitted patients was being met in the earlier months, this masked poorer performance at specialty level, orthopaedics in the case of GST and SLHT and autistic spectrum disorders at LHT (the service was transferred to the Trust from the PCT in September 2010).

At GST, there has been a mismatch between capacity and demand in orthopaedics for a sustained period of time, particularly in certain areas of specialist activity (paediatric spinal surgery and foot and ankle surgery). Actions to mitigate this have been put in place in year, such as musculo-skeletal referral management services by the local PCTs and significantly enhanced theatre capacity, however the capacity issues remain.

At SLHT, orthopaedic waits is similarly a long standing issue, with a backlog of cases awaiting treatment first identified in Q3/Q4 2009/10. The Trust has extended theatre sessions to 4 hours and improved theatre scheduling and productivity. Also additional activity was commissioned in 2010/11. However, the backlog has not yet been completely cleared.

Both GSTT and SLHT have received extensive input from the national Intensive Support Team.

Median Waits and 95th Percentile

In June 2010, the Operating Framework was revised and the above standards were removed from the DH performance framework and replaced with monitoring of median waits and 95th percentile for admitted, non-admitted and incomplete pathways. The table below summarises the thresholds used for assessing performance:

Performance is assessed as good if within the following thresholds

	Admitted	non-admitted	incomplete pathways
Median	<=11.1 wks	<=6.6 wks	<=7.2 wks
95th Percentile	<=27.7 wks	<=18.3 wks	<= 36.1 wks

Outturn Performance

For admitted patient pathways both performance against median waits and 95th percentile has been good since the new measures were introduced in June. SLHT is the only exception where the median waits have been above the threshold since June and 95th percentile above the threshold since December.

For non-admitted patient pathways, King's and LHT have consistently managed within the median and 95th percentile thresholds however GST has been above the 95th percentile threshold since November and SLHT since January.

For incomplete pathways, the only outlier was Lewisham Heathcare NHS Trust (LHNT). Since October the point at which the trust's data included community service provision (October 2010), its incomplete patient pathways have been above the 95th percentile threshold. This is as a result of patients waiting on the paediatric autistic spectrum pathway. The trust has put an action plan in place to address this, including a revised patient pathway and additional clinic capacity at weekends. Provisional data for March, shows that the position has improved to within the threshold.

Performance in January and February has been significantly down on earlier months, other than at King's which has sustained its strong performance. The poor performance was partly due to the severity of winter pressures in terms of weather and H1N1 influenza, with significant bed pressures and higher than usual cancellation rates.

The provisional March figures across all the measures is summarised below:

March 2010/11 (provisional) performance

	Admitted <18 weeks	Non-Admitted <18 weeks	Admitted Median Wait	Non-Admitted Median Wait	Incomplete Median Wait	Admitted 95th centile Wait	Non-Admitted 95th centile Wait	Incomplete 95th centile Wait
GST	87.2%	92.4%	6.6	3.6	6.7	27.9	20.7	28.5
KCH	94.0%	96.0%	8.1	3.7	6.6	23.8	16.6	17.6
LHT	89.95%	97.5%	11.0	1.0	5.8	24.9	12.5	35.6
SLHT	75.7%	94.2%	12.7	4.0	5.6	29.7	19.0	34.6

Lessons learnt and issues for 2011/12

The pre-existing standards for 18 weeks and the new median and 95th percentiles measures are included in the performance framework and national contract for 2011/12. The 95th percentile thresholds indicating good performance have reduced from 27.7 weeks to 23 weeks for admitted patient pathways, and 36.1 weeks to 28 weeks for incomplete pathways. The incomplete pathway threshold, in particular, will be very challenging (it reduces from 36 to 28 weeks) given performance over the last year. Thresholds for non-admitted pathways remain the same.

It is crucially important that providers manage their non-urgent waiting lists in date order (through a priority treatment list or PTL), SLHT will have much more accurate prospective data at the QEH site to run an accurate PTL in 2011/12 due to data improvements and improved validation. It appears that GSTT also needs to make improvements in this area.

The introduction of an amended Treatment Access Policy, taking account of the latest evidence on clinical effectiveness, together with QIPP plans to improve the effectiveness of referral management may reduce some referrals/activity and thereby release some capacity in 2011/12.

2. Healthcare Associated Infections (HCAIs)

MRSA (VSA01)

Reduction in healthcare associated infections is a tier 1 priority for the NHS, as set out in the 2010/11 NHS Operating Framework. The ultimate aim is for zero preventable infections. For 2010/11, new organisation specific MRSA objectives were separately set for both acute trusts and PCTs, with the aim of reducing the variation in performance nationally.

Outturn Performance
The table below summarises performance across NHS SEL against the MRSA trajectories.

	2010/11 MRSA Actual	Objective
SLHT	1	9
GST	4	9
KCH	16	9
LHT	2	3
Acute Total	**23**	**30**
Bexley	6	10
Bromley	4	7
Greenwich	4	6
Lambeth	8	12
Lewisham	7	12
Southwark	8	9
PCT Total	**37**	**56**

N.B. Commissioner data comprises all infections for PCT residents, whereas provider data is all infections 'attributable' to the Trust in accordance with national guidance.

At year end, all acute trusts and PCTs delivered within their respective trajectories, with the exception of Kings College Hospital FT. Although KCH managed a reduction from the 2009/10 level (19), it had already breached its 2010/11 trajectory by August.

The trust was visited by the DH support team in September and subsequently revised its action plan to reflect feedback from the review. Corporate ownership of the need to reduce HCAIs is high, however further work is needed by the trust to embed this at ward level and the action plan includes awareness raising, training, additional dedicated staffing and performance management measures to ensure these. It should also be noted that feedback from the trust is that it has a cohort of patients seen by the specialist diabetic foot service which due to the severity of their condition, are at a high risk for MRSA and for which some infections may not be preventable.

Clostridium difficile (VSA03)
Reduction in healthcare associated infections is a tier 1 priority for the NHS, as set out in the 2010/11 NHS Operating Framework. The national standard for *C.* difficile infections (CDI) was to achieve a reduction of at least 30% in the number of infections in 2010/11 compared to a 2007/08 baseline. Acute trusts and PCTs were therefore given organisation specific trajectories.

Outturn Performance
The table below summarises performance across NHS SEL against the CDI trajectories.

	2010/11 CDI Actual	Standard
SLHT	65	218
GST	120	102
KCH	106	162
LHT	24	38
Acute Total	**315**	**520**

Bexley	60	108
Bromley	86	227
Greenwich	48	115
Lambeth	110	194
Lewisham	80	110
Southwark	108	179
PCT Total	**492**	**933**

N.B. Commissioner data comprises all infections for PCT residents, whereas provider data is all infections 'attributable' to the Trust in accordance with national guidance

At year end, all acute trusts and PCTs delivered within their respective standards with the exception of Guy's & St Thomas' FT. GST introduced a more sensitive two stage testing regimen in September, which identified more carriage of CDI in patients. The effect is that this has meant that the trust had identified a higher number of cases than their trajectory, the baseline for which was based on the trust's previous testing regimen. There was a reduced number of infections in March (9 compared with a monthly average of 13 since September), but it is too early to judge whether this is the start of a downward trend.

Lessons learnt and issues for 2011/12

New organisation specific trajectories for both MRSA and CDI have been set for 2011/12. These are set out below:

	2011/12 Objectives	
	MRSA	CDI
SLHT	5	71
GST	7	58
KCH	5	75
LHT	3	27
Acute Total	**20**	**231**
Bexley	7	48
Bromley	4	75
Greenwich	6	38
Lambeth	9	73
Lewisham	8	58
Southwark	7	68
PCT Total	**41**	**360**

For MRSA at acute trusts, the new 2011/12 trajectories are set at a lower level than for the 2010/11 objectives, except for Lewisham Healthcare where the already low objectives have been maintained. For KCH, despite reductions over two years in the number of MRSA cases, its 2011/12 trajectory presents a significant challenge. The actions outlined in their action plan would need to be fully embedded in order for the trust to achieve this new trajectory.

For CDI at acute trusts, the new 2011/12 trajectories are set at a significantly lower level than for 2010/11. However, it should be noted at both SLHT and LHT their 2010/11 outturn is below the new objective and therefore should be achievable. This is not the case for GST, due to the change in the

testing regimen mentioned above. KCH had already started work in 2010/11 on developing an action plan to further reduce CDI cases in anticipation of a challenging objective for 2011/12.

The CDI commissioner trajectories for 2011/12 represent a 27% reduction on the 2010/11 outturn, which will be extremely challenging, partly due to the impact of the GST change in testing and also because there has been no general downward trend over the last two years, since the very substantial reductions made in CDI infections in 2008/9, which were delivered through changes to practice (i.e. early cohorting of infected patients and revised prescribing policies) which are now embedded as standard practice

In the 2011/12 national acute contract, two further HCAIs have been identified for monitoring: MSSA (Methicillin Sensitive Staphylococcus Aureus) and Escheria Coli bloodstream infections. These are referenced in the 2011/12 Operating Framework, however no national standards or objectives have been set for these areas. The Operating Framework does however require mandatory reporting of these by acute trusts. The expectation would be for the same process of undertaking root cause analysis of cases, summarising and discussing emerging themes and subsequent action plans at the Quality Review meetings as is currently the case for MRSA and CDI.

3. A&E 4-hour Maximum Wait and Winter Pressures

The 2010/11 Winter posed significant challenges due to the severe weather and H1N1 being the prevalent seasonal influenza virus which resulted in unusually high levels of hospital admissions, and especially critical care admissions, particularly in December and January. The H1N1 flu resulted in a higher acuity of illness than would normally be experienced. Despite these pressures, the system across South East London coped well, due in part to the strength of Winter planning and the escalation arrangements that were put in place. There was a marked dip in performance in early January when demand on ambulance services and A&E departments was greatest, but across the Sector all providers achieved the 95% standard across the year (measured from Q2-Q4 in line with the Revised Operating Framework) and all providers also achieved the 95% standard in Q4.

Provisional Outturn Performance

The provisional outturn South East London performance has been calculated below, based on the formal quarterly returns for Q1-Q3 and the informal weekly sitrep data for Q4 (as Q4 data will not be published until 13 May):

% of A&E attendances treated within 4-hours	2010/11 Q1		2010/11 Q2	2010/11 Q3	2010/11 Q4 (provisional data)	2010/11 Provisional Outturn (Q2-Q4)
	Standard = 98%		Standard = 95%	Standard = 95%	Standard = 95%	Standard = 95%
Guy's & St Thomas'	95.4%		96.1%	95.5%	96.9%	96.2%
King's	98.1%		97.9%	97.4%	97.6%	97.4%
Lewisham Healthcare	98.1%		98.4%	98.6%	98.2%	98.4%
South London Healthcare	98.5%		96.8%	92.4%	95.9%	95.1%

SEL Total	**98.3%**		**97.1%**	**95.3%**		**96.2%**

All providers achieved the revised standard for the year (Q2-Q4). There has been a considerable recovery by South London Healthcare Trust from the deterioration in performance experienced in Q3 and January. A recovery trajectory had to be submitted to the DH. SLHT has achieved the 95% standard every week since the last week in January, which is ten successive weeks, and performance has been above 98% in six of those weeks. This has been the result of increased prioritisation, with all escalation beds open, including at the Queen Mary's Sidcup site, and improved throughput across the system. SLHT has been receiving support from the National Intensive Support Team, which is continuing into 2011/12. A post-implementation review of the emergency closure of the QMS Emergency Department (ED) concluded that services were safer as a result and safety has been monitored by the Clinical Quality Group. Reassuringly there have been no Serious Incidents relating to emergency care since the emergency closure (other than some ambulance handovers of over 1 hour).

Guy's & St. Thomas' did not achieve the previous 98% standard in Q1, although performance was above the new 95% standard. The Intensive Support Team provided input particularly over the first half of the year. The Trust implemented a comprehensive action plan, to address issues across the two hospitals not just within the ED, and this resulted in performance recovering to 95-96% over the remainder of the year.

In South East London we have managed without recourse to requesting external support. There have been brief, one or two hour, ambulance diverts on just a handful of occasions through the Winter months.

There have been some instances of extended ambulance handover times and this has been a particular issue at the Princess Royal University Hospital site where the average handover time has been over 20 mins, compared with the expected maximum of 15 mins.

Key learning going forward into 2011/12

It was not possible to fully re-commence routine elective inpatient admissions following the Christmas / New Year break until well into January, particularly at SLHT and Lewisham. This impacted on RTT waiting times in January and into February. Future planning will need to consider alternative options for ensuring that elective activity is not disrupted for prolonged periods, taking account of resource constraints.

There have been some concerns about the extent to which delayed discharges are an issue at SLHT, especially for patients who no longer need acute medical care and are fit for discharge (some of whom do not come within the strict definition of delayed discharges). There are around 40 patients in this category at each of the three hospital sites (PRUH, QEH and QMS). The Trust and the PCTs and Social Services have held meetings to review this and also the plans for investing the additional resources for re-ablement and social care. The Emergency Care Programme Board is coordinating the work on this issue, which is a priority for action in 2011/12.

Around one third of critical care beds across London were occupied with patients with H1N1 influenza at the peak of the outbreak. Guy's & St. Thomas' was asked to open an ECMO service (3 and

subsequently 4 beds) for the most seriously ill patients at very short notice, which it was able to do successfully. Future Winter planning will need a particular focus on critical care capacity planning and escalation arrangements.

For a short period there were concerns nationally about the availability of flu vaccine stocks. PCTs ensured that processes were in place to share stocks of vaccine so that the high priority populations continued to be vaccinated. During this period briefing notes were circulated setting out the position on vaccine supply and also the position on antiviral supply and reiterating the national guidance on the priority population groups for the vaccination programme. Primary care commissioning is now centralised in a single Cluster team which will aid the coordination of these issues in future.

During December there was a norovirus outbreak at the PRUH which caused the closure of a number of wards to new admissions. This was well-controlled by the Trust and all beds were re-opened to new admissions for week commencing 10 January.

There were subsequently small numbers of patients affected by diarrhoea and vomiting (D&V) at King's, St. Thomas' and the PRUH, and these cases were contained by cohorting and the usual infection control procedures. A further D&V outbreak at the QEH site in March led to up to 3 wards being closed to new admissions for around two weeks.

All of these D&V outbreaks were well managed and contained. This emphasises the crucial importance in maintaining rigorous infection control procedures all year round, but particularly over the Winter months.

A new London-wide ED Capacity Policy was effective for this Winter. A rota of senior managers from across the Cluster was on call to respond to Winter pressure issues and to coordinate a sector-wide response. These new arrangements worked well, with Trusts working to support one another during the times of greatest pressure and sharing information on bed and A&E status in real time through the Capacity Management System (CMS) online. On a small number of occasions providers requested support from other hospitals, through an ambulance diversion (not affecting 'blue light' journeys) and these requests were dealt with through Cluster-led sector-wide conference calls including the LAS. This on call responsibility has been brought within a single on call 'Gold' rota from 1 April.

4. Childhood Immunisation (Vital Sign VSB10)

There is national and international concern to end the transmission of preventable life-threatening infectious diseases. Vaccines prevent spread of disease and can reduce disease and complications in early childhood as well as mortality rates. In 2010/11 PCTs were expected to ensure that 90% of children from ages 1 to 5 are immunised against diseases such as diphtheria, tetanus, polio, pertussis, measles, rubella and meningitis C to control spread of disease.

Projected Outturn Performance

The table below shows the latest, Q3, data for each vaccination.

2010/11- Quarter 3 data (Source Health Protection Agency COVER data)

Percentage of children vaccinated

Q3 Oct -December 2010

	VSB10_03	VSB10_08	VSB10_09	VSB10_10	VSB10_14	VSB10_15	
	Immunisation (DTaP/IPV/Hib at age 1)	**Immunisation (PCV booster at age 2)**	**Immunisation (Hib/Men C at age 2)**	**Immunisation (MMR at age 2)**	**Immunisation (DTaP/IPV pre-school booster at age 5)**	**Immunisation (MMR at age 5)**	**PCT average**
Vital Sign Target	**90.0**	**90.0**	**90.0**	**90.0**	**90.0**	**90.0**	
England	**93.9**	**89.0**	**91.3**	**88.9**	**84.0**	**85.6**	
London	**90.3**	**81.8**	**84.8**	**83.2**	**76.5**	**74.7**	
NHS SEL	**91.6**	**80.1**	**84.7**	**82.4**	**75.3**	**74.0**	
NHS SEL Projected Outturn	**91.0**	**80.0**	**84.0**	**83.0**	**74.0**	**75.0**	
Bexley Care Trust PCT	91.5	78.9	88.2	80.3	79.7	83.3	83.7
Bromley PCT	91.2	85.4	86.7	86.9	78.6	74.0	83.8
Greenwich PCT	92.5	78.2	83.4	82.4	82.3	81.4	83.3
Lambeth PCT	93.0	83.2	86.0	84.6	74.0	72.8	82.2
Lewisham PCT	90.1	75.4	80.1	79.2	65.3	62.5	75.4
Southwark PCT	91.6	79.7	83.9	81.2	71.9	70.1	79.7

The uptake target for all childhood vaccinations is 90%. The NHS SEL actual performance for immunising children aged 1 for DTa/IPV/Hib is currently at 91% and is expected to remain at this rate until year end. The other immunisation targets of 90% are extremely challenging given the historical performance in London and will not be met in 2010/11. The immunisation for children aged 5 is particularly poor with a quarter of children not immunised.

The Q3 PCT performance headlines are:

- All PCT's are achieving the children aged 1 year immunisation target.
- There is a real disparity between the BBG (80% average) and LSL (69%) areas for 5 year old immunisation. This is an opportunity to be explored via the performance network for best practice to be shared to improve performance across the cluster.
-
- Bromley PCT performance improved in Quarter 3 across all of the immunisation indicators and is close to achieving the target for 2 year old immunisation.
- Lambeth PCT is close to achieving the 90% target for the 2 year old targets but is below the Sector average for immunising 5 year olds.
-

- Lewisham PCT has the lowest immunisation rate across all indicators, especially for children at 5 years of age where the rate is significantly below the target as well as the London and sector average.

Actions taken and lessons learned

Bexley Care Trust's Immunisations and Vaccinations Committee has ensured the development of a local IT tool to process the data from GPs which supports the work of the child health team. The group has been exploring options for an IT solution to electronically input GP data into RiO whilst awaiting rollout of a pan London GP data extraction solution. The Care Trust now constructs quarterly practice coverage league tables and shares the results with GPs and the primary care team to ensure that issues are discussed and addressed. The end-to-end processes for childhood immunisations reporting has been mapped and agreed by the Immunisations and Vaccinations Committee to ensure high quality data is inputted into RiO and as a result accurately reflects the information on GP IT systems. The Care Trust based payments for 2010/2011 incentive schemes on HPA COVER parameters and intends to link future contract payments to these parameters as well to ensure consistency. All colleagues involved with any aspect of childhood immunisations attended short training sessions on Pan London READ codes, call and recall system and a clinical update on PCV in 2010. The Care Trust intends to organise similar training sessions for all colleagues in 2011 with updates on topics such as vaccination of babies with Hepatitis B.

Bromley PCT implemented a clinical quality guarantee on 2 year old childhood immunisations in the new PMS contracts, as well as an added value incentive payment for the achievement of 95% across two and five year old immunisations and introduced quarterly performance feedback to practices to improve performance. Practices are required to self-assess against an immunisation best practice guidance checklist. Support visits will be carried out by the immunisation coordinator where required. The PCT now compares practice data with COVER data to identify problems and anomalies between the two data sources. A pre-school settings project run by health visitors has been introduced. CQUINS have been agreed with Bromley Healthcare Community (BHC) aimed at improving immunisation data entry onto RiO, improving HPV data submission and supporting the immunisation defaulter pathway which is starting in pilot form in 10 practices shortly.

Greenwich PCT has ensured the Immunisation and Vaccination QCIT continues to steer improvement work in this area with a particular focus on data cleansing, collection and reporting. To further improve the quality of data and reporting, new immunisation templates have been deployed to GP practices. The PCT immunisation action plan has been updated for 2010-11 and reflects guidelines from NHS London and recommendations from the Vaccination and Immunisation National Support Team. The PCT PMS contract review requires practices to deliver 90% targets and a CQUIN is now in place with Greenwich Community Health Services to deliver hard to reach groups. Social marketing techniques are also being explored with the National Support Team.

Lambeth PCT revised its process map in June to improve the flow of information. The PCT has expanded the team to help manage the backlog and to identify unimmunised children. Data quality and list cleansing remained a focus and the ten poorest performing practices are now part of a pilot to identify the most effective ways to improve performance. The PCT also carried out regular support visits to 18 selected practices with immunisation uptake, and provided all practices with London wide READ codes to use to standardize the data recording.

Lewisham PCT revised its action plan with a continued focus on improved collection and use of data, but with an increased focus on improving performance by GPs and on individual patient management. The Trust has implemented a new MMR care pathway and prepared new pathways for immunisation with Pre-School Booster and HPV. In response to recommendations made during a National Support Team visit in October, the Immunisations Strategy Group has been re-organised with amended Terms of Reference. Communication has also been improved with the publication of a new electronic newsletter and the distribution of immunisation schedules to the parents of all children under 5, reminding them of the importance of immunisation. A survey of parents of children who remain unimmunised is planned, as recommended by the NST, and will focus on the barriers to immunisation experienced or perceived by parents. Despite the fact that Lewisham's performance has not been as good as other PCTs in the sector, it is encouraging that during the period December 2008 to December 2010, improvements in uptake of vaccine in Lewisham have been at least as great as those in London as a whole; for half of the indicators, Lewisham's improvement has been more than three times that of London.

Southwark PCT revised its action plan to establish best practice, such as updating population lists, data reconciling and making call and recall processes more robust within practices. Poor performing practices have been visited and supported by the Immunisations & Vaccinations Clinical Champion. Communications resources have been produced to support practices and health visiting teams including a 1st birthday card to call in patients for vaccinations. Locality based training for practice nurses and their relating health visitor team took place with very positive feedback and plans for a regular programme.

Going forward in 2011/12

The immunisation targets have not been specifically included in the Headline or Supporting measures in the 2011/12 NHS Operating Framework, but the framework confirms that all Public Health targets should be maintained in 2011/12. NHS London has indicated that the monitoring of all existing Public Health targets will continue.

5. Breast, Bowel and Cervical Cancer Screening

Objectives for 2010/11

Vital Sign (VSA09) - Extension of NHS Breast Screening Programme to women aged 47-49 and 71-73

Around 130,000 people die from cancer each year, of which about 65,000 are aged under 75. In February 2006, a report from the advisory Committee on Breast Cancer Screening estimated that the breast screening programme in England is saving 1,400 lives per year. At present, women are invited for screening seven times at three yearly intervals between 50 and 70 years. In September 2007, the Prime Minister announced that this would be extended to nine screening rounds between 47 and 73 years with a guarantee that women will have their first invitation for screening before the age of 50.

Vital Sign (VSA10) - Extension of NHS Bowel Cancer Screening Programme to men and women aged 70 up to 75th birthday

Evidence suggests that implementation of national screening programme should reduce bowel cancer mortality by around 16% in those people screened. Evidence suggests efficacy of screening up to age 75, and 61% of bowel cancers occur in those aged 70 and over. Every PCT that has completed the original two-year screening round for 60-69 year olds was expected to commence the 70-75 roll out from 2010. All other PCTs are to commence roll out on completion of their first two-year screening round.

Vital Sign (VSA15) - All women to receive results of cervical screening tests within two weeks

The International Agency for Research on Cancer, part of the World Health Organisation, concluded that organised and quality controlled cervical screening can achieve an 80% reduction in the mortality of cervical cancer. The NHS Improvement for Cancer Organisation is providing focused service improvement resources across the cervical screening pathway to support the delivery of faster turnaround times. The target is that women should receive the results of their cervical screening tests within two weeks by 1 January 2011, with an operational standard of 98%.

Projected Outturn Performance

Performance broken down by PCT for Breast and Cervical Screening is below:

			Breast Cancer Screening Annual Data to 31/03/09	**Cervical Cancer Screening Annual Data**	
			31/3/2009 53-70	**25-49**	**50-64**
PERFORMANCE				2009-10	2009-10
SE	TAK	BEXLEY CARE TRUST	77.3%	76.7	81.1
SE	5A7	BROMLEY PCT	75.4%	76.2	82.1
SE	5A8	GREENWICH PCT	66.5%	67.7	75.3
SE	5LD	LAMBETH PCT	59.2%	63.8	74.8
SE	5LF	LEWISHAM PCT	65.1%	66.7	76.7
SE	5LE	SOUTHWARK PCT	61.7%	64.8	74.7

Lambeth, Southwark and Lewisham function as one screening commissioning area and Bromley, Bexley and Greenwich as another. Some of the cancer screening programmes are run as a single sector programme and some are PCT based. Breast cancer screening is led by Southwark PCT and bowel cancer screening by Bromley PCT. The Call/recall team from BBG is managed by NHS Bromley.

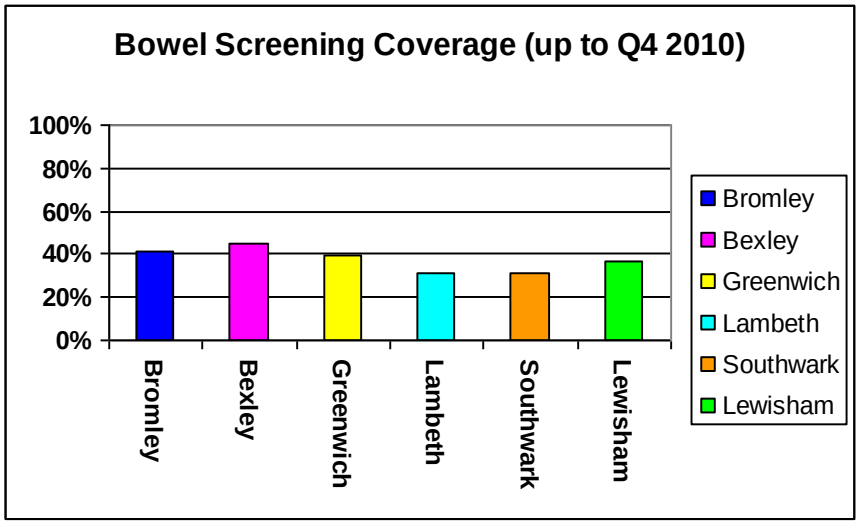
Breast cancer screening coverage

All PCTs have a detailed programme of work to improve coverage. This includes having a patient management approach by practices for women who have not attended for screening, as well as social marketing and a health promotion programme. This work will continue.

Bowel Cancer Screening

This is a relatively new programme, still focusing on uptake rather than population coverage. A health promotion programme is in place for the whole of SE London run through the SE London Bowel cancer screening centre at University Hospital, Lewisham. All six PCTs are part of the Department of Health National Awareness and Early Diagnosis Initiative (NAEDI) project (with SELCN) that is raising awareness of symptoms of bowel cancer screening and will improve uptake of bowel cancer screening.

The NAEDI programme will be helpful with supporting increased awareness of bowel cancer and increasing uptake. As can be seen from the graph there is variable coverage between the 6 PCTs. However all six PCTs are achieving coverage so far that is much lower than the national target of 60%, while the England average is 52% and the overall London achievement is 42.9%. South East London was in a later phase of roll out of this relatively new national programme compared with some parts of the country.



Improving the Cervical Cytology 14-day Turnaround times

The laboratories in LSL met this target in March but those in outer South East London have found this more challenging.

The merger of the three hospitals into a single trust (SLHT), combined with the three laboratories merging onto a single site have contributed to the difficulties in meeting this standard from January 2011. Until the end of December 2010, SLHT were meeting the national target of processing all samples and getting results to women within 4 weeks. Improvement in the new target was being achieved from the end of 2010 but unfortunately, structural problems in the new lab (ceiling collapse) in February resulted in delays. These combined with IT problems meant there was insufficient capacity to recover the position by the end of the financial year. Over the last two months, along with action plans including elements such as call/recall sending all results by first class post, improvements in collection of specimens by transport systems, SLHT has had support from the NHS Improvement Foundation to advise on improvements and the SELCN has undertaken a 'walk through' to ensure that LEAN principles have been adopted in the operation of the laboratory. This work is

ongoing. Commissioners and providers are also reviewing the demand and capacity for cervical tests.

The South East London Cancer Network agreed to facilitate a pathway mapping exercise for SLHT. Problems identified and solutions applied included the following:-

1. Currently call / recall send pre-printed HMR101 cytology request forms to practices when a woman's smear is due. Not all practices use these forms; many still handwrite the standard HMR101 form and omit information or make errors. A programme for the full implementation of electronic HMR101 forms has been agreed, supported by training for practices with an implementation date of 1 June 2011.

2. After the reconfiguration of the three laboratories, patient data did not transfer between computer systems as expected and since December, all samples arriving from Greenwich or Bexley have to be keyed in manually by staff. This includes all patient demographics, NHS number, and originating GP. This slows the processing of samples considerably and thus is being escalated as a matter of urgency by the Screening Commissioner to laboratory IT. This is being addressed by aligning GP lists and computer systems as soon as possible and is part of a detailed action plan.

3. Work is being undertaken with practices and their staff to improve the transfer of samples from practices to the laboratories and improve communications relating to any queries about samples.

Actions taken and learning

Bexley Care Trust conducted an analysis of each practice's performance on breast screening and cervical screening in order to identify those that were not meeting the required thresholds. Those identified were then visited by a senior team. Where necessary action plans were agreed with the practices and monitored on a regular basis.

Bromley PCT has been undertaking a programme of improvement of coverage at practice level using the new PMS contract negotiations to target practices where coverage is less than ideal. In addition, coverage is being improved through a programme of social marketing using external support. This has included improving the accuracy of practice lists and aligning them more closely to the Open Exeter database where necessary and contacting women who have not been screened and booking them directly in for screening.

Greenwich PCT has worked on improving access to cervical screening through improving practice based information such as list cleansing, also introduced the use of newsletters to practices to ensure increased awareness of screening. The PCT provides support and feedback to practices on smear taking activity and the activity required to achieve NPS. Projects currently running include a cytology catch-up project and a cervical smear process walk-through with women to understand the barriers being experienced. To improve breast screening performance, the PCT employed a cancer screening facilitator to address health inequalities and ensure sustainable improvements. Arrangements have also been made with the Bromley call and recall team for an active patient management approach. GPs are now also actively managing people who do not attend for screening.

Lambeth PCT has focused on patient list cleansing to improve breast screening performance. The PCT has also worked with practices to ensure that they follow up pre-invites and DNA's. To improve cervical screening performance the PCT has introduced a list inflation policy in the practices and

provided dedicated focused support for outlier practices. The PCT has also rolled out a cervical cytology action plan.

Lewisham PCT is implementing an operational patient management system that is expected to have a positive impact on DNA's and improve breast screening performance. To improve cervical screening performance the Lewisham Healthcare Trust has agreed to fund the sending of smear results by first class post and has committed to replace the IT system in 2011/12. The PCT has written to GP practices and practices nurses to remind them not to delay in sending samples to the lab. It is expected that as these recommendations are implemented that the PCT will return to high levels of achievement.

Southwark PCT has received pilot funding for 'patient navigation' for harder to reach groups to improve performance on breast screening. To improve cervical screening performance the PCT has sought to increase the proportion of practices using electronic prior notification lists. The PCT is also in the process of reviewing the reasons for the high level of patients excepted from screening at outlier practices and registration list cleansing.

6. Cancer Waits

Overview of targets 2010/11 – Year to date (April 2010 – February 2011)

Ref	1.1	1.2	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3
	2ww (1st seen)		31 day (Decision to treat to treatment)					62 day (referral to treatment)		
Target	Urgent referrals	Breast symptoms (all referrals)	1st treated	Subsequent - surgery	Subsequent - drugs	Subsequent - other (inc palliative care)	Subsequent - radiotherapy From January 2011 only	2ww GP referral to 1st treatment	Screening to 1st treatment	Consultant Upgrade to 1st treatment
Provider										
GSTT	96.4%	96.2%	96.0%	93.1%	99.3%	100.0%	93.1%	77.8%	97.9%	95.4%
KCH	95.4%	98.5%	99.5%	99.1%	100.0%	99.0%	-	90.2%	100.0%	100.0%
SHLT	96.4%	95.6%	99.4%	98.5%	100.0%	100.0%	-	89.2%	97.8%	92.6%
LHT	96.0%	96.1%	99.2%	100.0%	100.0%	100.0%	-	89.7%	80.6%	95.9%
SELCN (provider)	**96.2%**	**96.5%**	**97.8%**	**96.2%**	**99.6%**	**99.4%**	**93.1%**	**85.2%**	**97.1%**	**95.3%**
PCT										
Bromley	94.5%	93.2%	98.9%	98.7%	99.7%	98.6%	92.4%	90.5%	98.5%	95.8%
Greenwich	97.2%	97.3%	98.1%	98.9%	100.0%	100.0%	94.5%	80.9%	94.7%	89.7%
Lambeth	95.5%	97.4%	98.8%	96.9%	100.0%	100.0%	94.2%	85.6%	96.8%	94.7%

Lewisham	96.3%	96.8%	97.3%	96.9%	100.0%	97.0%	90.5%	88.2%	94.6%	93.8%
Southwark	96.3%	97.4%	97.7%	95.1%	99.6%	100.0%	100.0%	85.0%	100.0%	100.0%
Bexley care	97.7%	97.5%	97.8%	97.9%	99.6%	100.0%	82.4%	85.7%	96.9%	96.3%
SELCN (PCT)	**96.2%**	**96.5%**	**98.1%**	**97.6%**	**99.8%**	**99.5%**	**92.2%**	**86.2%**	**96.9%**	**95.0%**
Standard	93.0%	93.0%	96.0%	94.0%	98.0%	n/a	94.0%	85.0%	90.0%	n/a

Key performance issues that arose in 2010/11

2 week wait – Urgent suspected cancer referral and symptomatic breast referrals

During the early part of 2010/11 capacity and booking issues at the Princess Royal University Hospital site of South London Healthcare Trust, led to an underperformance within Bromley PCT for both the 2 week wait targets. The Trust has since amended its booking process ensuring all patients are telephoned to book an arranged an appointment. The performance has now recovered and the year to date performance for both of these targets is above the operational standards.

There was also a capacity issue within the breast service at Kings College Hospital in December 2010 and January 2011. The trust has now appointed a locum consultant, which has resulted in a recovery of performance against this target. In the longer term the Trust is preparing a business case for an additional breast surgeon to join the Trust.

31 day time from decision to treat to treatment targets

Within Quarter 2, a data quality issue was identified at GSTT in the recording of the start point for the 31 day target for some patients. This uncovered underperformance against both the 31 day first treatment and 31 day subsequent treatment targets at the Trust. The area with the most number of breaches to the standard was Urology. GSTT introduced interim weekend lists and now have an additional robot to perform surgery. In February 2011, GSTT met both 31 day targets for the first time since July 2010. It is expected that this performance will be sustained.

The new target for subsequent radiotherapy treatment by 31 days went live on 1 January. Through the year up to this point, it was clear that only approximately 60% of patients were being treated within the target. Radiotherapy within SEL is provided by GSTT and the Trust installed a new radiotherapy machine which delivered its first treatment in November 2010. Along with revised booking processes this increased capacity has meant that the overall performance for Quarter 4 is expected to be above the 94% operational standard.

62 day targets from referral to treatment

The 62 day GP referral to treatment target, has remained a challenge at GSTT, as well as across the whole network as a whole. Particular issues have been identified with the Lower GI pathways at GSTT as well as the Urology pathways across the whole network. Root cause analysis has been undertaken at both GSTT and SLHT to support the Trusts in understanding the reasons for the delays. The detailed pathway analysis undertaken by the network has shown a significant decrease in the number of 'avoidable' breaches at GSTT since October 2010. However this has not yet been

reflected in an increased level of performance, partially due to an increased number of late referrals to the Trust from other providers.

At LHT the 62 day screening target has not been met for 2011/12. This was due to colonoscopy capacity issues during Quarter 1, in when patients experienced long waits for colonoscopies following an abnormal screen. This issue was resolved in Quarter 2. However LHT reports a relatively low number of cases against the screening target as the Trust does not have a breast service, so the 3 patients who breached the target in Q1 resulted in underperformance for the whole year.

The lessons learnt which can be taken forward into 2011/12

Patient choice management

During the analysis of the 2 week wait performance at Trusts it became apparent that a large number of breaches to the 2 week wait standard were attributed to patient choice. However on discussing the processes for booking appointments within Trusts it was found that some Trusts were not phoning two week wait patients routinely and instead sending an appointment letter to the patient. These Trusts amended this process which then resulted in more patients being seen within target. This highlights the importance of fully analysing delays attributed to patient choice to establish if a process at a Trust contributes to the level of patient choice seen.

Audit process

The data recording issue identified at GSTT, which resulted in long surgical waits not being reported highlights the importance of audit processes being in place to ensure that data being submitted by Trusts is consistent with National Guidance and also other Trusts within the sector.

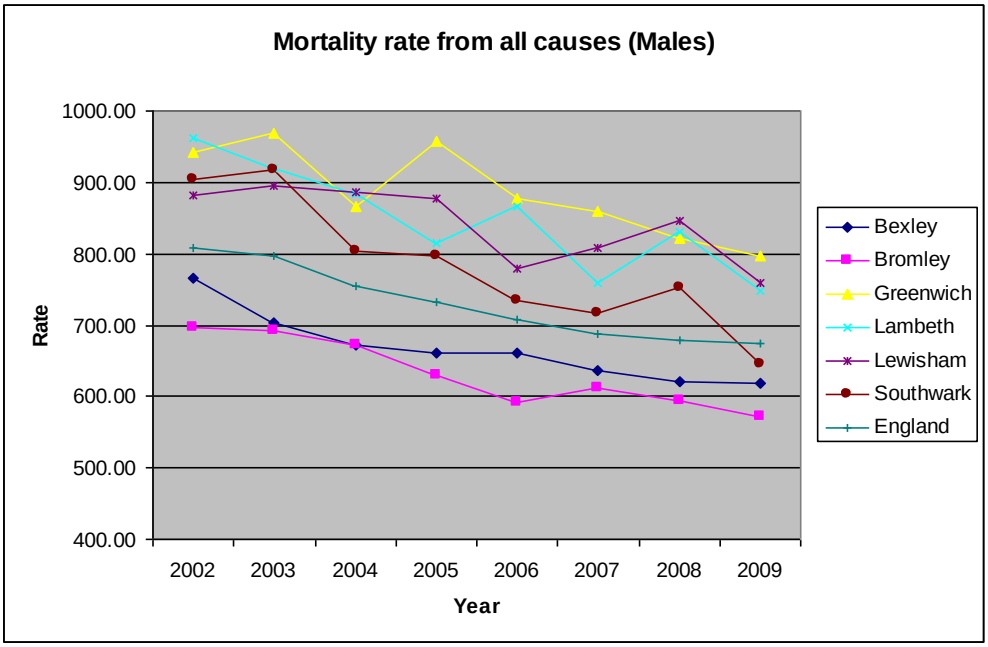
Pathway analysis

During this year the Network introduced a detailed pathway analysis of every 62 day breach. This identified a number of trends which may otherwise have been overshadowed by other delays which were for medical or patient choice reasons. The identification of these trends, and the supporting actions has highlighted the importance of this detailed pathway analysis.

Going forward, as well as analysing performance against breaches the Network also plans to compare median waits for the 62 day pathway by tumour site to identify if these are significantly different from either the national average or other Providers locally. From this it is hoped that Trusts will be able to learn good practice from each other and improve their median pathway wait times.

7. All-Age All-Cause Mortality (AAACM)

South East London



Performance across the sector on this target is generally good and most of the PCT's are doing well with improving performance. However, Greenwich PCT is an outlier on male mortality rates. The Greenwich PCT trajectory is 720/100,000 but the actual rate in 2009 was 796.2/100,000. Through analysis of its data Greenwich identified that the major contributors to its excess mortality are lung, cancer, CVD, stroke, COPD and suicides.

The PCT identified this area as a priority in the 2009/10 JSNA and modelling showed that to reach the AAACM target Greenwich needed to:

- Institute a rapid programme of implementation of NHS Health Checks, targeting high risk groups initially. The aims were to find those most at risk of CVD and to find those missing from long term condition registers
- Improve the care of those on long term condition registers, in particular those on hypertension registers
- Increase stop smoking quitters by 300%. Modelling showed that the actions above would close the gap but underlying smoking related deaths would widen the distance from target at 5 years if stop smoking increases did not start in 2010.

The mortality rate in Greenwich has improved, from the highest in London to the third highest. The following initiatives have contributed to this improvement:

- Implementing NHS Health Checks plus programme implemented between September and December – significant delays for those not signing new PMS contract
- Using Outreach services outside local supermarkets and in mosques
- Developing a multi-pronged programme to increase stop smoking rates including 'Lung Age' bus. Over 16,000 had lung age; more than 50% were men; 490 set quit dates on the bus.

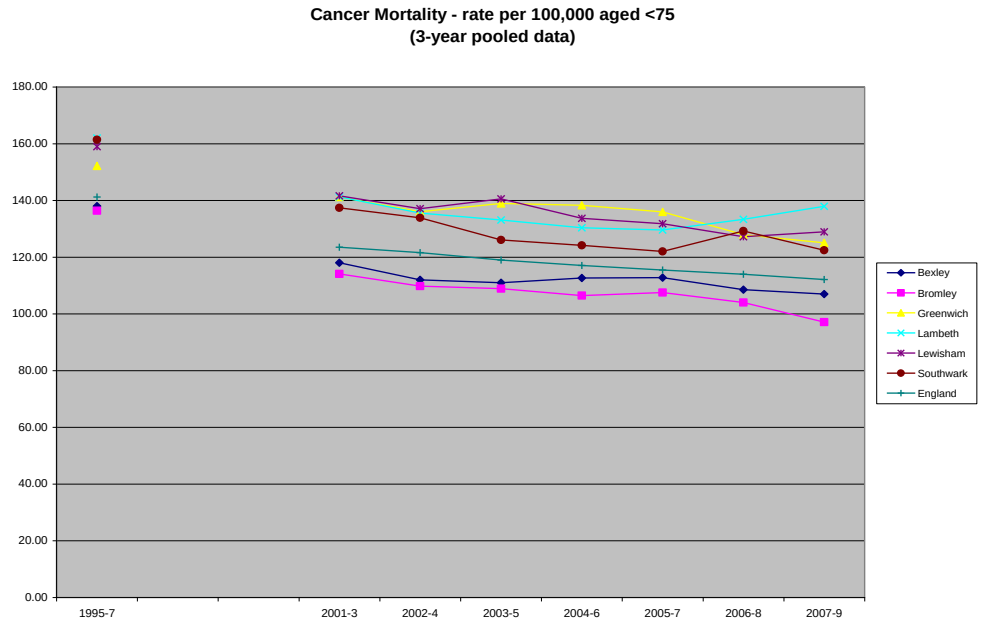
- Procuring a Diabetes audit all practices. Pilot audit showed excellent improvement in outcomes.
- Analysing local quarterly data using deaths registered to date show a rate of 734/100,000 DSR in Q1 and 672 in Q2. These numbers are liable to change, but they do show improvements in the right direction.

The learning on these issues has been:

- Men's health forum has been useful for highlighting issues; obtaining buy-in and driving the strategy
- Outreach is essential and needs to be focused in a way that engages with men. Greenwich experience relates that outreach needs "sweepers" who pull people in. Young men attending matches at Charlton Athletic Football Club have been very successful for the lung age bus. Parking a health bus outside local authority depot was not so successful as this had no 'sweepers' and looks too clinical.
- Access to primary data to improve long term condition management has proved difficult as Greenwich has no system to extract real-time primary care data without lengthy computer queries. Procurement of a supportive audit for diabetes with audit staff visiting each practice has proved the only method so far to gain access to audit data. There are a range of programmes that extract data from practices including MSDI; health intelligence could be procured but additional server space is needed and Information Governance issues need resolving.

NHS
South East London

8. Cancer Mortality



There has been improvement in the cancer mortality rates for under 75s for all PCT areas in SEL as shown above. For some areas the decreases have been consistent and steady while for others there has been a greater degree of variability year on year.

Year on year variability is smoothed through a three year rolling average and the most recent data shows that all PCTs have made improvement against the 1995-97 baseline. The largest and most significant cause of the mortality for all areas is lung cancer, being 20- 28% of the total of all cancer deaths in each area.

	2007-9	1995-97 baseline		
	Mortality rate per 100,000	Mortality rate per 100,000	% reduction	Lung cancer as % of cancer deaths
Bexley	106.99	137.98	-22.5%	26.9%
Bromley	97.11	136.37	-28.8%	19.5%
Greenwich	125.02	152.02	-17.8%	28.4%

Lambeth	137.90	161.79	-14.8%	24.8%
Lewisham	128.92	159.08	-19.0%	22.3%
Southwark	122.42	161.63	-24.3%	26.3%
London	108.18	141.96	-23.8%	22.9%
England	112.07	141.21	-20.6%	23.5%

The most important action to reduce cancer deaths is to reduce smoking. However the impact of reduced smoking on cancer mortality will not be evident for some years to come. Other approaches are to improve uptake of screening, increase early awareness of symptoms and ensure early referrals for investigation and care. Quality of care is the major contribution to the outcomes for all cancers.

The SEL Cancer Network is participating in the National Awareness and Early Intervention Project and is responding to the request from national government to focus on saving an extra 5000 lives from cancer across the country. There has been a survey of awareness of cancer symptoms in Lambeth to inform the planning of a number of awareness campaigns across SEL. These have been head and neck cancer awareness campaign, bowel cancer awareness campaign, Spot the Sun Cancer Campaign and a pharmacy campaign working with pharmacy staff to raise awareness of symptoms suggestive of lung, stomach or bowel cancer.

An audit to study patient pathways from first symptoms to first specialist appointment was carried out in Lambeth, Greenwich, Southwark and Bromley and found delays were particularly common for lung and bowel cancers. This has led to a project to improve pathways and in particular focus on aspects of the diagnostic parts of the pathways to speed up the time to commencement of treatment e.g. establishing a standard pathway for abnormal chest x-rays.

There will be a stakeholder meeting in June to bring together all relevant people to consider how SEL will contribute to '5000 lives saved' programme.

Cardiovascular (CVD) Mortality

Progress is being made for most of the PCTs against their trajectories for improvement in Cardio Vascular Disease (CVD) mortality for those aged under 75. Under 75s age group is chosen as it gives an indication of premature or preventable early mortality for this major cause of death. All PCT areas have been making progress, but rates in two PCTs (Bexley and Lewisham) have not fallen as quickly as the national rate and are projected to fall short of their 2010 trajectories.

Table – CVD mortality (Directly Age Standardised Rate) for under 75s – 2007-09

	DSR Male	DSR Female	DSR All Persons
ENGLAND	99.44	43.22	70.49

LONDON	108.14	45.52	75.30
Bexley LB	92.10	40.39	64.73
Bromley LB	78.42	33.18	54.30
Greenwich LB	137.77	53.08	93.39
Lambeth LB	130.32	55.14	90.24
Lewisham LB	126.04	59.60	90.73
Southwark LB	111.94	49.50	79.45

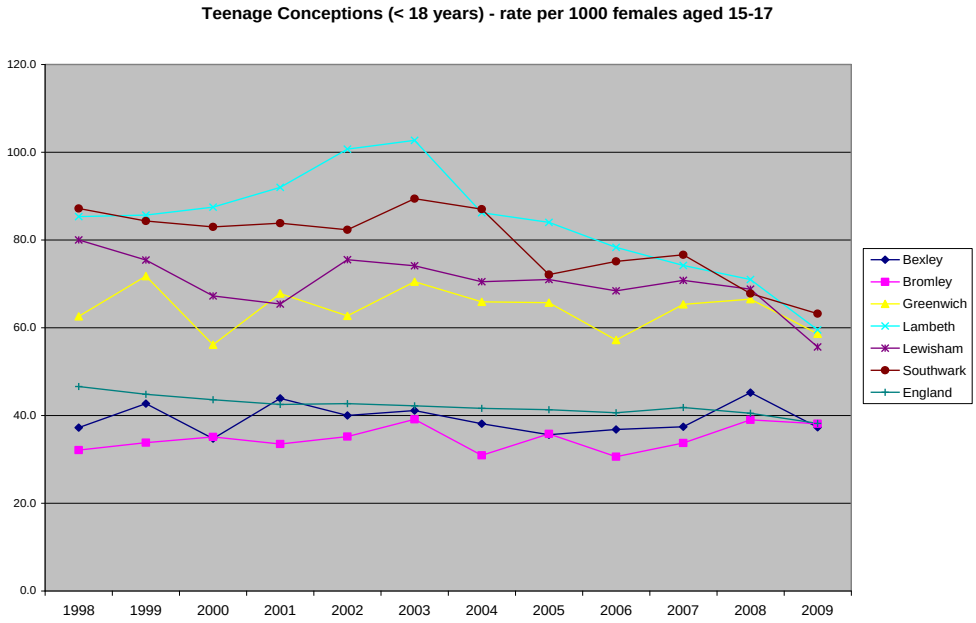
Lewisham - The premature mortality from CVD in 2008 was affected by an anomalously high rate (standardised per 100,000) among females in that year, from 55.4 to 75.2. In 2009 this fell to 48.2. Over the same period the rate among males fell from 145 to 138 to 111.

The 3-year pooled data shows an improvement, but the high number in 2008 continues to affect the 3-year data and will do so in next year's figures too, but it is expected that the 2010 target will be achieved.

Despite improving the CVD premature mortality rate, the widening gap may be partly explained by in the Index of Multiple Deprivation in that recently published data shows that Lewisham has deteriorated from 57th in 2004, to 39th in 2007, to 31st in 2010.

All Lewisham practices record lower prevalence of CHD than would be expected based on the national prevalence models. Lewisham practices record less than half the expected prevalence of hypertension (46%), indicating that there could be an additional 31,900 patients with hypertension not on GP disease registers.

9. Teenage Conceptions



Reducing teenage conceptions has been a target for most of the last decade. Teenage pregnancy has been associated with poorer outcomes for both mother and child, with young mothers being less likely to complete education and training, and babies born to young mothers being more at risk of poor outcomes such as infections and increased risk of infant mortality. In general increased rates of teenage conceptions are more likely to be seen in deprived areas, with an increased chance of young motherhood happening amongst those who themselves were born to young mothers.

None of the PCTs will achieve their 2010 target reductions. Only Lambeth and Southwark were below their 2009 trajectories, but these were re-set to take account of trends since the baseline and will not deliver the nationally set 2010 reductions.

	2009 Rate in conceptions in females aged <18 per 1000 females aged 15-17	% change from 1998 baseline
Bexley	37.3	0.2%
Bromley	38.1	18.7%
Greenwich	58.6	-6.4%
Lambeth	59.5	-30.2%

Lewisham	55.6	-30.5%
Southwark	63.2	-27.5%
England	38.2	-18.1%

Some of the PCTs were set more stretching targets of a 60% reduction compared with the national target of 50% reduction from 1998 to 2010. There is no single approach to reducing teenage conceptions. It requires a combination of approaches including supportive and appropriate education in managing relationships, good information, young-person friendly services that are easily accessible and confidential and a focus on young men as well as women.

Although the 2010 targets will not be met there have been significant decreases in rates in some of the boroughs. While not reaching the target, three of the boroughs with the highest rates have made significant progress in reducing their rates with Lewisham (55/1000) and Lambeth (59/1000) achieving a 30% reduction against baseline, and Southwark 27% (63/1000). While remaining higher than the national rate, the percentage reduction is much higher than the national average (an 18% reduction).

In contrast Bexley has had little change overall since the relatively low 1998 baseline but had seen an increase in rate for a number of years before reducing again to the original baseline rate. With limited resources activity has been focused providing a youth advisory service, access to condoms, SRE in schools and support for young parents. However, the support for young parents previously provided by the local authority has now been withdrawn.

Bromley starting from a low rate of 32/1000 has seen an 18% increase against baseline to 38/1000: and is now as high as the national average. While it has shown an increase this actually represents a very small number of pregnancies each year. An action plan has been implemented to address this and as the data relates only to 2009, an improvement in the figures is expected with the next set of data.

Greenwich has shown a small improvement and further improvement is expected in the last quarter of the year. A focused plan has been implemented to reduce rates with investment in specific services to target young people including 33 services awarded the 'You're Welcome' accreditation, increased access to contraception including LARC (long acting reversible contraception) and a free condom ordering scheme. Take-up of free Emergency contraception continues to increase. There are now 10 sexual health clinics providing it in the borough. The increasing uptake of Chlamydia screening also provides an opportunity to promote sexual health messages to young people.

It will be challenging to maintain the rate of progress as the specific Teenage Pregnancy grant made to Local Authorities has ceased and any funding to continue programmes will need to be found from within mainstream budgets, which are under pressure across all partner agencies.

10. Obesity

Childhood obesity is recognised as a national problem with increasing rates in many areas across the country. The National Child Measurement Programme has been fully established for four years which has allowed a comparison of rates between areas and a tracking of trends. Within South East London there are some contrasts between rates in different areas. The latest data is for the 2009/10 school

year, and suggests that all PCTs are managing to make some progress at slowing and reversing the trend of increasing weight.

There is a significant variation in the rates between different boroughs, with the inner more deprived boroughs showing the highest rates and outer boroughs showing rates lower than the London average. Greenwich, Lewisham, Lambeth and Southwark are showing higher than the London average with Southwark having the highest rates of all, with rates for reception year being the highest in the country.

	% obese in Reception Year 2009/10	% obese in Year 6 2009/10
Bexley	11.5%	20.6%
Bromley	8.2%	17.2%
Greenwich	13.2%	21.5%
Lambeth	12.6%	25.1%
Lewisham	13.6%	24.4%
Southwark	14.8%	25.7%
England	9.8%	18.7%

Much of the variation in rates will be due to the demographics of the local area. Obesity is more common amongst poorer communities and hence higher rates are found in the more deprived parts of the cluster, as would be expected given the deprivation scores. In addition there is an increased risk of obesity amongst Black Caribbean and Black African communities compared with other ethnic groups. Therefore, those boroughs with the higher numbers of young residents from these particular communities are more likely to have higher rates of obesity.

There are multiple factors leading to an increase in obesity including more sedentary lives, changes to the environment (more obesogenic), changing patterns of play for children, changing diets with increases in cheap high calorie foods that lack nutritional balance, and changing patterns of family eating. There is no single approach to reducing obesity. The evidence from National Institute of Clinical Excellence (NICE) and review of other evidence suggests that multiple approaches need to be taken. Across the cluster areas are using a number of approaches building on the evidence base. Population intervention include multi-component interventions with a public health media campaign to increase awareness of what constitutes a healthy diet and using social marketing interventions to improve outcomes associated with diet, e.g. fruit and vegetable intake, fat consumption e.g. Change 4 Life programme. Family-based interventions that target improved weight maintenance in children and adults, focusing on diet and activity, can be effective, at least for the duration of the intervention e.g. MEND. Maintaining a healthy weight through reducing sedentary behaviours and through a low fat diet with increased consumption of fruit, vegetables and fibre and decreased consumption of sugary drinks, take away food and alcohol are promoted. However, focusing solely on the treatment of individuals is not sufficient to reduce the rising levels of obesity across the entire population, so

needing to combine targeted programmes for those who are overweight and obese with a wider more community based approach.

11. Chlamydia

Chlamydia testing is offered to all young people aged 15-24 years. The 2010/11 target was 35%. This programme is designed to support the reduction of the transmission of the infection and the reduction of the long term complications.

Significant progress has been made particularly in the inner boroughs. Lambeth, Southwark & Lewisham continue to be national leaders for Chlamydia Screening. LSL PCTs are ranked 1st, 5th and 2nd respectively for their screening rates and performance for all three PCTs is significantly higher than the national average of 17.1% and London average of 21.1% (Q3 positions). Their positivity rates are above the London (4.8%) and National (5.4%) average which gives assurance of effectiveness in targeting and engaging the right young people.

Over 90% of LSL screening happens in core services (Sexual Health Services & General Practice) which is the NCSP's recommended model of screening programmes and optimises effectiveness, sustainability and value for money. LSL PCTs successes in Chlamydia Screening has been a result of the modernisation of local Sexual Health services and subsequently the comprehensive provision of integrated sexual health and contraceptive services across community and primary care. This success is considered an indication of the excellent access to community sexual health services available to young people locally.

	% of population aged 15-24 tested for Chlamydia 2010/11 to Q3
Bexley Care Trust	12.3%
Bromley PCT	21.5%
Greenwich PCT	24.8%
Lambeth PCT	35.6%
Lewisham PCT	34.5%
Southwark PCT	28.5%

However, Bexley remains a significantly lower performer. This relates to contractual difficulties with potential and actual providers. Negotiations with one provider did not reach a successful conclusion, and a different provider was found. Following commencement with this provider in November 2010, concerns were raised about their practice and consequently the service was suspended until February when assurances were received that their practice had improved. Obviously this has impacted on the ability to reach the target. Work is ongoing to increase the number of screens taking place in GP surgeries and in pharmacies.

12. Admission to Specialist Stroke Units

OrgID	Name	Q3		
		Patients who spend at least 90% of their inpatient stay on a stroke unit	Number of people who were admitted to hospital following a stroke	Percentage of patients who spend at least 90% of their inpatient stay on a stroke unit
	England	13,798	18,496	74.6%
TAK	Bexley Care Trust	73	79	92.4%
5A7	Bromley PCT	114	134	85.1%
5A8	Greenwich PCT	75	91	82.4%
5LD	Lambeth PCT	65	70	92.9%
5LF	Lewisham PCT	82	97	84.5%
5LE	Southwark PCT	60	60	100.0%

The Quarter 3 performance for stroke is detailed by PCT in the table above and shows all PCT's achieved the 80% target that stroke patients should have at least 90% of their inpatient stay on a specialist stroke unit. All PCT's are also well above the average for England. Provisional Q4 data shows a slight dip in overall performance 88.3% in Q3 to 86.9%, but still well above the target. Performance is likely to improve further when the Hyper Acute Stroke Unit (HASU) open at the PRUH, subject to an accreditation visit in May.

13. Early Access to Maternity Care

		Q2	Q4	Q2
OrgID	Name	Number of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy.	Number of maternities (provisional)	Percentage of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy.
TAK	Bexley Care Trust	665	662	100%
5A7	Bromley PCT	825	945	87%
5A8	Greenwich PCT	807	887	91%
5LD	Lambeth PCT	1123	1133	91%
5LF	Lewisham PCT	802	1040	77%
5LE	Southwark PCT	1060	1134	93%
	NHS SEL	5282	5801	91%

Formal assessment of performance involves a time lag as the number of women seen within 13 weeks of pregnancy is divided by a denominator of the number of maternities which is not known until two quarters later. Therefore, we now have provisional Quarter 2 performance (i.e. using the number of maternities provisionally reported in Q4). Performance in Q2 increased from 85% in Q1 to 91%, which is above the 90% standard. Performance appears to have improved further in 2010/11 as the number of women seen within 13 weeks increased to 6040 in Q4 (provisional data), although the fertility rate also seems to have increased.

PERFORMANCE SCORECARD: 2010/11

VITAL SIGNS PERFORMANCE
SOUTH EAST LONDON - PROJECTED OUTTURN

	2010/11 Target	2010/11 Latest	2010/11 Projected Outturn	Issues
Vital Signs Tier 1				
C. diff. cases (provider)	523	315	315	GSTT failed its target (partly due to introducing new, more effective test in September)
C. diff. cases (commissioner)	933	492	492	All PCTs within their trajectory
MRSA bacteraemias (provider)	30	23	23	King's failed its annual target
MRSA bacteraemias (commissioner)	56	37	37	All PCTs within their trajectory
Referral to Treatment waits (admitted)	-	86.7%	c. 85%	February data. Only King's and Southwark PCT above 90%. SLHT was 78.7%
Referral to Treatment waits (non-admitted)	-	95.9%	95%+	February data. GSTT and SLHT below 95%. Bromley PCT below 95%
Referral to Treatment waits - median wait (admitted)	<11.1 weeks			SLHT above the threshold
Referral to Treatment waits - median wait (non-admitted)	<6.6 weeks			
Cancer waits - 2 weeks to first outpatient appointment (all)	93%	96.0%	c. 96%	
Cancer waits - 2 weeks to first outpatient appointment (breast symptoms)	93%	96.4%	c. 96.5%	
Cancer waits - 62 days from referral to treatment	85%	85.6%	85%+	GSTT is 'red'
Cancer waits - 62 days from referral to treatment (consultant upgrade)	85%	95.5%	c. 96%	
Cancer waits - 62 days from referral to treatment (via screening)	90%	97.0%	c.97.5%	LHT is below target, but with small numbers, just 3.5 breaches (out of 18 patients)
Cancer waits - 31 days from decision to treat to first treatment	96%	97.9%	c.97.5%	GSTT is below target
Cancer waits - 31 days from decision to treat to subsequent treatment (drugs)	98%	99.6%	c. 99.7%	
Cancer waits - 31 days from decision to treat to subsequent treatment (surgery)	94%	96.2%	96%+	GSTT is below target
Cancer waits - 31 days from decision to treat to subsequent treatment (radiotherapy)	94%	89.7%	94.0%	15 of 21 breaches in January due to patient choice, without these would be 'green'
Breast Screening (age extension women aged 47-49 & 71-73)	8%			Age extension being implemented
Bowel Cancer Screening (age extension ages 70-75)	30%			Age extension being partially implemented in 2010/11, however uptake is very low
Stroke care (% spending >90% of stay on stroke unit)	80%	84.4%	85.1%	Bexley and Greenwich below 80% for YTD, and Greenwich slightly below in Q4
Cervical Screening (test results within 14 days)	98%	63%	63%	98% target applies from January 2011. Lambeth & Southwark achieved 98% in March, and Lewisham 97.3%. BBG PCTs were below 30%
Vital Signs Tier 2				
All-age all-cause mortality (males)				Latest data is for 2009. Greenwich is 'red'. Only Lambeth & Southwark below target trajectory
All-age all-cause mortality (females)				Latest data is for 2009. All PCTs, except Lambeth, are below target trajectories
CVD mortality (ages <75)				Latest data is for 2007-9, Bexley and Lewisham are 'red', other 4 PCTs are below their trajectories
Cancer mortality (ages <75)				Latest data is for 2007-9, Lambeth is 'red', Lewisham & Southwark 'amber'
Smoking quitters (at 4-week follow-up)	8883	6594	8800	Data to Q3, Southwark is 'amber', other PCTs 'green', but with back-loaded trajectories
Maternity (access within 13 weeks)	90%	89.5%	c.92%	Performance is now above the 90% standard
Teenage conceptions	40.0	51.6		Latest published data is for 2009. Lambeth & Southwark were below their trajectories
Childhood obesity (reception year)	11.1%	12.3%		Annual data, latest is the 2009/10 school year. Scoring uses z-scores for statistical significance
Childhood obesity (year 6)	22.4%	22.2%		Annual data, latest is the 2009/10 school year
Immunisation (DTaP/IPV/Hib at age 1)	90%	91%	c. 91%	Latest data is for Q3
Immunisation (PCV booster at age 2)	90%	79%	c. 80%	Latest data is for Q3
Immunisation (Hib/Men C at age 2)	90%	84%	c. 84%	Latest data is for Q3
Immunisation (MMR at age 2)	90%	81%	c. 83%	Latest data is for Q3
Immunisation (DTaP/IPV pre-school booster at age 5)	90%	73%	c. 74%	Latest data is for Q3
Immunisation (MMR at age 5)	90%	74%	c. 75%	Latest data is for Q3
Immunisation (HPV for girls at age 12/13)	90%	44%	?	1st & 2nd dose to Nov.. Just below London average. Bexley = 0
Breast screening (coverage for women aged 53-70)	70%	68.9%	c69%	Latest published data is for 2009/10
Breastfeeding (prevalence)	69.3%	61.1%	60%	Q4 provisional performance 60.3%
CAMHS	4	4	4	All PCTs now at level 4 for all services
Chlamydia screening (people aged 15-24)	35%	26.4%	35%	Bexley is 'red', Bromley 'amber' at Q3
Drugs users in effective treatment				Time lag for data, LSL PCTs all likely to be 'red'
Patient experience		-		Survey scores issued on different basis to the Vital Sign trajectory
Staff satisfaction		-		
Dental access (in last 24 months)	100%	101.5%	100.0%	Latest data is to Q3
Cervical screening (women aged 25-49 within last 3.5 years)	80%	69.7%	c. 70%	Latest published data is for 2009/10
Cervical screening (women aged 50-64 within last 5 years)	80%	77.2%	c. 77%	Latest published data is for 2009/10
Existing Commitments				
A&E 4-hour waits	95%	96.2%	96.2%	All Trusts above the 95% standard (for Q2-Q4)
Revascularisation 13 week waits	99.5%			No breaches to date
GUM waits (appointment offered within 48 hours)	98%	c. 99.9%	c. 99.9%	99.5% commissioner performance in March
Delayed transfers of care (rate per 100,000 population)				
Ambulance response - Cat. A in 19 mins	95%			
Ambulance response - Cat. A in 8 mins	75%	75.1%	75%+	
Ambulance response - Cat. B in 19 mins	95%	87.3%	c87.5%	LAS has never achieved the 95% standard, and this indicator has been replaced in 2011/12
Diabetic retinopathy screening	95%	100%	100%	Latest data is to Q3
Early intervention in psychosis (new patients)	100% of plan	156.5%	c.150%	Latest data is to Q3
Home treatment / Crisis resolution (episodes)	100% of plan	125.7%	c.125%	Latest data is to Q3

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 12

ENCLOSURE 12

FINANCE REPORT

DIRECTOR RESPONSIBLE: Marie Farrell, Director of Finance

AUTHOR: Marie Farrell, Director of Finance

TO BE CONSIDERED BY: All

SUMMARY:
This paper summarises:

- the 2010/11 performance against statutory financial targets as illustrated in the draft accounts
- the 2011/12 budget position for the cluster PCTs
- the contractual position with acute providers
- the risks inherent in financial positions for the 11/12 financial year including the delivery of QIPP schemes and key areas of mitigation

KEY ISSUES:;
This paper outlines the financial outturn performance for the cluster in 2010/11, and updates the Board on the settlements associated with acute contract positions which were not known when budgets were initially set. All the impacts can be met within the financial envelopes, except for some elements of the settlements with SLHT and Lewisham Hospitals which have been funded from use of 2% non recurrent funds. The paper also outlines the significant increase in QIPP delivery requirements and the processes adopted to secure delivery.

RECOMMENDATIONS:
The Board is asked to **note**:

1. The 2010/11 financial performance of the cluster (based on unaudited positions)
2. The overall budget for the NHS SEL cluster previously agreed by PCT Boards
3. The impact of acute contract settlements
4. The commitments in the use of the 2% non recurrent funding
5. The overall financial savings anticipated from the cluster QIPP programme

The Board is requested to **agree** to:

1. delegate authority for adoption of the audited accounts to the cluster Audit Committee prior to submission to the Department of Health on 10th June, and to authorise the Chairman, Chief Executive and Director of Finance to sign off the accounts on behalf of the Board.

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2010/11 Financial Performance

1.1The draft financial accounts for 2010/11 have been submitted to the Department of Health in line with the deadline of 18th April 2011 by all cluster PCTs. A preliminary consideration of key issues in the accounts together with a summary statement from internal auditors of any issues that may impact on the accounts was undertaken on 16th April by an informal session of Non Executive Directors.

1.2 Performance against the key statutory financial duties was reported in the draft accounts as follows:

Table 1 : Revenue Resource Limit

PCT	10/11 Plan Control Total (Based on Opening RRL) £000's	Outturn as per draft accounts £000's	Variance £000's
Bromley	4,902	6,899	1,997
Bexley	1,651	506	-1,145
Greenwich	4,784	5,326	542
Lambeth	6,200	6,266	66
Southwark	1,295	1,291	-4
Lewisham	5,172	5,285	113
Total	**24,004**	**25,573**	**1,569**

The 2010/11 Operating Framework required a 1% surplus from all PCTs – this set a control total for each PCT and the Cluster as a whole. The surpluses set for Bexley and for Southwark in agreement with NHSL were less than the 1% requirement as a result of repayment of deferred debt and historic deficit. The Bexley position includes £1.2m of historic debt repayment which had been deferred to 11/12. Overall, all PCTs in the cluster have achieved the statutory financial duty of breakeven, and overall the sector delivered its control total.

Under RAB, this surplus will be returned subject to draw down confirmation from the SHA. This will therefore ensure that there is a relatively robust position for at least four PCTs as we move forward into 2011/12.

1.3 Cash Limit

PCTs are required to manage within the cash limit and to minimise cash balances at the end of the year. There were some significant variances in the drawdown from the Department of Health. In the case of Lewisham this was in respect of a capital receipt which occurred late in the financial year. Overall though cash balances were minimised and within acceptable limits.

Table 2: Cash Limit

PCT	10/11 Cash Limit £000's	Outturn as per draft accounts £000's	Variance Under/(Over) £000's
Bromley	508,636	508,588	48
Bexley	349,485	347,226	2,259
Greenwich	466,834	463,994	2,840
Lambeth	663,519	663,516	3
Southwark	541,847	541,586	261
Lewisham	533,950	530,275	3,675
Total	**3,064,271**	**3,055,185**	**9,086**

1.4 Capital Resource Limit

There were some significant changes to capital arrangements in 2010/11 with the delegated capital limit being withdrawn from all PCTs by the Department of Health. All transactions involving capital (revenue/ capital adjustments, transfers to local authorities, acquisitions and disposals and leases) have to be outlined in a business case and approved by NHS London. These changes were introduced at short notice relatively late in the year and were subject to variation. This introduced some delays in expenditure plans, resulting in slippage against the capital programme.

Table 3: Capital Resource Limit

PCT	10/11 Capital Resource Limit £000's	Outturn as per draft accounts £000's	Variance Under/(Over) £000's
Bromley	1,021	821	200
Bexley	280	220	60
Greenwich	3,250	2,935	315
Lambeth	4,747	4,597	150
Southwark	5,255	4,541	714
Lewisham	1,300	1,230	70
Total	**15,853**	**14,344**	**1,509**

1.5 The audited accounts are due for submission to the Department of Health by 10th June 2011. External audits are currently underway, and the Board is requested to delegate responsibility for adoption of the audited accounts to the Audit Committee at its meeting on 6th June, and for the Chair , Chief Executive and the Director of Finance to sign the financial statements on behalf of the Board.

2011/12 - Update on Operating Plans and Budgets

2.1 The cluster financial plans for 2011/12 were set within the context of the 2011/12 Operating Framework which was published in December 2010. The Framework set out the approach to be adopted and in the context of significant management cost reductions set out the overarching requirements for the health system to:

- Maintain and improve quality
- Keep tight financial control
- Deliver on the quality and productivity challenge (QIPP)
- Create energy and momentum for transition and reform

2.2 In financial terms, the average growth allocated to PCTs was c 2%. Whilst this compares favourably with other public sector funding settlements, it is a significant reduction compared to recent levels of growth allocated to the NHS. Furthermore, the settlement includes a requirement to fund pressures now included in PCT baselines, for example Social Care reablement funding and pressures arising from previously non cash limited items of expenditure.

2.3 As illustrated by the following table, the Operating Framework required a series of planning assumptions, most of which were in place in the 10/11 positions. However the new requirement was for PCTs to identify 2% of the resource limit on a non recurrent basis. The intention was that this would be held centrally and PCTs would submit bids against this resource to the SHA, strictly on the basis of expenditure that could be evidenced to be non recurrent and was intended to support transitional arrangements or accelerate delivery of QIPP. This was a fundamental change to 10/11 where PCTs simply had to identify non recurrent commitments in their positions.

Assumption	Operating Framework Requirement
Recurrent Resource Limit Uplift (growth)	2% (average)
Tariff Based Services uplift	-1.5%
Non Recurrent "Reserve"	2.0%
Contingency Reserve	0.5%
Planned Surplus	1.0%

2.4 In March 2011 all PCT Boards approved the indicative budgets for 2011/12. (Annex 1). At this stage however, the contract negotiation process was not complete, and the purpose of this paper is to update the Board on the impact of the settlements and the mitigating actions taken.

3 Acute Contracts

3.1 SEL Cluster is the co-ordinating commissioner for four key provider contracts and at this stage the contract values are known (except for SLHT) and the contractual process is summarised below:

- **Lewisham Healthcare**
  SEL wide agreement has been reached following an internal mediation process between the Trust and the Cluster. The proposals are based on projected outturn adjusted for additional emergency activity. Whilst the proposal includes QIPP initiatives, significant cost pressures were identified for commissioners, in particular Greenwich and Lewisham PCTs, relating mainly to anticipated increases in activity following closure of the QMS A&E services (Greenwich) and local plans (Lewisham). It was identified that some of the issues were clearly of a non recurrent nature and NHSL approval has been sought for the use of 2% non recurrent funding (summarised in the Table below).

- **Guys and St Thomas**
  Agreement has been reached with SEL PCTs and a proposal has also been put to the Associate PCTs. The proposals are based on projected 10/11 outturn with additional validated volumes to support delivery of the waiting times target which has been a problem with the Trust in 10/11.

There are no issues in relation to price and volume and the aim is to sign the contract by the end of May 2011.

- **Kings**

  An agreement has been reached with SEL PCTs and the proposal is now out with Associate Commissioners. The proposal is based on 2010/11 projected outturn with no further volume growth built in. This therefore represents a risk to PCTs if activity increases at the Trust which has been a strong trend in recent years.

- **South London Healthcare**

  An arbitration was heard by NHSL on three specific issues in April 2011. The panel found in favour of the Trust, and the impact of the arbitration has been factored into PCT positions. All three issues were non recurrent in nature. A bid has therefore been made against the 2% non recurrent reserve which means that the impact can therefore be managed in the Bromley and Greenwich positions. However, the impact on Bexley is particularly significant as in addition to managing the consequences of the SLHT arbitration, there is a further requirement to invest in DVH. Although the arbitration was in respect of three specific issues, subsequent to the arbitration a further gap has been identified. Work is ongoing to resolve this.

3.2 The proposed contract values are set out at Annex 2 to this paper. All contracts, except those in respect of Lewisham and SLHT are within the budgets approved by PCT boards and as such are part of the overall approved budgets for the cluster. The mitigation of the Lewisham and SLHT settlements are outlined in section 4 of this report.

4 Use of 2% Non Recurrent Funds

The 2% contributions are PCT funds and will be held separately on behalf of each PCT by the SHA. An approval process is in place whereby "bids" on behalf of each PCT are reviewed and authorised by the Chief Executive and subject to approval by the SHA. The main criteria for the use of the funds is that they are applied for non recurrent purposes and cannot be used to address underlying financial problems. Business cases are currently being reviewed, but as outlined above, bids have

already been made to mitigate some non recurrent elements of the impact of settlement with Lewisham and SLHT.

PCT	Bid £000's
Bromley	2,333
Bexley	5,989
Greenwich	2,718
Lewisham	2,896

5 QIPP

5.1 The achievement of financial targets in 2011/12 is predicated on the delivery of QIPP schemes. Historically, delivery has been patchy with some real successes but also significant slippage. It is particularly important in terms of delivery that providers have shared ownership of schemes as planned savings will only be made if the planned reductions in capacity are made. This can only happen if providers have confidence in the schemes . The target for the cluster in 2011/12 is £76million, which represents a step change in volume from previous years. A significantly different approach has been undertaken to developing these schemes in 2011/12,to ensure that there is confidence in the ability to deliver.

5.2 PCTs developed initial schemes in conjunction with clinical leads. A peer review process was then facilitated by the cluster with a self assessment process on the robustness of project management arrangements and implementation plans. Deep dives were then undertaken by the cluster into the most significant schemes to further assess the robustness of the planning process and deliverability of the financial savings. An initial stocktake meeting of the cluster with each BSU and clinical leads was then held and a joint RAG based risk assessment agreed. PCT clinical leads also presented QIPP schemes to acute clinicians at some providers. The financial risk of non delivery was assessed based on this process and factored into the overall position as outlined below:

BSU	2011/12 QIPP £000's	Green	Amber	Red	2011/12 Risk Assessed Saving £000's
Bromley	8,995	5,532	1,470	1,991	7,232
Bexley	10,203	2,802	4,130	3,370	6,505
Greenwich	14,840	3,112	9,720	2,008	10,470
Lambeth	13,626	4,837	8,138	651	11,613
Lewisham	14,893	4,870	6,751	3,272	10,989
Southwark	13,914	6,768	6,076	1,069	11,814
Total	**76,470**	**27,921**	**36,285**	**12,360**	**58,333**
% of overall Schemes		**37%**	**47%**	**16%**	

5.3 The main schemes assessed as high risk are:

- Lewisham – outpatient referral reductions
- Bromley – referral management centre
- Bexley – unidentified QIPP of c £4m

5.4 The risk assessed position leaves a "gap" of c£18m. Work is ongoing to identify alternatives in case of slippage, including:

- investment of the 2% non recurrent funding to accelerate and pump prime QIPP schemes
- reduce running costs
- rationalise estates and contracts

5.5 Further stocktake reviews are scheduled throughout the remainder of the financial year, with the next tranche scheduled for completion by the end of May.

6 2011/12 Financial Risk

6.1 Based on the four year strategic planning, 2011/12 is the most financially challenging, mainly as a result of the reduction in growth, the non recurrent 2% commitment and funding of pressures now included in the baseline. This is in the context of rising demand for services and increasing costs of new technology.

This has resulted in a challenging QIPP programme which is essential to delivery of sustainable financial balance.

6.2 There are also other potential pressures and risks in the system including:

- acute over performance
- potential impact of reductions in social care funding
- delivery of QIPP including provider sign up and joint ownership
- increases in costs of continuing care
- recruitment to key posts

6.3 These are significant pressures, with only 0.5% contingency included in positions to fund adverse variances. Effective and robust monitoring systems which detect adverse variances at an early stage are therefore a priority for the cluster. Work is underway to establish a robust claims management and contract monitoring system, and the rigorous approach to the development and acceleration of QIPP schemes has been outlined above. A Financial Planning and Delivery Unit has been established as part of the cluster structure and a PMO approach is being established to monitor the financial performance of the cluster including delivery of QIPP schemes. Work will be ongoing to identify further opportunities to reduce costs and opportunities to utilise the 2% non recurrent funding to accelerate and secure delivery of QIPP savings will be maximised.

NHS

South East London

ANNEX 1

2011/12 BUDGETS APPROVED BY PCTS

Description	Notes	Annual Budget 2011/12 Bexley £'000	Annual Budget 2011/12 Bromley £'000	Annual Budget 2011/12 Greenwich £'000	Annual Budget 2011/12 Lambeth £'000	Annual Budget 2011/12 Lewisham £'000	Annual Budget 2011/12 Southwark £'000	Annual Budget 2011/12 Total £'000
Commissioning								
Acute Commissioning	(1)	167,129	263,289	212,480	316,626	250,262	279,252	1,489,038
Other Commissioning	(2)	77,697	97,751	130,768	187,289	140,412	122,627	756,544
Sub-Total Commissioning		**244,826**	**361,040**	**343,248**	**503,915**	**390,674**	**401,879**	**2,245,582**
Primary Care								
Premises						3,985		3,985
Prescribing	(3)		46,745	35,754	37,875	45,059	32,758	198,191
Primary Care	(4)	73,552	62,036	63,450	82,093	57,662	68,220	407,013
Sub-Total Primary Care		**73,552**	**108,781**	**99,204**	**119,968**	**106,706**	**100,978**	**609,189**
Central & Earmarked Budgets								
Earmarked budgets	(5)	8,730	4,966	11,173	3,253	5,824	2,205	36,151
Central Costs/Initiatives	(6)	13,829	11,390	14,348	17,242	14,346	16,381	87,536
Contingency	(7)	1,703	2,500	2,275	3,147	2,704	2,580	14,909
Capital Charges	(8)		2,713	2,029		1,850	1,106	7,698
Contribution to Central Budgets	(9)	6,814	12,436	9,629	12,274	13,388	10,973	65,514
1% Surplus	(10)	3,558	5,000	4,549	6,574	5,256	5,500	30,437
Sub-Total Central Budgets		**34,634**	**39,005**	**44,003**	**42,490**	**43,368**	**38,745**	**242,245**
Total		**353,012**	**508,826**	**486,455**	**666,373**	**540,748**	**541,602**	**3,097,016**

(1) Includes the purchase of outturn, growth, changes in the Market Forces Factor and the impact of QIPP.

(2) Includes the reduction in respect of LD budgets.
(3) An uplift of 4% has been applied to the PPA outturn forecast.
(4) Primary Care budgets include the non recurrent allocations for dental, pharmacy and ophthalmology.

(5) Earmarked budgets include the 'Joint working between Social Care and Health' budgets and planned investments (Bexley £-4.149K unidentified QIPP)

(6) Includes Cluster and BSU running cost budgets.
(7) Contingency has been set at 0.5%
(8) Budget set based upon capital charges estimates.
(9) Includes the 2% non-recurring reserve, management cost target and GP Investment Fund.

Annex 2

SEL Cluster Acute Provider Budgets

	Lambeth	Southwark	Lewisham	Greenwich	Bromley	Bexley
	£'000	£'000	£'000	£'000	£'000	£'000
Acute Service Agreements						
Barts and The London NHS Trust	1,380	1,917	1,790	2,486	1,577	1,906
Chelsea and Westminster Hospital NHS Foundation Trust	4,317	1,500	918	528	544	181
Dartford & Gravesham	0	0	0	953	0	0
Epsom & St Helier University Hospitals NHS Trust	969	189	0	0	356	0
Great Ormond Street Hospital For Children NHS Trust	453	673	432	992	1,067	864
GStT	112,955	102,714	51,901	28,941	31,108	29,547
Homerton University Hospital NHS Foundation Trust	253	234	0	492	0	107
Imperial College Healthcare NHS Trust	1,954	1,048	997	860	928	490
Kings	86,551	103,593	40,603	18,279	31,092	14,005
Kingston Hospital NHS Trust	203	73	0	0	0	0
Lewisham Healthcare	1,267	3,191	110,571	13,600	8,990	4,145
London Ambulance Service NHS Trust	10,984	10,744	9,066	8,296	8,365	6,407
Maidstone and Tunbridge Wells NHS Trust	0	0	0	0	0	308
Mayday Healthcare NHS Trust	3,768	299	504	0	3,632	0
Medway NHS Foundation Trust	0	0	0	0	0	545
Moorfields Eye Hospital NHS Foundation Trust	1,463	817	687	951	763	467
North West London Hospitals NHS Trust	139	109	170	94	169	0
Queen Victoria Hospital NHS Foundation Trust	36	29	59	161	985	753
Royal Brompton and Harefield NHS Foundation Trust	1,080	512	393	535	1,250	889
Royal Free Hampstead NHS Trust	986	648	394	682	538	349
South London Healthcare Trust	512	674	7,153	100,151	137,841	81,930
The Royal Marsden NHS Foundation Trust	1,623	352	449	458	888	206
Royal National Orthopaedic Hospital NHS Trust	433	285	224	584	550	625
St George's Healthcare NHS Trust	22,908	1,327	1,067	640	1,520	421
Wandsworth PCT (Acute Element)	75	0	22	0	0	0
University College London Hospitals NHS Foundation Trust	3,285	2,652	1,963	2,174	2,388	1,670
Whipps Cross University Hospital NHS Trust	78	71	0	0	0	0
The Whittington Hospital NHS Trust	245	204	0	198	0	0
Total External Acute Service Agreements	**144,962**	**131,142**	**177,463**	**153,114**	**203,443**	**116,268**

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 13 **QUALITY AND SAFETY – HISTORICAL ISSUES & CURRENT ARRANGEMENTS**
DIRECTOR RESPONSIBLE: Dr Jane Fryer , Medical Director
AUTHOR: Dr Jane Fryer , Medical Director and Sarah Gardner, Deputy Director Integrated Governance
TO BE CONSIDERED BY: All
INVOLVEMENT REQUIRED FROM THE BOARDS: 1. To NOTE the content of the Quality Report
SUMMARY: The purpose of this paper is to provide the Joint Boards with a high level overview of current quality issues across the cluster and current governance arrangements in place to gain assurance that patient safety, clinical effectiveness and patient experience are being addressed and monitored effectively. A Quality Framework is being developed across South East London Cluster to ensure that the Joint Board can be assured that our commissioned services are providing safe and high quality services. This framework will cover four main components to enable a matrix of Quality intelligence to be gathered, presented at appropriate forums and that a culture of quality is embedded in all key areas of work conducted by the cluster.
KEY ISSUES: **Governance Assurance - Quality Arrangements:** • A Quality and Safety sub committee of the Joint Boards established that will oversee the clinical governance framework for the five SEL PCTs and Bexley Care Trust • Regular meetings with each provider, including mental health, led by the relevant lead clinical commissioner.

ENCLOSURE 13

- Separate structure for management of quality in primary care using the London Framework as a foundation
- Continuation of BSU quality sub groups to ensure quality issues are retained at a local level

Key Historical Issues:

Lambeth PCT

- Developing further our quality assurance processes will be a priority for our Lambeth Clinical Commissioning Collaborative Board.
- Further development of a balanced scorecard to enable comparative information between GP practices within SE London.
- Adult safeguarding
- Continued work with King's Health Partners

Southwark PCT

- Implementation of recommendations following CQC inspection to care homes
- FOI & CAS arrangements
- Business continuity

Lewisham PCT

- Addressing latest Patient Survey results
- Primary Care access
- Care of the elderly assurance systems
- Quality Alerts

Bexley PCT

- Actions to improve access to healthcare in Bexley care homes
- Actions to improve services for people who have had a stroke
- Reviewing quality of anti-coagulation services
- Review of the quality of unscheduled care services

Bromley PCT highlighted the following quality issues:

- SLHT - continued quality monitoring
- Learning Disability Services - continued monitoring of the transitional service (this may be agreed to be an LCCC duty)
- GP Performance monitoring including GP appraisals
- CQUIN - setting and performance monitoring

Greenwich PCT highlighted the following quality issues:

- Safeguarding Adults and Children
- Emergency Planning.
- Prison Health
- Newborn Hearing

Primary Care

- Screening rates
- Breast and Cervical Cytology
- Poor immunisation rates
- Improvements in quality at SELDOC
- Primary Care access

INVOLVEMENT:
COMMITTEE INVOLVEMENT:
A Quality and Safety sub committee of the Joint Boards will be established that will oversee the clinical governance framework for the five SEL PCTs and Bexley Care Trust; providing assurance to the Joint Boards that commissioned services are safe and high quality and that there are adequate plans in place to respond to issues of poor quality.

RECOMMENDATIONS:
The board (s) is asked to:-

- NOTE the contents of this report

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ENCLOSURE 13

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 13

Quality and Safety – Historical Issues & Current Arrangements

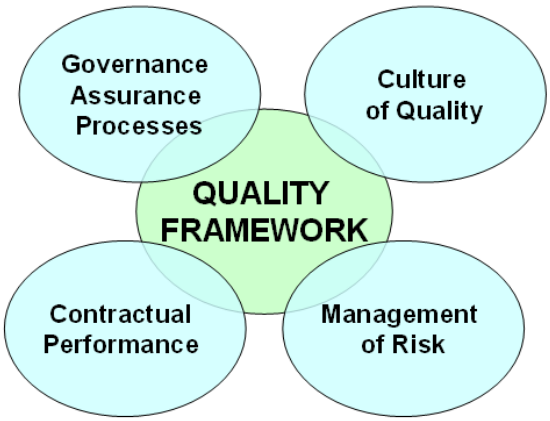
DIRECTOR RESPONSIBLE: Dr Jane Fryer, Medical Director

AUTHOR: Dr Jane Fryer, Medical Director
Sarah Gardner, Deputy Director Integrated Governance

1. Introduction

A Quality Framework is being developed across South East London Cluster to ensure that the Joint Board can be assured that our commissioned services are providing safe and high quality care. This framework will cover four main components to enable a matrix of Quality intelligence to be gathered, presented at appropriate forums ensure assurance in this area is gained.

The following diagram outlines these four components:



ENCLOSURE 13

2. Quality Framework

Governance Assurance

A Quality and Safety sub committee of the Joint Boards has been established that will oversee the clinical governance framework for the five SEL PCTs and Bexley Care Trust; providing assurance to the Joint Boards that commissioned services are safe and high quality and that there are adequate plans in place to respond to issues of poor quality. A Quality Planning Workshop will be held on the 15th June 2011 with the first meeting of the sub committee to be scheduled in early July 2011. The purpose of the work shop is to establish clear processes for managing quality across the cluster and in particular to ensure that this intelligence is managed efficiently and effectively in all major areas or work such as QIPP and Contracting.

A separate structure is in place for the management of quality in primary care using the London Framework as a foundation reporting into the Quality and Safety committee of the Joint Boards. (A confidential paper about high risk issues in primary care will be considered in Part 2 of this board meeting)

Contractual Performance

There will be regular quality meetings with each trust, including mental health, led by the relevant lead clinical commissioner that will ensure that quality issues are addressed. These meetings will be supported by the Medical Director, the Director of nursing and senior contracting staff.

We will develop Key Performance Indicators on Quality and ensure that links are made between the contracting cycle with our providers and clinical leads within the cluster. We will also continue to utilise existing systems and processes such as the use of Serious Incident Reporting, Safety Alerts and networks such as safeguarding.

We will start discussions with the BSU's about the best way for the board to obtain assurance about quality for other smaller contracts.

Quality Accounts for all the main providers are currently being prepared by the Trusts and a full report will come to the July board meeting

An initial analysis on primary care quality to include 10/11 QOF performance will come to the July board

Culture of Quality

This will be fostered across all elements of commissioning and service redesign, particularly with the implementation of the QIPP and delivery of the GP consortia to ensure that patient safety, experience and clinical effectiveness remains an explicit driver in these changes.

Management of Risk
As part of the implementation of a Risk Management Framework across the cluster, the management of clinical risk will be incorporated into the Governance Structures through the Quality and Safety sub committee and the local BSU based Quality Assurance processes.

3. Historic Issues

This information has come from the individual boroughs and will be presented in a more consistent way in the future.

Lambeth PCT highlighted the following quality issues:
Over the year 2010/11 we have further strengthened our commissioning function by developing more rigorous and systematic quality assurance processes. A summary of priorities and outcomes for the year is presented below.

Quality reporting schedules and performance systems

- quarterly provider quality reports received and reviewed by the Board throughout the year
- performance reviewed at contract and quality meetings
- Commissioning for Quality and Innovation (CQUIN) priorities agreed for all providers and monitored in-year. This if a form of payment framework which makes a proportion of providers' income conditional on the achievement of ambitious quality improvement goals.
- GP quality and performance framework developed. Patient information from the analyses will be developed during 2011.
- An independent contractor performance policy was developed and implemented.

Patient safety

- Provider serious incident processes developed and implemented in line with updated National Patient Safety Agency guidance to ensure issues are fully addressed, learning shared and risks to patients reduced.
- Data cleaning and validation of GP practice register information undertaken to provide more accurate information to focus interventions. A balanced scorecard has been developed which will enable comparative information between GP practices within SE London.
- Adult safeguarding training has been targeted for GPs and community staff.
- Adult and children safeguarding clauses are included within all contracts and monitored.
- An updated incident reporting system was implemented across all GP practices and community services.
- All Lambeth GPs continue to be appraised annually.

Clinical Effectiveness

- The implementation of guidance issued from the National Institute of Health and Clinical Excellence (NICE) is followed up in provider quality meetings.
- Those who commission health services ensure that the best evidence, including NICE guidance, is used to inform commissioning decisions.

Patient Experience

- All provider contracts include patient experience requirements and metrics which are monitored
- Acute Trusts have a national CQUIN on patient experience
- Programmes of work by commissioners through the year included patient and user experience to inform decision-making including: LiNKs event 'Right care, Right place' which sought user views on a number of areas including mental health and diabetes health care provision.

Clinical Leadership

- In order to provide more specialist GP services the PCT commissioned services from GPs with special interests around diabetes, cardiac, dermatology and headaches.
- The PCT continues to work with King's Health Partners to develop robust services across the South East.
- Clinical leaders were involved in developing the Neighbourhood Resource Centres including the Akerman Road build which is due to complete June 2012. This is a facility for GP practice provision and community based care. There was also significant public involvement in this development.
- Participation in the Department of Health pilot for revalidating doctors, bringing together teams across South East London.

Developing further our quality assurance processes will be a priority for our Lambeth Clinical Commissioning Collaborative Board.

Lewisham PCT highlighted the following quality issues:

- The recently published patient survey indicated an issue regarding the relationship between patient and their GPs where satisfaction levels were below the norm
- Primary Care Service accessibility
- The development of an assurance process that enables the quality of care being provided to the care of the elderly to be effectively monitored
- Development of the primary care clinicians lead Quality alerts to ensure that feedback from this mechanism is incorporated into quality monitoring assurance processes.

Southwark PCT highlighted the following quality issues:

The last meeting of the Southwark Integrated Governance Committee was held on 10th March 2011. Agenda items included Safeguarding Arrangements; the risk management report (including transition risk), Serious Investigation Update; the CQC inspection of healthcare needs in Care Homes; revised governance structures; revised TOR for the future Integrated Governance Sub Group and the Research Governance Annual Report.

- The Committee was advised that Safeguarding arrangements included a designated nurse post and a designated doctor post for Southwark.
- The Transition Risk register was presented with key themes identified. The importance of business continuity and capturing key handover tasks were discussed as well as clearly identifying which risks remain at BSU level and which should be transferred to the cluster (e.g. FOI & CAS would function best at a cluster level). The BSU governance lead was tasked to take these issues forward with governance leads at the cluster as appropriate.
- Preparation was underway for the CQC inspection scheduled for 6th May 2011. Following on from the 9 visits to care homes and a GP survey, this consists of interviews with key staff and managers in commissioning.

In addition reports were received on the revised governance structure for the BSU and draft terms of reference for the BSU Integrated Governance Sub Group which will be taken forward with the cluster. The Research Governance Annual Report was also received.

Bexley PCT highlighted the following quality issues:

<u>Actions to improve access to healthcare in Bexley care homes</u>
Actions are underway to improve access to healthcare services and further develop the monitoring of quality in Care homes in the Bexley area. Joint meetings have been held with Bexley Council and it has been agreed to establish a Care Home Quality Monitoring Group in collaboration with the Council

<u>Actions to improve services for people who have had a stroke</u>
Following the CQC review of services for people who have had a stroke in the Bexley Care Trust area, various actions are underway including the development of community based stroke services.

<u>Reviewing quality of anti-coagulation services</u>
In consideration of an extension of service, a review of the quality of anti-coagulation services in the community is underway.

<u>Review of the quality of unscheduled care services</u>

A review of the quality of urgent care services and out of hours doctor provision is underway. This review will examine care pathways and is aiming to make these more streamlined.

Greenwich PCT highlighted the following quality issues:

- Safeguarding Children
  There are joint arrangements in place that reflect the London wide and national requirements with Local Safeguarding Executive Group (SEG) and full participation in the multi-agency Safeguarding Children's Board. The newly established post of GP with a special interest in Safeguarding Children has been appointed to with a start date in May. NHS Greenwich remains without a Designated Doctor for safeguarding Children but does have a Designated Nurse. SLHT have agreed to include the Designated Doctor responsibility in a vacant paediatrician's JD which is being drafted currently but a gap remains.

- Safeguarding Adults
  NHS Greenwich is continuing to work with London Borough of Greenwich and providers to ensure that vulnerable adults are protected from harm. Case reviews continue to identify areas for the improved management of vulnerable adults who are cared for in their own homes, in care homes and in hospitals. The incidents of pressure ulcers has been a focus of concern and quality monitoring in this area is being strengthened and improvements incentivized through CQuINs.

- Emergency Planning.
  There is a risk of: services being overwhelmed and services break down; particularly in light of the fact that Greenwich Borough will host a third of all Olympic events during 2012. This will report into the new Joint Quality and Safety sub committee of the Joint Boards.

- Prison Health
  There have been ongoing concerns about the quality of health services available to prisoners in Belmarsh. Also in August last year a new Youth Offending Institution – Isis – was opened and is slowly increasing its intake. New health services were procured following a tendering process for both prisons and work is continuing to assure the quality of services and improve these. Each year prisoners die in custody and each time this occurs this is managed as a Serious Incidents and investigated by NHS Greenwich. Where there is learning from any death an action plan is developed and NHS Greenwich monitors the implementation of these actions through the Prison Partnership Board and the Clinical Quality Group for Prison Services. In-mates are vulnerable and often experience poor general health.

- Newborn Hearing
  Delay in babies progressing through all newborn hearing assessment pathways resulting in babies being too old to have a tertiary audiology assessment poses a

risk of babies with a childhood hearing impairment being missed and a loss of opportunity for early diagnosis. From November 2010 a full time member of staff has been tasked with conducting hearing test on babies in QEH neo-natal unit while a longer term solution is put in place.

Bromley PCT highlighted the following quality issues:

- Learning Disability Services - continued monitoring of the transitional service (this may be agreed to be an LCCC duty)
- GP Performance monitoring including GP appraisals
- CQUIN - setting and performance monitoring
- SLHT - continued quality monitoring – see below for detail

Quality Issues at South London Healthcare NHS Trust
(Provided by Acute Contracting Team)

A&E
There have been issues with the quality of service delivery and achievement of the previous 4 hour waiting time targets, compounded by serious Winter pressures experienced across the Sector. This culminated in the temporary closure of the A&E department at Queen Mary's Sidcup site. Staff and resources have been reassigned to the departments at Woolwich and Orpington and performance has improved subsequently, particularly with the support of the DH Intensive Support Team.

Serious Incidents
There has been a focus on the management of serious incidents, particularly clarifying roles and responsibilities within the Trust, PCTs and NHS London, and processes to learn from incidents and avoid their recurrence. A Joint Action Plan was developed to improve the management of Serious Incidents, which commissioners are now working with the Trust to ensure its implementation.

Maternity Services
Considerable progress has been made in the past year to consolidate the service specification across the Trust's sites, undertaken through a Joint Action Plan and strategy. A detailed progress report was presented at the Clinical Quality Group in March.

Annual Report 2010/11
An annual report will be prepared for the Clinical Quality Group to review achievements and progress on the work plan in 2010/11. The CQG will take the opportunity to review roles and responsibilities and align the work plan accordingly.

Contract 2011/12
The new Contract for 2011/12 incorporates a number of local commissioning priorities and national requirements where scrutiny is believed to be necessary. These broadly comprise:

- Service Specifications
  e.g End of Life care, Stroke services, and Diabetes Inpatient care.
- Key Quality Requirements:
  As with other acute contracts a combination of local and national standards and Key Performance Indicators.
- Service Reviews:
  A number of ongoing reviews such as for diabetes services and falls, undertaken by the individual PCTs that will yield results with wider relevance across commissioners. These in turn may be reflected in commissioning intentions and revised service specifications in future years
- CQUIN:
  An explicit approach has been adopted to apply CQUINs to incentivise good practice. A programme of work has been outlined for CQUIN schemes in 2011/12 that build on successful schemes rolled forward from 2010/11 e.g. smoking cessation and enhanced recovery, and to develop service delivery e.g. the assessment of patients by a consultant in A&E

Primary Care highlighted the following quality issues:

The Cluster Primary Care team are acutely aware of the variability of quality across primary care and are developing action plans to address these issues.

At a high level there are concerns in the following areas of Primary Care

- Screening rates
- Breast and Cervical Cytology
- Poor immunisation rates
- Improvements in quality at SELDOC
- Primary Care access

4. Conclusion

The Joint Boards are asked to note the highlighted historical quality issues across the cluster. The cluster is making good progress in implementing a robust quality framework and assurance systems to ensure an accurate picture of quality issues can be presented to the Boards on an ongoing basis.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 14

LONDON REVIEW OF CANCER SERVICES

DIRECTOR RESPONSIBLE: Andrew Eyres, Chair South East London Cancer Network and Managing Director, NHS Lambeth

AUTHOR: Alastair Whitington, Network Director, South East London Cancer Network

TO BE CONSIDERED BY:

- All Boards

SUMMARY:
The purpose of this report is to update Boards on the work being undertaken to implement the national *Improving Outcomes: A Strategy for Cancer* and the London Review of Cancer Services.

KEY ISSUES:
Improving Outcomes - a Strategy for Cancer, published by the Department of Health in January 2011, translates the underpinning principles of the Government's reforms for health and social services into the steps that need to be taken to improve cancer outcomes across England. The national Strategy for Cancer sets out a range of actions to improve cancer outcomes through earlier diagnosis and improved treatment. *Improving Outcomes: A Strategy for Cancer* is available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf
A summary of the work already in progress to implement the national Cancer Strategy is outlined within this paper.

Improving cancer care is an important priority for the NHS in London. The implementation of the London-wide plan for cancer services across the capital is underway. This paper outlines the four work streams currently being undertaken to implement the proposed Model of Care for cancer services and provides a progress report on the development of Integrated Cancer Systems. The Review will consider how the commissioning of cancer services from Integrated Cancer Systems

is best taken forward from April 2012.

Work to take forward the development of cancer services across South East London is coordinated by the South East London Cancer Network, which currently includes both providers and commissioners. Cancer Networks across London are working with the London Cancer Review Programme to determine the use of resources across both local Network priorities and to support the London-wide work programme.

INVOLVEMENT:
The London-wide cancer proposals were developed over a 12 month period by cancer clinicians from across the capital with an active patient panel and took into account national and international evidence and best practice. The proposed model of care was the subject of a three-month engagement process with GPs, the public and Local Authorities where levels of support were assessed and suggestions for implementation were gathered. The feedback received was supportive.

Within South East London we are now seeking to broaden engagement with the priorities for cancer, working through Cluster and local arrangements. The Network has a comprehensive infrastructure for clinical engagement via the site specific and sector-wide work streams.

The South East London Cancer Network has a dynamic partnership group which consists of service users from across South East London who undertake cluster-wide work. This group is supported by three locality groups, who work with service users, healthcare professionals and commissioners to implement these initiatives locally and monitor service quality through the peer review process. The Partnership Group has an agreed work plan for 2011.

RECOMMENDATIONS:

The PCT Boards are asked to note and support progress and priorities in the development of the commissioning of cancer services across both South East London, and London as a whole, and to ask the South East London Clinical Strategy Group and the six borough Local Clinical Commissioning Committees to consider those actions required to take forward the delivery of improved outcomes for people at risk of, or diagnosed with, cancer.

1. The Boards are specifically asked to note:
- *Improving Outcomes: A Strategy for Cancer* and the work being undertaken across South East London to improve outcomes and service quality in cancer services.
- The background, progress to date and next steps with regards to the London Review of Cancer Services

2. The Boards are asked to ensure that:
- The six borough Clinical Commissioning Committees Boards consider actions necessary at local level to support the delivery of improved outcomes for local people at risk of, and diagnosed with cancer.
- The Clinical Strategy Group reviews progress in developing cancer services across South East London, in particular the development of integrated systems of cancer care across London and the associated development of new approaches to the commissioning of services from Integrated Cancer Systems.
- Stakeholders are involved and can help develop engagement plans through the Stakeholder Reference Group

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NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

Report on Improving Outcomes: A Strategy for Cancer and London Review of Cancer Services

1. Purpose of report

1.1. The purpose of this report is to update Boards on the work being undertaken to implement the national strategy for cancer *Improving Outcomes: A Strategy for Cancer* and the London Review of Cancer Services.

2. Improving Outcomes : A Strategy for Cancer

2.1. Improving Outcomes - a Strategy for Cancer published by the Department of Health in January 2011 translates the underpinning principles of the Government's reforms for health and social services into the steps that need to be taken to improve cancer outcomes across England. The Strategy sets out a range of actions to improve cancer outcomes through earlier diagnosis and improved treatment, including;

- diagnosing cancer earlier
- helping people to live healthier lives to reduce preventable cancers;
- screening more people;
- introducing new screening programmes; and
- making sure that all patients have access to the best possible treatment, care and support.

2.2. Whilst the national Cancer Strategy covers a range of outcomes, a major focus is on improving cancer survival rates. The commitment is made that, by 2014/15, an extra 5,000 lives will be saved every year, which would bring England in line with the European average and aims to narrow the inequalities gap at the same time.

2.3. The national focus for cancer awareness campaigns is based on the four tumour types: lung, breast, colorectal and urology which have the highest mortality rates in the England. Information from the International Cancer Benchmarking Project shows that England has poorer survival rates for colorectal, lung, breast and ovarian cancer compared with other (non-UK) countries.

2.4. In South East London cancer is one of our five major health challenges, as a major cause of premature mortality with varied outcomes for different people. The Network implements the National Strategy through the Integrated Plan. SE London is the only London Network to have achieved full compliance with the NICE Improving Outcomes Guidance within the prescribed timeframe.

2.5. Within South East London the Network management are now seeking to broaden engagement with the priorities for cancer, working through Cluster and local arrangements. The Network has a comprehensive infrastructure for clinical engagement via the site specific and sector-wide working groups.

2.6. The South East London Cancer Network (SELCN) has a dynamic partnership group which consists of users from across SE London who undertake sector-wide work. This group is supported by three locality groups, who work with service users, healthcare professionals and commissioners to implement these initiatives locally and monitor service quality through the peer review process. The Partnership group has an agreed work plan for 2011.

2.7. The SELCN initiated a Primary Care Audit of urgent two week referrals for cancer which was adopted and rolled out Nationally.

2.8. Areas requiring further work include:

- Implementation of National guidance on the development of Acute Oncology Services and more local provision of chemotherapy services.
- Development of a radiotherapy satellite in outer SE London to improve access for residents of Bromley and Bexley.
- Achieving and maintaining Cancer Waiting Times performance
- Further work on rehabilitation, psychological care and information prescriptions.
- Preparation for the annual peer review visit in October 2011.

2.9. An initial review of the mortality data from 2008 undertaken by the South East London Cancer Network has been undertaken to support how the focus for future work across South East London should be determined. This initial analysis shows that:

2.10. Lung cancer is an issue across the sector with Lambeth, Southwark, Lewisham and Greenwich having mortality rates in the highest 25% in England.

2.11. The second highest mortality across the sector is hepatobilary cancer with one of the worst rates in England, however, this requires further investigation to fully to understand the reason for this. The Tumour Working Group is working to explore this further.

2.12. The gap between one year mortality (2008) for breast cancer for the over 65s and under 65s has decreased, but the gap between over 75s and under 75s still requires further work.

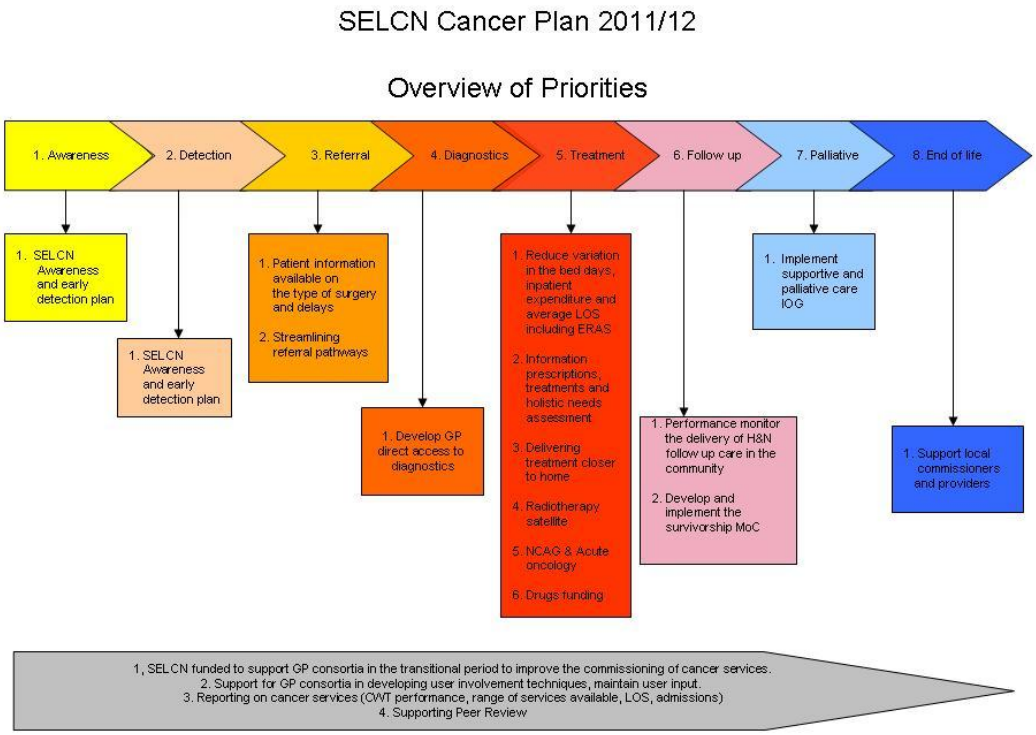
2.13. South East London has highest age standardised mortality rate for urology cancers in England. Lambeth has the highest rate in England. The rate is higher in the under 75s but further investigation is required to understand the issues surrounding this.

2.14. Colorectal cancer accounted for 9.9% of all cancer deaths in South East London (2008). It is the third largest killer in South East London and England has one of the poorest survival rates when benchmarked.

2.15. Work to take forward the development of Cancer services across South East London is coordinated by the South East London Cancer Network, supported by the Cancer Network team, led by Alastair Whitington. The Network currently includes commissioners, cancer care providers and service users. The Secretary of State has confirmed that the Department of Health will continue to centrally support Cancer Networks in 2011/12 to

support GP Consortia in improving the commissioning of cancer services. Cancer Networks across London are working with the London Cancer Review Programme to determine the use of resources across both local Network priorities and to support the London-wide work programme.

2.16. A schematic outlining the Networks current 2011/12 work programme is set out below. The Cancer Network has identified the key areas of work required to implement the national Cancer Strategy and deliver the recommendations of the London Review of Cancer services. The emerging Work Plan beyond 2011/12 will be prioritised through discussion with local commissioners and other local stakeholders to address the key aims of improving outcomes and in light of the available resources to support implementation.



3. Key Actions Underway in South East London

3.1. A Local Awareness and Early Detection (LAEDI) Plan is being developed and a South East London-wide event incorporating commissioning teams, public health, GPs and secondary care is planned for 13 June 2011. This event will build on learning from previous awareness initiatives and prioritise activities over the next two years. Following a successful bid to National NAEDI funding the Network was awarded £ 284,000 to fund an awareness campaign which is being led by Bromley PCT.

3.2. Efforts are continuing to streamline the patient pathway to minimise waiting times for treatment and work is planned to improve GP access to diagnostics.

3.3. Central to the national cancer strategy is implementing best practice to achieve a reduced length of stay and avoid unnecessary admissions through implementation of the Enhanced Recovery Programme and National Chemotherapy Advisory Group (NCAG) recommendations. Enhanced recovery is a fairly new approach to preoperative, intra-operative and post-operative care of patients undergoing surgery. The enhanced recovery pathway can improve both patient experience and clinical outcomes and can also lead to a significant reduction in length of stay, shorter waiting times, reduced risk of hospital acquired infections, increased capacity for Trusts and longer term tariff benefits. Implementation of the NCAG recommendations, through the development of Acute Oncology Services supported by implementation of ePrescribing across South East London, will reduce unnecessary admissions, support reduced length of stay and provide the platform to enable more chemotherapy to be delivered locally.

3.4. The South East Cluster has recently submitted a business case to NHS London for non-recurrent funding to pump prime this initiative. Improved access to Radiotherapy will be delivered through the development of a satellite treatment facility in outer South East London.

3.5. The SE London Cancer Network developed and leads the Pan London Cancer Networks cancer drug prioritisation process, which now covers 50% of the cancer Networks in England, to determine which drugs should be commissioned in 2011/12 and also directs use of the London cancer drugs fund (CDF). The CDF arrangement for London was also developed and led by SE London.

3.6. Improved outcomes have resulted in more people living with or surviving their cancer and there will be increasing demand for survivorship programmes and develop alternative models of follow-up care. Following an extensive mapping of current models of survivorship across South East London and identified best practice, work is in hand to develop a business case to Macmillan to fund project management support to deliver consistent and equitable models of survivorship and follow up care.

3.7. The recent National Cancer Patient survey highlighted that the care and treatment in London remain is comparatively poor across the whole pathway. The Cancer Network team is leading work on five areas of particular concern identified by patients and is developing action plans with local Trusts. The areas of concern are:

- Finding out what is wrong with you;
- The quality of the ward nurses;
- The quality of hospital care as outpatients and day cases;
- Care provided by general practice;
- The interface between primary and acute care.

3.8. The Cancer Network is responsible for ensuring specialist palliative care is integral to the cancer patient pathway and for some patients this begins at diagnosis. Significant progress has been made in implementing the Supportive and Palliative Care Improving Outcomes Guidance.

3.9. End of Life Care is broader than cancer care and it has been agreed that this should be the responsibility of local commissioners and providers. Work is ongoing through borough teams to implement best practice guidance and standards in end of life care across all conditions.

4. London Review of Cancer Services

Background and Case for Change

4.1. Improving cancer care across London is an important priority. In March 2010 the case for change for cancer services in London was published. It demonstrated a compelling argument for the need to improve cancer services in London. It showed that the lack of progress in implementing co-ordinated cancer services across London means that services may be excellent in some instances but is hugely variable. This has an impact on clinical outcomes and means patients often experience fragmented care. Improving survival rates in England to match the best in Europe could save an estimated 1,000 lives per year in London.

4.2. A proposed model of care was published in August 2010. The model of care details clinically-developed solutions that will ensure that radical improvements are made to London's cancer services. These improvements will enable earlier diagnoses to be made, improve inpatient care and reduce inequalities in access to services.

4.3. The proposals were developed over a 12 month period by forty-five committed cancer clinicians from the capital and an active patient panel and took into account national and international evidence and best practice.

4.4. The proposed model of care was the subject of a three-month engagement process with GPs, the public and Local Authorities where levels of support were assessed and suggestions for implementation were gathered. The feedback received was supportive and the proposals can now be taken forward.

4.5. The paper covers how the implementation of this model will be taken forward, focusing on the development of integrated cancer systems and subsequent changes to the commissioning structure.

Implementation Programme

4.6. The implementation of this model of care is being led by Rachel Tyndall, former North Central London Sector Chief Executive who has been appointed as the Senior Responsible Officer and Chris Harrison, Medical Director of The Christie, Manchester's specialist cancer hospital as the Clinical Lead. They are supported by an implementation team at London Health Programmes, the five cancer networks in London and staff at the London SCG. The implementation board will ensure that the agreed model of care is strongly commissioned and that the work is closely aligned to the QIPP agenda. Their role is to drive the implementation of this model forward, ensuring that commissioners are regularly consulted, with particular regard to the changes to commissioning structures.

4.7. The implementation programme addresses those areas indentified for improvement; ensuring early diagnosis; spreading best practice; and improving radiotherapy. In addition to this and central to the model is the expectation that providers will work together in Integrated Cancer Systems (ICS) to ensure that patients experience seamless care. It is proposed these

systems, rather than individual organisations, will be commissioned to deliver pathways of care from April 2012. There are four workstreams:

- **Public health and primary care**, including the ongoing implementation of NAEDI and other recommendations to improve public awareness, GP access to diagnostics, referral to secondary care, uptake of screening, and health inequalities. This work stream also includes the ongoing implementation of new models of community follow-up care.

- **Best practice**, including the ongoing implementation of NHS Improvement's transforming inpatient cancer care programme to improve access to day case breast surgery and laparoscopic colorectal surgery, as well as the roll-out of enhanced recovery programmes and acute oncology services.

- **Radiotherapy commissioning,** including the consideration of centralised commissioning of radiotherapy services. This work stream is being lead by South East London.

- **Provider development**, including the creation and development, along with providers, commissioners, existing cancer networks and other stakeholders, of the Integrated Cancer System (ICS) model. This work stream includes work on the governance arrangements, incentive structures, organisational development and cultural change that will be necessary to deliver the programme of change necessary to make Integrated Cancer Systems work. This work stream also includes the potential for the consolidation of specialist surgical services for rarer and some common cancers into fewer centres.

Integrated Cancer Systems

4.8. An Integrated Cancer System (ICS) is defined as a group of providers that come together in a formal, governed way to provide services across the whole of the cancer pathway. This will ensure comprehensive, seamless cancer care for patients. The ICSs will be commissioned to provide cancer care based on defined care pathways to meet patients' needs.

4.9. The model of care sets out that ICSs should:

- Be clinically led;
- Have responsibility for delivering the specified care pathways for different tumour sites as developed by cancer commissioning networks and Network Site Specific Groups; and
- Have responsibility for governing and delivering services across the system.

4.10. To facilitate the development of ICSs the implementation team have worked closely with provider Chief Executives, Medical Directors, Directors of Finance and Cancer Managers to develop a specification by which providers will submit their proposals to establish an ICS.

4.11. The emerging picture is for two systems across London, one encompassing the providers in the current North East and North London networks and the other the providers in South East, South West and North West London. This early stage of ICS development highlights that there are different expectations about governance arrangements, including the roles of lead organisation and lead contractor. These issues will be addressed by the Cancer Implementation Team during a robust period of support given to providers and emerging system leaders until June 2011. Proposed systems, as opposed to the individual provider organisations, will be required to submit three separate documents by June 30th.

4.12. Responses must demonstrate that they can meet the final specification and deliver the recommendations of the model of care and co-dependencies framework:

- A memorandum of agreement between all NHS providers in the proposed system.
- An integrated cancer system plan.
- A service plan.

4.13. It is at this time that implications for local service disposition will become clear and the plans will provide clarity regarding consolidation of specialist cancer surgery onto fewer sites.

Changes for commissioning

4.14. The model of care recommends cancer services should be commissioned by pathways, which will be delivered through ICSs. This new approach to organising services means a new approach to commissioning is also necessary. There will be closer alignment between pathway specifications, quality standards, outcome measures and the way that services are paid for and monitored.

4.15. It is proposed that instead of contracting separately for different parts of cancer care pathways with each individual service by provider, commissioners will contract with the ICS, through one lead contracting body, and the ICS will be responsible for the whole pathway and in turn sub-contract various parts of the pathway to providers within its ICS.

4.16. Developing this new way of working will require Clusters and the London Specialised Commissioning Group to work together in a structured and coordinated way, as will future Clinical Commissioning Consortia and the National Commissioning Board. It is key to secure involvement now of clinical commissioners and the London GP Council, the latter were supportive of the implementation programme for the cancer model of care and see their role as facilitating the commissioning of cancer services.

4.17. A work stream has been established to explore and develop relevant commissioning processes. The working group will build on work already completed by the existing cancer networks and will identify key success measures, develop commissioning specifications for pathways, as well as identifying future tariffs and contracting arrangements.

4.18. Part of this work will involve engaging with the cancer network directors who are currently exploring future roles of the cancer networks. The model of

care recommended that they are consolidated and embedded in commissioning structures.

Next Steps and Key milestones

4.19. The headline milestones are set out below. Where appropriate formal proposals will be presented to the PCT and Care Trust Boards.

30th June 2011	Submissions against the final specification due. This will allow assessment of service changes required to deliver the model of care and prompt planning on public engagement or consultation.
September 2011	Results of a formal, clinically led assurance process available.
October 2011	Cancer Commissioning Intentions published, these will cover recommendations relating to early diagnosis, best practice and radiotherapy as well as proposals for the pathway commissioning.
Autumn 2011	London wide cancer board will be established, responsible for overseeing the delivery of the model
December 2011	Contractual arrangements developed
April 2012	Implementation of ICS and new contracting takes place

4.20. There remains much work to be done to establish the ICSs, develop service plans to respond to the model of care and to introduce pathway commission arrangements. Further reports will be presented back to PCTs/Clusters on progress, and where necessary for decision making, aligned with the key milestones as set out above.

4.21. The London cancer implementation plan is ambitious in its target to improve quality of care across London and to save 1,000 lives and in the timescales set, with the expectation to have ICS established by next April and new commissioning arrangements in place for at least some cancer services. The five cancer networks across London and the London SCG are providing joint leadership for this work. The level of engagement by provider organisations and clinicians has been high. The emergence of two proposed ICSs for London is very exciting.

5. Conclusion

5.1. Improving cancer outcomes is a key priority both for NHS South East London as one of our top five major health challenges, and for London's NHS as a whole. The work of the Network to improve cancer outcomes is incorporated in the South East London Integrated Plan. This paper updates on progress being made in taking forward national *Improving Outcomes: A Strategy for Cancer* and the London Cancer Implementation Plan

5.2. The Boards are asked to note:

- Improving Outcomes: A Strategy for Cancer and the work being undertaken across South East London to improve outcomes and service quality in cancer services.

- The background, progress to date and next steps with regards to the London Review of Cancer Services

5.3. The Boards are asked to ensure that:

- The six borough Clinical Commissioning Committees Boards consider actions necessary at local level to support the delivery of improved outcomes for local people at risk of, and diagnosed with cancer.

- The Clinical Strategy Group reviews progress in developing cancer services across South East London, in particular the development of integrated systems of cancer care across London and the associated development of new approaches to the commissioning of services from Integrated Cancer Systems

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 15

PROPOSAL TO ESTABLISH A PHARMACEUTICAL APPLICATIONS PANEL

DIRECTOR RESPONSIBLE: David Sturgeon, Director of Primary Care

AUTHORS: Jill Webb, Assistant Director, lead for Community Pharmacy; Sally-Anne Kayes & David Long, Heads of Pharmacy & Optometry for LSL & BBG respectively

TO BE CONSIDERED BY: All Primary Care/Care Trusts

SUMMARY:
PCTs must have suitable arrangements in place to consider pharmacy applications they recieve under the NHS Pharmaceutical Services Regulations 2005 and its subsequent amendments. This paper sets out proposals for consistent decision making arrangements on behalf of the 6 PCT/CTs which make up NHS SE London.

KEY ISSUES:
The key issues in the paper are to determine:

- the appropriate delegated level of consideration of and decision making for pharmaceutical applications on behalf of NHS SE London 6 PCTs
- membership of The Pharmacy Panel, taking into account formal and informal guidance relating to the Regulations
- the requirements of The Panel members in order to mitigate the potential for appeal against decisions made

The cost of running The Panel should be contained within individual PCT budgets. It is not anticipated that there will be savings associated with streamlining arrangements form 6 to 1 Panel in that it is likely that The Panel will need to meet more frequently, and potentially for longer periods than would have been the case with 6; and proposed involvement of LINks representatives is likely to incur some cost.

Legal advice is not required at this stage.

INVOLVEMENT:
Primary Care Commissioning resources have been utilised in the production of the Terms of reference at Appendix 1.

RECOMMENDATIONS:
The Boards are asked to approve:-

1. The proposed configuration of and scope of responsibilities of a Panel (referred to in sections 5 & 6 of attached paper and set out in detail in Appendix 1) which will consider pharmacy applications received by the six PCTs under the NHS Pharmaceutical Services Regulations 2005 and its subsequent amendments
2. The list of applications under the above Regulations that may be delegated to officers of the Cluster, rather than being considered by the full Panel as detailed on page 8 (Appendix 1) of the paper
3. The proposed arrangements via the Joint Quality & Safety Subcommittee for reporting decisions of the Panel to the Boards, set out in section 6 of the paper
4. The proposed full membership of The Panel, referred to in section 7 of the paper and detailed on page 6 (Appendix 1)
5. A named non Executive Director to join The Panel

This will enable all PCT/CTs to operate under consistent decision making processes in so far as consideration of pharmaceutical applications it receives are concerned.

The establishment of a Panel to consider pharmaceutical applications is for the Board's urgent consideration given there are 2 applications which were previously submitted to PCTs which are should have already been reviewed in April, but have been put on hold pending formal authority to establish The Panel.

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NHS

South East London

Proposal to establish a Pharmaceutical Applications Panel

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1. Recommendations:

1.1 The SE London PCT/Care Trust Boards are asked to approve:-

- The proposed configuration of and scope of responsibilities of a Panel (referred to in sections 5 & 6 below and set out in detail in Appendix 1) which will consider pharmacy applications received by the six PCTs under the NHS Pharmaceutical Services Regulations 2005 and its subsequent amendments
- The list of applications under the above Regulations that may be delegated to officers of the Cluster, rather than being considered by the full Panel as detailed on page 8 (Appendix 1)
- The proposed arrangements via the Joint Quality & Safety Subcommittee for reporting decisions of The Panel to the Boards, set out in section 6 below
- The proposed full membership of the Panel, referred to in section 7 below and detailed in Appendix 1, together with a suitable non Executive Director nominee

2. Context

2.1 In April 2005 the NHS (Pharmaceutical Services) Regulations 2005 (referred to as the "Regulations" from now on) were introduced under the NHS Act 1977. These superseded previous Regulations introduced in 1987 and amended in 1992. Although they are commonly referred to as the **"Control of Entry Regulations"** they in fact regulate the provision of NHS pharmaceutical services, including applications to join the pharmaceutical list, to move premises from which services are provided, to change opening hours etc.

2.2 In January 2003 the Office of Fair Trading (OFT) published a report, which in effect called for the abolition of the then controls of a pharmacy dispensing NHS prescriptions. After a wide a lengthy consultation the government decided not to abolish the controls, but rather to modernise them and to also introduce some exemptions to them. The Regulations are part of a range of measures, including the Community Pharmacy Contractual Framework and Fitness to Practice requirements for pharmacists.

3. Background

3.1 Historically the responsibility for considering all applications has been slightly different in each of the PCTs. In some PCTs, officers were able to take some decisions; in others all applications were sent to the PCT's Panel. However in all of the PCTs new applications and "major" relocations were agreed by a Pharmacy Panel.

3.2 This paper sets out proposals for PCT/CTs in SE London to operate under consistent decision making processes in so far as consideration of pharmaceutical applications it receives are concerned

4. Types of Decision

4.1 There are essentially eight different types of application that a PCT may have to consider. These are:

- Applications to join the pharmaceutical list
- Minor relocations from persons already on a list
  - Under 500m
  - Over 500m
  - Cross boundary, both over and under 500m
- Change of ownership
- Change to services
- Change to opening hours (core hours)
- Preliminary Consent
- Applications exempt from necessary and expedient test
- Other applications

4.2 In addition, decisions about Local Pharmaceutical Services applications need to be considered, in accordance with LPS Regulations 2008.

4.3 How PCTs deals with these applications and come to a decision may vary depending on the type of application. Regulation 24(1) allows a PCT to determine the application as it sees fit. However there are some factors that should be taken into consideration when agreeing due processes for managing applications. These include:

- The timescales imposed by 2005 Regulations
- Right of appeal to the application and therefore risk if a decision is challenged
- Those that are decided purely on matter of fact
- Applications that require “consultation”
- Difficulty in reaching consensus of opinion

5. The Panel

5.1 Previously those decisions that required consultation, in accordance with the Regulations, were considered by the relevant Pharmaceutical Panel. For most PCTs, a sub-committee of the Board or PEC was used for this purpose. Panels were chaired by a Director or Non-Executive Director and also included the deputies to Primary Care Directors and other senior posts.

5.2 The only formal guidance that relates to the make-up of a Panel relates to oral hearings, where these are considered necessary. This suggests that a chairperson

should either have legal experience, or experience of similar such applications. A further recommendation is that a Panel should have a minimum of three persons; however this is NOT a requirement.

5.3 Regulation 24 (6) includes a list of those who are unable to take part in any decision. This list is prescriptive, and does not allow for the fact that a person may be on the Panel in a different capacity. **The list specifically excludes the following persons from taking part in the decision**:

- A person who provides or assists in providing pharmaceutical services under Part 2 of the Act.
- A person who is an LPS chemist.
- A person who holds a GMS contract, or is a legal and beneficial shareholder in, or director or company secretary of, a company which holds a GMS contract, or is employed or engaged by a GMS contractor.
- A person who is a PMS contractor, or is a legal and beneficial shareholder in, or director or company secretary of, a company which is a party to a PMS agreement, or is employed or engaged by a PMS contractor.
- A person who is an APMS contractor, or is an officer, trustee or other person concerned with the management of a company, society, voluntary organisation or any other body which is an APMS contractor, or is employed or engaged by an APMS contractor.
- A person who is employed or engaged by a Primary Care Trust for the purposes of providing primary medical services within a PCTMS practice.
- A person who is a party (other than a Primary Care Trust) to a pharmacy pilot scheme, or an officer or employee of such a person, or who provides or assists in providing local pharmaceutical services under a pharmacy pilot scheme.

5.4 **This in effect means that no person who acts as a community pharmacist or GP, in any capacity, in England (and probably Scotland and Wales) can be party to the making of a decision on ANY application under the 2005**. Such persons are able to give advice to any decision making Panel, but must not be seen to be part of the decision making. Hence if any persons are present to give professional advice to the Panel, they should withdraw before any vote on a decision is made. A declaration at the start of any Panel meeting to determine if any persons are excluded from the decision making process should be made. There are forms designed for this purpose.

5.5 The importance of 5.4 above is that if this guidance is not followed, a successful appeal or judicial review could be based on the fact that due process has not been followed and that inappropriate persons have been party to the decision making process.

6. Configuration and Scope of The Pharmacy Applications Panel

6.1 Taking into account the above information, the following proposals are made:

- The Panel is configured as the Pharmacy Applications Panel and henceforth considers applications under the Pharmaceutical Regulations 2005 on behalf of the six PCTs
- All Pharmaceutical Applications that require consultation are to be considered by the Pharmacy Applications Panel
- Decisions on some applications, which are not normally deemed controversial, are delegated to responsible Officers for reporting back at the next Pharmacy Applications Panel meeting
- Details of all relevant applications will be sent to the relevant BSU as part of the normal process of consultation and they will have the opportunity to comment on applications within the prescribed timescales
- Applications that do not have a consultation period, will be sent to the BSU prior to any decision so that the BSU will have the opportunity to comment, if they wish
- All members of the Pharmacy Applications Panel shall, at each and every meeting where it considers an application under the Pharmaceutical Regulations, declare if they are eligible to take part in making any decision
- All decisions of the Pharmacy Applications Panel shall be reported to the Joint Quality & Safety Subcommittee of the SE London Board

6.2 A more detailed exposition of the above proposed arrangements is set out in Appendix 1, proposed Terms of Reference of the Pharmacy Application Panel.

7. Membership of the Pharmacy Applications Panel

7.1 It is proposed that this should include a Non Executive Director, preferably with legal experience. The full proposed membership of and advisory arrangements for the Panel are set out in Appendix 1.

South East London

Appendix 1

TERMS OF REFERENCE FOR PHARMACY APPLICATIONS PANEL

Purpose of the Panel

To support the exercise of its obligations under the terms of the The National Health Service (Pharmaceutical Services) Regulations 2005 (the Regulations), NHS South East London has established a Pharmacy Applications Panel, henceforth called 'The Panel'.

The Panel will consider all matters that may be placed before PCTs within the meaning of the Regulations. In addition the Panel will receive follow-up reports following its decisions at earlier meetings and reports of decisions made by responsible officers.

Decision Making Process

All decisions made under these Regulations are quasi-judicial and are subject to the Principles of Natural Justice and the Humans Rights Act 1998 (Right to a Fair Trial).

The applicant, affected contractors or other relevant bodies (where specified) have a right of appeal against decisions of the Committee. Appeals are made to the NHS Litigation Authority Appeals Unit that has delegated powers from the Secretary of State.

Any failures in the processes and reasonableness of decisions made either by the Panel or more usually the NHS Litigation Authority are also open to Judicial Review. The decision making process are the responsibility of the PCTs.

Types of Decision

There are essentially eight different types of application that a PCT may have to consider, they may be full and/or outline applications to join the pharmaceutical list, this includes identical and overlapping applications where applicable:

- Applications to join the pharmaceutical list
- Minor relocations from persons already on a list
  - Under 500m
  - Over 500m
  - Cross boundary, both over and under 500m
- Change of ownership
- Change to services
- Change to opening hours (core hours)
- Preliminary Consent

- Applications exempt from necessary and expedient test
- Other applications

In addition, decisions about Local Pharmaceutical Services applications need to be considered, in accordance with LPS Regulations 2008.

All pharmaceutical applications that require consultation will be considered by The Panel.

Accountability

The Panel will report to the Joint Quality & Safety Subcommittee of the South East London Board on decisions that relate to BBG & LSL respectively.

Membership of The Panel

The full membership of The Panel will consist of:

- A Non Executive Director, preferably with legal experience.
- Director of Primary Care
- Assistant Director of Primary Care, SE London lead for Community Pharmacy
- Senior Primary Care Finance Lead
- A LINk representative[1] from one of the PCTs areas

A Chair person of the Pharmacy Applications Panel will be appointed by the membership at the first meeting

Membership of the Panel may be substituted if Panel members are on leave and a meeting is needed due to the timescales within the Pharmacy Regulations

Management Advice in relation to the Regulations will be provided by the Head of Pharmacy & Optometry LSL and/or the Head of Pharmacy & Optometry BBG

Professional Advice (which must withdraw before a decision is made) will be provided by the SE London Pharmacy Adviser or the SE London Cluster Chief Pharmacist

Contract & administrative support will be provided by appropriate officers within the Pharmacy & Optometry team

Quorum & Voting Rights

At least three members of The Panel (or their designated substitutes) must be present to form a Quorum one of which must be a non-executive Director.

[1] To avoid potential conflicts of interest: For any given meeting, the nominated LINk representative/organisation to which they belong may not be party to any decision making if their organisation has been consulted on an application prior to its formal consideration.

Voting rights are restricted to one vote for each full Panel member (or their designated substitutes).

A majority decision is acceptable, with the Chairman having a casting vote in the case of a tied position.

Frequency of Meetings

The Panel will be scheduled to meet on a monthly basis; meetings will be cancelled if they are not required.

It may not be necessary, where the decision is straightforward e.g. applications made under Regulation 13, to call a Panel meeting. In such cases the Chairman may, at their discretion, approve the decision being made through correspondence only.

In the event of the need for an emergency meeting at least two members must be present one of which must be a Director. Emergency decisions should only be made in extreme cases and the decision reported with full justification at the next full Panel meeting.

Declaration of Interest

At every meeting all Panel members will be required to declare any interest at the outset, which will then be recorded.

The Panel will need to consider the question of bias in this context as no decision taker must have a personal or financial interest in the outcome of the hearing. It is necessary therefore for any member of The Panel who might possibly feel they may be placed in a position where they may need to subsequently defend an allegation of bias to declare their interest at this stage. If necessary The Panel should declare bias if they think it is appropriate. A form will be produced for this purpose.

Guidelines in respect of the relevant principles of Administrative Law will be available at every Panel meeting to assist if further clarification with regard of declaration of interest should be required.

Agendas for, Supporting papers & Minutes of Meetings

An agenda together with supporting papers prepared by responsible NHS SE London Officers will normally be distributed to all Panel members no less than one week prior to the date of the meeting.

Minutes will be prepared and distributed to all attendees of a Panel meeting and substantive members of The Panel, normally within 2 working weeks following the meeting.

Delegated Decision Making Authority

PCT Boards have agreed that some decisions, which are not normally deemed controversial, can be made without the need to convene The Panel and these are delegated to responsible.

Delegated authority is limited to decisions that do not require consultation, including, but not definitively: -

- Minor relocations under 500m, where officers have assessed the application is within the same neighbourhood
- Change in ownership
- Change in hours
- Temporary suspension of Contracts in respective of issues such as closure due to refurbishment or leasing problems (not performance issues)
- Decisions where an application may need to be considered by way of an oral hearing. However, The Panel may also make this request if they have difficulty in making a decision on an application

All decisions made by responsible Officers will be reported to the next meeting of The Panel for information and ratification.

If a decision is made to hold an oral hearing, the oral hearing will be considered by the standing membership of The Panel.

A separate document is attached which details the scope of this delegation to officers.

South East London

SCOPE OF (RESPONSIBLE) PHARMACY OFFICER'S DELEGATED AUTHORITIES

Responsible officers have delegated authority to make decisions regarding certain types of pharmacy applications instead of these being taken to the Pharmacy Panel for applications.

The list of applications under the Pharmaceutical Regulations 2005 that may be delegated to officers of the Cluster, rather than being considered by the full Panel relate to decisions that do not require consultation, including, but not definitively:

- Minor relocations under 500m, where officers believe the application is within the same neighbourhood
- Change in ownership
- Change in hours
- Temporary suspension of contracts in respective of issues such as closure due to refurbishment or leasing problems (not performance issues)
- Decisions where an application may need to be considered by way of an oral hearing. However, the Panel may also make this request if they have difficulty in making a decision on an application

All decisions made by the officers will be reported to the next meeting of the Pharmacy Applications Panel and thus ratified.

If a decision is made to hold an oral hearing, the oral hearing will be considered by the standing membership of the Pharmacy Applications Panel.

Responsible Officers will need to ensure that any decisions taken are within the regulations and within the scope of the authority given.

Minor relocations under 500m

Officers will need to determine the neighbourhood in which the current pharmacy is located and ascertain if the new premises are within this location. The applicant should also be providing the same services and same hours in both premises. Applicants that fulfill these criteria should be automatically approved; applicants that do not should not be approved.

Change in ownership

Officers will need to determine that the new owner is an individual / individuals or corporate body that fulfils the terms of the Medicines Act and has provided the appropriate fitness to practice information to NHS South East London or if a corporate body this may be completed to its "Home" PCT. The applicant should also be providing the same services and same hours as the current pharmacy.

Change in hours

Officers will need to determine if the change is to the core or supplementary hours. Supplementary hours can be changed with 90 days notice. Changes to Core hours must be approved by the PCT. There are two types of pharmacies, most pharmacies have core hours of 40 hours per week only, the exception is those who have joined the list as an exempt pharmacy under Regulation 13 and

are required to remain open for 100 hours per week. Any changes to core hours must remain in line with either 40 hours or 100 hours. Changes to core hours will be made in line with current NHS South East London policies or the predecessor PCT's policies, if the former are not in place.

Temporary suspension of contracts

A temporary suspension in contract should only be given with at least 90 days notice in respective of issues such as closure due to refurbishment or leasing problems, as per the regulations (schedule 3, 22.5). However there are arrangements where a pharmacist is prevented by illness or other reasonable cause to allow a temporary closure with less than 90 days notice. A pharmacist may also make arrangements with another local provider of pharmaceutical services to cover services during the time they are closed.

Appeal letters

After decisions by either responsible officers or The Panel are made, applicants and/or objectors to the application, depending on the decision made, will have the right of appeal to the application. Appeals are made to the NHS Litigation Authority Appeals Unit, which has delegated powers from the Secretary of State to deal with such appeals.

Officers of NHS South East London will deal with such correspondence within the appropriate timescales drafting a response on behalf of NHS South East London. If there are any issues that are not able to be dealt with in this way they may be referred back to The Panel or The Panel's Chairman.

Details of all appeals will be sent to the following Panel meeting for information.

LPS designations

Where LPS designations are made in any area within NHS South East London, they will need to be reviewed within 6 months of the original designation. The Regulations give timescales for how long an LPS designation can be in place and the timescales for reviews of the designations.

Officers of NHS South East London should ensure that they review all LPS designations within the relevant timescales and make recommendations to either renew or remove an LPS designation. This should be given to The Panel who will be responsible for the final decision on designations.

Accountability

Decisions of responsible officers will be reported to the next Panel meeting.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 16

ENCLOSURE 16

BEXLEY CARE TRUST
TO DISCUSS PROGRESS ON THE QMS CAMPUS OUTLINE PROPOSAL

DIRECTOR RESPONSIBLE: Dr Joanne Medhurst, Bexley Managing Director, SRO Bexley Health and Wellbeing Campus

AUTHOR: Dr Joanne Medhurst, Bexley Managing Director, Senior Reporting Officer Bexley Health and Wellbeing Campus

TO BE CONSIDERED BY:

- Bexley Care Trust
- Bromley Primary Care Trust
- Greenwich Teaching Primary Care Trust

Board approval of this proposal allows local stakeholders to begin a series of projects that will ensure the on-going sustainability of health and wellbeing provision on the QMS site. This mitigates for local residents the loss of an acute DGH as identified through the recent NHSL review of the 'A Picture of Health' (APOH) which was endorsed by the Secretary of State. Service changes linked to APOH are now well established as SLHT consolidates its service provision. Community changes are required to occur in a similar time frame to deliver local services in well maintained infra- structure.

SUMMARY

Bexley GPs, together with the London Borough of Bexley, now have the ambition to establish a Health and Wellbeing Campus at Queen Marys, retaining and refreshing some existing services and delivering our vision progressively over the next 2-3 years.

Our aim is to provide a blend of primary, community and hospital services, networked with GP local surgeries, which will better meet the health needs of the local community and address today's challenges of an ageing population and the rising incidence of long term conditions. In doing this we would need to ensure that the primary care and community care

elements of the Campus portfolio form part of a coherent and balanced set of services for the whole of Bexley and make sense for neighbouring boroughs.

We see the Campus enabling the co-location of health and wellbeing services in a way which simplifies access, offers improved choices of local services, would allow for the repatriation of care for patients who require specialist care for conditions such as stroke, heart failure or cancer (for example we believe up to 80% of cancer care which is currently delivered at other locations could be provided on the campus), provides a common front door for patients requiring a range of services, improves convenience and helps local GPs to ensure their patients remain as healthy and independent as possible.

We envisage that these services would be specified by local commissioners, with patient input, and delivered by a range of NHS, Local authority, independent and voluntary sector providers. Collaboration with existing providers at the site – in particular South London Healthcare Trust (SLHT) and Oxleas NHS Foundation Trust – would be key to successful transition over the coming months, and we have received their commitment to working for the best outcome for the local population.

Board approval of this proposal allows local stakeholders to begin a series of projects that will ensure the on-going sustainability of health and wellbeing provision on the QMS site. This mitigates for local residents the loss of an acute DGH as identified through the recent NHSL review of the 'A Picture of Health' (APOH) which was endorsed by the Secretary of State. Service changes linked to APOH are now well established as SLHT consolidates its service provision. Community changes are required to occur in a similar time frame to deliver local services in well maintained infrastructure.

KEY ISSUES:

Background to the issue

A review of acute care across South East London recommended changes to the portfolio of services to be provided from Queen Mary's Hospital in Sidcup (QMS). It was proposed that QMS would specialise in planned surgery, offer a 24-hour Urgent Care Centre and become a base for community healthcare services.

The lead commissioning GPs across Bromley, Bexley, and Greenwich came together to review these proposals against the four tests set out by the Chief Executive of the NHS. These recommendations were presented to NHS London and they gave a clear indication that the development of a Health Campus at QMS would be a key mitigating action that helped balanced the service change and would keep appropriate services locally.

Subsequently, the Secretary of State asked for greater clarity on the proposals for QMS as a base for community health services, and NHS London in turn asked local commissioners (Bexley Clinical Cabinet and the London Borough of Bexley in consultation with Greenwich and Bromley boroughs) to collaborate on an outline proposal for a Health and Wellbeing Campus on the site of QMS.

The full proposal was sent to NHSL on the 31st March 2011 after being endorsed by the Cluster Accountable Officer.

Summary of issues
The proposal sets out a portfolio of services aligned to health needs within the borough of Bexley and especially South Bexley. They have been categorised into 4 areas which are expanded in the attached summary.

- Established and Planned Services – contains those services which are already operating on the site or form part of the APOH plan
- Proposed Required Services – contains additional services which we consider essential in serving the needs of the local population and driving footfall to the campus
- Potential Services – represents broader opportunities to bring together services and teams
- Broader and Speculative Services – represents useful and desirable additions which have not yet been fully explored

Any risks, and actions and mitigations taken to minimise these

Risk	**Action**
The QMS site is substantial and now very underused. Large sections of the buildings are empty. Staff morale is suffering. There is a risk that the site begins to decay quickly	Action; Look for ways to reinvigorate the site quickly, whether by relocating services or staff accommodation.
A decision will be required on site ownership in order for a full Campus implementation plan to be feasibly developed: • Refurbishment works will be needed • Before committing, providers will need to know the commercial arrangements for locating services on Campus property.	NHS London has undertaken to: • provide guidance on what forms of organisation could take on ownership • prevent SLHT from blocking the right solution
It is assumed that ownership will transfer from SLHT, but: • the rules for which organisation ownership it could transfer to are not clear • the timetable for such a transfer is unknown and there is potential for implementation to be held up	There could be a temporary arrangement with SLHT to move low fixed cost services into the Campus for a fair rent.
Will the implementation of the Campus proposals be affordable from a capital	Work needed on: • Where NHS services or staff could be

ENCLOSURE 16

perspective? Will the service portfolio proposed for the Campus be affordable from a revenue perspective?	relocated, what capital could be released from existing estate? Action -an inventory of all fixed/committed and core services proposed – are they: • existing and flat/growing/reducing demand? • existing, with opportunity to reduce cost of supply? • new, with agreed funding? • new, not yet funded? • Feasibility work on LTC management services/ admissions avoidance

Finance Considerations
An Outline Business Case is required to fully analyze the impact of this proposal.
This is a programme of work which will require additional resource to get the current proposal into an OBC format.

There will be additional investment required to support Bexley BSU. A proposal was developed following a mapping exercise that was carried out against each of the discrete projects within the programme and which identified the skill mix, time and seniority required for that elements' delivery from May until December. There was an attempt also to separate work that was identified as 'core' to the BSU- ie it was part of QIPP, Operating framework, Prospectus etc. and that which was clearly additional and was a direct consequence of the campus proposal.

The summary forms the basis of the options analysis –see appendix B.

Option 2 is likely to deliver the most successful outcome. If this is adopted 2 things become clear.

1. External programme management support will be required – a reasonable estimate indicates in the region of 400k. This covers wider programme management plus external technical support such as quantity surveying, transport analysis etc.

2. Significant additional work will be required of the local commissioners, predominantly health. The separating out of the different elements has inevitably over emphasized some of the workload which will in some areas become composite but nevertheless the exercise has highlighted some key gaps. These are in finance, commissioning and contracting support and project management.

Legal considerations – None at this stage

Staffing & Equalities considerations not undertaken at this preliminary stage

INVOLVEMENT:
COMMITTEE INVOLVEMENT: Bexley GPCC and Bexley Health and Wellbeing Board ENDORSED by Oxleas and SLHT Chief Executives
PUBLIC AND USER INVOLVEMENT: LINKS have been briefed and Bexley Health & Overview Scrutiny Committee
IMPACT ASSESSMENT: None undertaken at this stage

APPENDIX A
Bexley Heath and Wellbeing Campus' Executive summary
APPENDIX B
Proposal for investment to support programme of work.

RECOMMENDATIONS:
The Boards are asked to:-

1. To NOTE the content of the Bexley Health and Wellbeing Campus
2. To NOTE the wide stakeholder agreement across Bexley borough
3. To AGREE the future development of the Bexley Health and Wellbeing Campus Outline Business Case.
4. TO AGREE funding to take forward the development of the Bexley Health and Wellbeing Campus

DIRECTORS CONTRACT:

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AUTHOR CONTRACT:

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Bexley Health and Wellbeing Campus

Executive Summary

Proposals are Subject to Approval

Dated: 05/04/2011

ENCLOSURE 16

An outline proposal, developed jointly by Bexley Care Trust and the London Borough of Bexley, for a Health and Wellbeing Campus to be developed on the site of Queen Mary's Hospital in Sidcup was submitted to NHS London on 31 March 2011.

This document provides a summary of the proposals and is intended to inform stakeholders about the plans for the hospital site. It also includes a copy of a statement of intent, signed by Bexley Care Trust, the London Borough of Bexley, South London NHS Hospitals Trust, and Oxleas NHS Foundation Trust, which shows that the four organisations are committed to delivering benefits to the local population through the revitalisation of the Queen Mary's Hospital site in Sidcup.

A programme of more detailed work to enact the proposals will now be undertaken, including a range of engagement activities with local people and stakeholders.

Executive Summary

Queen Marys Hospital in Sidcup has been delivering health services to the people of Bexley and neighbouring boroughs for nearly a century. It is a public asset of importance to the local community and is critical to improving health outcomes for many of our residents.

Bexley GPs, together with the London Borough of Bexley, now have the ambition to establish a Health and Wellbeing Campus at Queen Marys, retaining and refreshing some existing services and delivering our vision progressively over the next 2-3 years.

Our aim is to provide a blend of primary, community and hospital services, networked with GP local surgeries, which will better meet the health needs of the local community and address today's challenges of an ageing population and the rising incidence of long term conditions. In doing this we would need to ensure that the primary care and community care elements of the Campus portfolio form part of a coherent and balanced set of services for the whole of Bexley and make sense for neighbouring boroughs.

We see the Campus enabling the co-location of health and wellbeing services in way which simplifies access, offers improved choices of local services, would allow for the repatriation of care for patients who require specialist care for conditions such as stroke, heart failure or cancer (for example we believe up to 80% of cancer care which is currently delivered at other locations could be provided on the campus), provides a common front door for patients requiring a range of services, improves convenience and helps local GPs to ensure their patients remain as healthy and independent as possible.

We envisage that these services would be specified by local commissioners, with patient input, and delivered by a range of NHS, Local authority, independent and voluntary sector providers. Collaboration with existing providers at the site – in particular South London Healthcare Trust (SLHT) and Oxleas NHS Foundation Trust – would be key to successful transition over the coming months, and we have received their commitment to working for the best outcome for the local population.

We have also engaged with, and received support from GP and Local Authority colleagues in Bromley and Greenwich. Our local stakeholder reference group has been briefed on our thinking and is keen to play its part in the further definition of Campus services and facilities. Our thinking also draws on a wide-ranging survey on local people's views on healthcare in their local area, but further involvement of resident and patient groups will be a key part of our plan as we proceed.

In developing our ambition for a Health and Wellbeing Campus at QMS, we have been mindful of the tight financial constraints within which Bexley's local health and social care system will have to operate. When we do our detailed commissioning work over the coming months we will need to confirm that our proposed Campus service portfolio is affordable, particularly where services are part funded from savings made through redesign.

While endeavouring to make the most economical use of existing space, we anticipate there would be a limited programme of building and some remodelling and refurbishment of existing space. Bexley commissioners have no capital, and we would need assistance in identifying and accessing NHS or wider sources of capital. It may be possible, working with partners, to rationalise estate across the borough of Bexley in a way that would free up local capital, which would then be recycled into the Campus site and directly benefit Bexley residents.

<u>The Health Needs of the Bexley population and the South of the Borough</u>

Bexley is an outer London borough which includes 11 areas featuring in the most deprived 10% of the country.

The population of Bexley and Bromley boroughs is expected to grow at a rate of about 0.6% across the next twenty years. In Bexley, the largest increase is expected in people aged 65-69. The increase in elderly population will cause higher risk and incidence of falls, dementia, and long term conditions. Bexley has a relatively high incidence of all cancers, prevalence of stroke in Bexley is significantly higher than the London average, and recent estimates show over 12,000 people with diabetes and 38,000 at risk with pre-diabetes.

The Campus would be located at the Southern edge of the borough, where there is a preponderance of elderly people. Approximately 24% of the residents of the six wards in the South of the borough are 65 or older.

Proposed Campus Service Portfolio

In addition to the urgent and acute services recently recommended for the QMS site by local GPs, and existing inpatient mental health services, we propose that services from the Campus prioritise care of the elderly and the management of long term conditions and promote the avoidance of emergency hospital admissions. These would be in line with Bexley GPs' first commissioning prospectus.

The provision of an urgent care centre means we would not need to move existing local GP practices onto the Campus. Instead we are thinking that local GPs could collectively offer an extended service for better care of the elderly and patients with LTC with assistance from specialists in geriatrics and individual conditions, backed up by a comprehensive range of diagnostic equipment. Patients would benefit from holistic care planning, initial and regular health checks, prescribing and referral to co-located community services, together with a high quality shared facility for group consultations and education and training for patients and carers, enabling better self-management. In addition, patients would receive reablement and rehabilitation assistance and have access to a community equipment store and advice on wellness, benefits, legal issues and local services.

Our ambition is that cancer patients should have access to radio- and chemotherapy at the Campus, rather than having to travel into London, and to continue to offer haemodialysis for kidney patients.

For children, there is an opportunity to co-locate existing services for children with developmental problems into a Child Development Centre alongside the Paediatric Ambulatory Unit and midwifery consultation.

Overall, we aim for the Campus to provide a common front door such that patients who require a range of services are supported in navigating through the system in an efficient and straightforward way. We are also considering opportunities to consolidate workspace for health and social care commissioner and provider teams at the Campus in order to improve effectiveness and share and release fixed assets in line with Total Place thinking.

Next Steps

Subject to a positive response from NHS London to our proposals and the availability of the external assistance needed, we plan to proceed with the following priority actions:

- Set up steering and working group arrangements for the Campus programme, reporting in to respective NHS and Local authority governance
- Establish a formal communications and engagement programme to co-ordinate the involvement of, and information provided to existing staff, Bexley residents and stakeholders
- Identify services and/or teams which could be established quickly at the Campus to reinvigorate the site and create momentum
- Develop an overall delivery plan and financial case and initiate a rolling programme of commissioning sequenced in line with agreed priorities.

Statement of Intent

Queen Mary's Hospital in Sidcup has been delivering health services to the people of Bexley and neighbouring boroughs for nearly a century. The hospital is a public asset and its services are highly valued by local people. We know that some of the existing services need to be redesigned to meet predicted health needs and changes in the local population structure over the next decade. Bexley Care Trust and its GP commissioners have therefore worked with the London Borough of Bexley and local providers to produce an outline concept for the Bexley Health and Wellbeing Campus, to be delivered from QMH. This aims to provide a blend of primary, community and hospital services, networked with local GP's.

Benefits to residents will include improved, streamlined, more effective delivery of care, which is better integrated with services delivered by the local authority and voluntary sector providers. Services will, in the main, focus on those relevant to the local elderly population, and those with long term conditions such as cancer and diabetes. The campus will ensure these essential services continue to be delivered locally, minimising travel time for residents and service users.

Collaboration by the four key stakeholder organisations - the London Borough of Bexley, Bexley Care Trust, South London Healthcare NHS Trust and Oxleas NHS Foundation Trust – should help to deliver efficiencies in these tough economic times, whilst continuing to provide high quality services at the campus.

To ensure the campus concept is delivered, each organisation agrees to the following steps:

- The establishment, by mid April, of a system level project steering group which will direct the overall campus programme and agree the following:-
    - Working to achieve benefits for the residents of the London Borough of Bexley
    - Contributing to and supporting the strategic direction of the Bexley Health and Wellbeing Campus
    - Contributing openly, transparently, and without prejudice to the campus programme
    - Sharing critical information in a timely manner
    - Sharing knowledge and expertise to help the campus programme achieve its goals swiftly and efficiently
    - Aligning and coordinating organisational processes to deliver swift decision making

- Each organisation will collaborate in a joint estates planning exercise across the whole of the borough.

- Each organisation will participate in a coordinated communications and engagement plan.

- Participating organisations will prioritise this piece of work including the use of in house expertise as required to deliver the project in a timely fashion

- Participating organisations will agree to work through difficult and potentially conflicting issues and will work towards the common outcome that is set out in the strategic vision.

- Each organisation will agree to consider options concerning resource allocation and estate utilisation and to openly debate the best solution for the health system including considering the option of a joint resource fund

……
Dr Joanne Medhurst
Bexley Care Trust

……..
Dr Chris Streather
South London Healthcare
NHS Trust

……
Pamela Creaven
Bexley Care Trust

……
Mr Stephen Firn
Oxleas NHS Foundation Trust

……
Mr Will Tuckley
London Borough of Bexley

Date: 31 March 2011

ENCLOSURE 16

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 17

BEXLEY CARE TRUST
BUSINESS CARE AND TRANSFER OF £2.4 MILLION TO THE LOCAL AUTHORITY FOR SOCIAL CARE

DIRECTOR RESPONSIBLE: Simon Robbins, Chief Executive, NHS South East London

AUTHOR: Keith Wood, Deputy Chair Bexley Care Trust

TO BE CONSIDERED BY: Bexley Care Trust Board

SUMMARY:
The attached Business Case for 2011/12 NHS Funding for Social Care has been approved by the Bexley Clinical Cabinet Chair and supported by the Joint Managing Directors of the Bexley BSU.

It should be noted that this approval identifies that KPIs still need to be fully populated & that robust monitoring of performance is required. The Bexley Care Trust Board now needs to delegate authority to the NHS South East London Chief Executive and Director of Finance to finalise & sign the Memorandum of Agreement Section 256 National Health Service Act 2006 Transfer of Social Care and Health Funds between Bexley Care Trust and Bexley Council in order to effect the transfer of funds.

KEY ISSUES:
As noted in the attached Chair's Action paperwork.

INVOLVEMENT:
As noted in the attached Chair's Action paperwork.

ENCLOSURE 17

RECOMMENDATIONS:
The board (s) is asked to:-

- Ratify Chair's Action for the business case and transfer of £2.4 million to the Local Authority for Social Care.

DIRECTORS CONTACT:
Name: Simon Robbins
E-Mail: simon.robbins1@nhs.net
Telephone: 020 30494292

AUTHOR CONTACT:
Name: Keith Wood
Telephone: 020 8298 6255

NHS

South East London

CHAIRMAN'S ACTION

This form should be completed when the Chairman is asked to take emergency action under the provision of Bexley Care Trust's Standing Order 5.2.

When complete the form should be passed to the Corporate Office Manager to ensure that the action taken is reported to the next formal meeting of the NHS South East London Board Meeting.

Action required:
The attached Business Case for 2011/12 NHS Funding for Social Care has been approved by the Bexley Clinical Cabinet Chair and supported by the Joint Managing Directors of the Bexley BSU. It should be noted that this approval identifies that KPIs still need to be fully populated & that robust monitoring of performance is required. The Bexley Care Trust Board now needs to delegate authority to the NHS South East London Chief Executive and Director of Finance to finalise & sign the Memorandum of Agreement Section 256 National Health Service Act 2006 Transfer of Social Care and Health Funds between Bexley Care Trust and Bexley Council in order to effect the transfer of funds.

Reason for urgency:
Board approval needed before the next Public Board Meeting scheduled for 19 May 2011.

Agreed by the Chairman:
Caroline Hewitt has given Keith Wood – Bexley Care Trust Vice Chair delegation to sign Chair's Action in her absence

Keith Wood Signed:. …Date: 20.04.11

Agreed by two Non Executive Directors:

Paul Cutler Signed:..... ..... Date: 20.04.11

Chris Ball Signed:... … Date: 20.04.11

Agreed by the Chief Executive:

Simon Robbins Signed:..... Date: 20.4.11

ENCLOSURE 17

Bexley NHS Care Trust LONDON BOROUGH OF BEXLEY	NHS Funding for Social Care 2011/12	**Ref:** **Current Stage:** *In Development* **Author:** *Sue Robinson and Dave Holman*

Proposal:	NHS Funding for Social Care 2011/12
Document Reference:	
Version:	0.1
Issue Status:	FINAL DRAFT
Date Last Updated:	08/04/11
File Reference:	
Author:	Dave Holman and Sue Robinson
Directorate:	Bexley Care Trust and London Borough of Bexley

	NHS Funding for Social Care 2011/12	**Ref:** **Current Stage:** *In Development* **Author:** *Sue Robinson and Dave Holman*

Bexley NHS Care Trust

LONDON BOROUGH OF BEXLEY

Executive Summary

The 2010 Spending Review has allocated £2 billion to the NHS by 2014/15 to support the delivery of social care. For 2011/12 Bexley Care Trust is receiving 2.4 million into its baseline allocation. This case outlines the plans to agree and allocate the funding, taking into account local affordability. This fits with the BCT and LBB strategies of providing care for patients closer to their home, reducing unnecessary hospital admissions and reducing lengths of stay.

The proposal gives an overview of plans that have been developed to support social care which also benefits health and identifies health related outcomes. These schemes focus on mainly supporting the existing social care services and where new schemes are being devised and tested we are aiming to improve an integrated approach to care and provide increased multi disciplinary functionality within services which will enable patients to live more independently.

Background and Framework

Finance was allocated on a national basis across all PCT's. In 2010/11 the allocation was used immediately to respond to pressures this winter. The allocations are outlined in '2011/12 NHS Operating Framework ' - published 15th December 2010. Two further announcements were made by Secretary of State for Health on 5th October 2010 this was an announcement for a further £70m for reablement and as detailed in LAC(2010)6 and on 4th January 2011 a further £162m for winter pressures

Plans have been agreed between Bexley Care Trust , South London Health - Care Trust and London Borough of Bexley to allocate the money. A key element of Government policy is to increase integration between Health and Social Care as laid out in the White Paper Equity and Excellence 'Liberating the NHS'. The Government has made additional funds available through PCT allocations to deliver improvements in two key areas:

- Increase integration between Health and Social Care and improve outcomes and deliver efficiencies against agreed shared agendas.
- Build on reablement services locally and enable the NHS to take forward their new responsibilities in April 2011 for patients first 30 days at home after hospital discharge.

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Funds will be spent on helping people to leave hospital more quickly, get settled back at home with the support they need, and prevent unnecessary admissions to hospital. Examples of the services that could be invested in rapidly are set out below. This is not an exhaustive list but represents an outline as set out in more detail in this proposal.

- More capacity for home care support, investment in equipment, adaptations and Telecare.
- Investment in crisis response teams and other preventative services to avoid unnecessary admissions to hospital.
- Further investment in re-ablement and rehabilitation services and reduce the need for ongoing care.
- Additional short term residential places or respite and intermediate care.

PCTs will transfer this funding via an agreement under Section 256 NHS Act 2006 to local authorities for spending on social care services to benefit health and to improve overall health and social care outcomes. It is anticipated Local Authorities and PCTs will take a consistent approach to the transfer of funding. Agreements for 2011/12 should be completed as soon as possible with the money being transferred preferably at the start of the 2011/12 financial year.

Bexley Care Trust and The Council have developed plans based on the four separate funding streams using the funding within the criteria set by the DoH. A Section 256 is being completed to arrange transfer of the funding allocation. The plans incorporate a wide range of services to support timely hospital discharge and provision to prevent inappropriate admission or re admission to hospital . The detailed plans fall within the following areas:

- A range of assessment related and specialist staff working within Care pathway navigation between the acute environment and the community to provide a multidisciplinary response to patients at risk of admission or readmission to hospital. A range of rehabilitation related staff to promote reablement services and care arrangements and to support the increase in residential rehabilitation bed capacity

- The commissioning of residential rehabilitation beds to increase capacity in care provision for patients who require longer term rehabilitation provision. This type of care is beneficial for patients who have had a period of intensive rehabilitation and require a longer period to regain their full potential.

- The commissioning of enablement home care including 24hr community home care provision to enable people to return to their home with continued support and rehabilitation process following an acute period of care

- The commissioning of a range of equipment for daily living , including Telecare equipment, extending options for patients wishing to return home from hospital who may otherwise have had to consider long term care

- The maintaining of a range of social care provision that supports health and social care related outcomes, eg Learning disabilities complex day care.

The key benefits of the plans are;

- Anticipated reduction of inappropriate admissions/readmissions to hospital as patients undergo support and reablement through a multi-disciplinary planned programme .

- Ability to escalate packages of support to prevent inappropriate admissions/readmission to hospital through the extension of Care Navigation in the community.

- Improved case management approach for patients during the reablement phase and ensuring longer term support plan in place following reablement if needed .

- Provision of social care services to improve overall health and social care outcomes by ensuring a joint and co-ordinated approach to heath and well being

- Increased numbers of patients leaving hospital in a timely manner

- Alleviation of Winter pressures on the whole system across health and social care and including emergency services.

	NHS Funding for Social Care 2011/12	**Ref:** **Current Stage:** *In Development* **Author:** *Sue Robinson and Dave Holman*

Bexley NHS Care Trust

LONDON BOROUGH OF BEXLEY

Agreements have been reached to transfer the allocated funds from Bexley Care Trust to the council through a section 256 to enable the delivery of the new provision outlined above. These plans are subject to ratification at the Shadow Health and Well Being Board and through joint commissioning arrangements. and approval via the Cluster Board. Further agreement of future care pathways from the acute environment are required to prepare for 2012 when the first 30 days post discharge responsibility will be with SLHT.

Proposed Solution and Expected Quality Outcomes

Bexley Care Trust and The Council have developed plans based on the four separate funding streams using the funding within the criteria set by the DoH. The plans incorporate a wide range of services to support timely hospital discharge and provision to prevent inappropriate admission or re admission to hospital . The detailed plan for the 2.4 million 2011/12 Social care allocation plan is made up of the following areas:

1. **Locum Social Worker and Social Work Assistants posts** – These staff will be deployed within Care Central to enable earlier intervention for patients in crisis in the community and at risk of inappropriate hospital admission. **Outcome –** Reduced length of stay to enhance patient well being, safe, timely discharge.

2. **Occupational Therapy Support** – This locum will provide immediate assessments and response to patients in crisis within the community. They will form part of an enhanced multi disciplinary approach for Care Central. **Outcome -** To improve early assessment of needs re maintaining independent living through provision of OT related equipment

3. **Occupational Therapy Support** – This locum will support patients with medium to long care conditions of disabilities working within the Independent Living Teams. **Outcome –** Increased capacity will reduce waits in this area and improve early assessment of needs re maintaining independent living through provision of OT related equipment

4. **Social work assistants posts** – These posts support assessment related work and carers to enhance discharge processes both in the community and acute to prevent hospital admissions and re admissions **Outcome -** Reduced length of stay to enhance patient well being, safe, timely discharge and focus

on preventative assessment and care provision in the community

5. **Out of Hours and Weekend discharge work** – This resource will support the local acute trusts with discharge plans, enabling discharge planning to continue 7 days a week. **Outcome** – Safe and timely discharge over a 7 day 24 period during Winter timeframe as defined by DoH.

6. **Locum Stroke OT and OPMHN Dementia SW Locum** – Posts to assist with hospital discharge and community support focussing on Stroke provision and Older Peoples mental health .**Outcome –** To improve independent skills for Stroke patients reducing care provision, and to support discharge activity in a timely manner from Oxleas in patient dementia provision for patients with dementia

7. **Extension of the 24 hr care Enhanced Care** – Enhanced care has been used by LBB for a number of years to provide short episodes of intensive domiciliary support to people in the community who are at risk of inappropriate hospital admission or a carer crisis. Potential service users are assessed by a Social Worker. **Outcome** – Reduction in in appropriate hospital admissions and residential/nursing bed capacity

8. **Home Care hours for hospital discharge**– to enable hospital discharge New hospital discharge case will be identified, this care will enable patients to be discharged in a timely way. New provision to 180 new cases identified as needing care packages to prevent an inappropriate hospital admission. **Outcome –** Improved capacity for hospital discharge , reduction in length

9. **Home Care hours for prevention of hospital admission** - New provision to 180 new cases identified as needing care packages to prevent an inappropriate hospital admission. **Outcome –** Improved capacity for hospital prevention of hospital admission, reduction in inappropriate hospital presentations.

10. **Residential / nursing capacity for hospital discharge** - It has been identified that there is the need to maintain and develop bed capacity to enable the transfer of hospital discharge cases that require places in residential or nursing homes. **Outcome** - To speed up discharge through the provision of choice in the residential and nursing sector

11. **Emergency residential / nursing admission** – This will enable patients to

be directly admitted into residential or nursing care from the community in response to a crisis**. Outcome -** To maintain existing emergency respite care provision

12. **Linkline and Telecare** – The use of Telecare linked with Telemedicine to support people with short or long term health conditions at home **Outcome** – Enhances independent living by enabling patients to remain in their own homes through provision of Telecare adaptive technology

13. **Equipment** – Provision to expand joint equipment store in response to additional demands for equipment for people with long term health related disability conditions **Outcome –** Maintaining independence skills in the community.

14. **Commissioning/Brokerage staff** – Staff to support purchasing of care arrangements following care assessments **Outcome** – Care provision provided to enable patients to remain in own homes.

15. **LD Provision** - Contribution to maintain existing LD services that meet the additional costs in this area due to demographics and increase in long term conditions and complex needs clients who receive health support – **Outcome** Continue to meet the needs of this client group through a range of multidisciplinary care provision.

16. **Speech and Language Therapy** – To maintain the current joint children's community speech and language service. **Outcome -** to improve children's communication needs.

17. **Continuing Health Care** - To maintain and enhance CHC capacity through the provision of new assessment related staff. **Outcome** – Qualitative assessments that define actual need leading to agreement of relevant funding streams.

18. **Residential and Nursing Care** – To maintain the provision of long term residential and nursing home capacity to match demographic trends and potential increase in discharge activity. **Outcome** – Care capacity to meet the increasing needs of older people.

19. **Preventative day care** – contribution to continued provision of day care including clients with Long term conditions and complex learning Disability

day care needs. **Outcome** – appropriate community based provision to support independent living and support carers.

20. **Handyman scheme** – New funding to support Handyman scheme to facilitate hospital discharges through the provision of minor adaptations linked to falls prevention **Outcome -** Increased hospital discharge and improved care provision in patients own homes

21. **Children's Transition –** A range of new and existing provision for children including transition workers, special education needs, therapy interventions and health prevention eg obesity **Outcome** - Improving children's lives through a range of care provision and capacity

22. **Safeguarding** – Provision of new staff to enhance capacity within the Safeguarding framework including focussed work with care providers and acute colleagues **Outcome** – Prevention of harm and abuse for vulnerable clients in Bexley and complete investigations where abuse has occurred

23. **Community care management** – Provision of new staff to provide assessment related work in the community to enhance home care support **Outcome** – Timely assessment related work to prevent deterioration of needs through care provision

	NHS Funding for Social Care 2011/12	**Ref:** **Current Stage:** *In Development* **Author:** *Sue Robinson and Dave Holman*

Bexley NHS Care Trust

LONDON BOROUGH OF BEXLEY

Spending Plan

NHS FUNDING FOR SOCIAL CARE 2011/12

£2,411,000

SPENDING PROPOSALS

No.	TOTAL	MAINTAIN EXISTING	SERVICE AREA	NEW	COMMENTS
1	60		Locum SW Care Central / Hospital Discharge	60	2 add. SW staff at front door-community &hospital -rapid assess and response
2	40		OT in Care Central	40	OT to provide immediate assess and response - crises and urgent health related conditions building on previous business case provision
3	20		OT Assessment	20	Agency spot purchase OT med/long term health condition/disability working with ILT team
4	76	24	SWA Capacity LTC	52	3 additional Social Care assts supporting people with medium /long term health related conditions in community incl. preventative (2 new and 1 existing post maintained)

5	5	5	Out of hours / weekend discharge and assessment		SWs working weekends to support hospital discharges - winter months Maintain provision of £5,000 for winter 2012 commencing Nov 2011
6	95		Staffing to avoid delays in assessments and to facilitate hospital discharge for clients into the community etc.	95	Locum Stroke OT to assist hospital discharge and community Locum SW to OPMHN community team to support hospital discharge from Oxleas in patient Camden and Leyton wards
7	25	25	Enhanced home care		Agency purchased care - urgent and 24 hour response to health related crises - short term - prevention of emergency admissions to res. Care. 2,000 hours of home care provided, sustaining existing service.
8	94	34	Home care hours for hospital discharge	60	Based on 180 new hospital discharge cases in the quarter x 6 weeks x 7 hour care package x £12.35 = £94,000 of which £34,000 sustaining existing service
9	94	34	Home care hours for prevention of hospital admission	60	As above - possible £94,000
10	322	110	Residential / nursing home capacity for hospital discharge	212	90 new hospital discharge cases x 6 weeks x £600 cost =£322,000 of which £110,000 sustaining existing service
11	80	80	Emergency residential / nursing admissions		Admissions from the community in response to crisis/emergency to ensure safe care/support £80,000 maintaining existing service, providing 140 weeks of care

12	70		Linkline and telecare / telemedicine	70	Use of telecare linked with telemedicine to support people with short or long term health conditions at home Current unit costs are £15 each unit = 466 new cases
13	100	50	Equipment	50	Provision to expand joint store in response to additional demands for equipment for people with long term health related conditions/disability
14	55	25	Commissioning / Brokerage Teams staffing input	30	Commissioning/arrangement of community or residential services post discharge to meet care needs £30,000 locum new costs; £25,000 sustaining existing posts
15	200	200	LD demographics		Contribution to maintaining existing services that meet the additional demographic costs people with LD incl. with health conditions by council of £500,000, this will include complex need clients who receive social care provision and health support through multi discipline approach. Equivalent to 3.5 long-term specialist residential placements.
16	100		Speech and Language Therapy (SALT)	100	To maintain current joint childrens community speech and language service to meet assessed communication difficulties
17	60	40	CHC co-ordinator and add. Staff	20	Support Care Trust CHC processes for all CHC frameworks including LD assessments this will include provision a FTE post
	200	200	residential and home care capacity to match demographic trends and increased discharge activity		Contribution to additional costs for council to meet increasing needs of older people incl. with dementia and nursing and long term conditions and to reflect the potential increase in demand through more effective discharge processes and capacity. Funds

18					additional 100 hours of home care per week and 6 long-term residential placements.
19	55	55	Contribution to preventative day care and transport costs		Contribution to service costs this will include clients with long term conditions and health conditions eg LD complex needs day care
20	35		Handyman service	35	New funding for handy man service to replace 50% of loss of CLG grant; work to enable hospital discharge = 380 hospital discharges based on current costs
21	540	225	Children's / Transition	315	OT in Children's services to support hospital discharge, CAMHS for children linked to Bexley GP's, 2 x transition workers in disability team 3 x workers re statement children, therapy support for children's, preventative work with children with obesity and/or long term conditions
22	40		Adult Safeguarding	40	B7 safeguarding post to enhance safeguarding capacity across the borough this will include nursing home support and acute frameworks
23	45		Prevention	45	2 Posts to support preventative Care management
	2411	1107		1304	

Key Risks

- Ability to recruit to identified positions both locum and permanent
- Use of locums/agencies may constrain the measurable patient outcomes as these staff will need time to familiarise with policy/procedures and services and timescales for delivery are short.

- Locums will need additional supervision to ensure accurate performance data collection.
- Ensuring focus of outcomes are maintained at a time of organisational reconfiguration linked to legislative guidance
- Capacity to manage and monitor the delivery of the detailed plans
- Definition and ownership of savings plans that cut across different service lines
- Lack of capacity of available residential and homecare provision

Key Stakeholders

- NHS Sector
- GP Clinical Cabinet and BSU
- London Borough of Bexley
- Shadow Health and Wellbeing Board
- South London Healthcare NHS Trust
- Dartford and Gravesham NHS Trust

Governance and Monitoring Framework

The monitoring framework for this plan will be as followed

1. Strategic monitoring through the Health and Well Being Shadow Board, and through the BSU Executive Team who will receive quarterly reports on progress. These reports will include KPI's against service outcomes and financial updates.
2. Operational performance framework to be agreed, Health and social care operational and commissioning management will develop a robust set of

KPI's and expected qualitative and quantitative outcomes within Quarter one in order to be able report to the strategic forums

3. Finance colleagues to develop a financial; monitoring plan in quarter one set against elements of plan

Critical Success factors/ KPI's

The following KPI's will be developed more fully to achieve measurable outcomes in quarter one with key operational and commissioning staff

No	Service Area	KPI description	Threshold
1	Locum SW Care Central / Hospital Discharge	% of patients assessed in A+E/AMU of overall hospital discharge workload	To be developed in qtr 1
2	OT in Care Central	% of patients assessed as having improved function on discharge from care central	To be developed in qtr 1
3	OT Assessment	% drop of patients on the waiting list	To be developed in qtr 1
4	SWA Capacity LTC	% drop of patients on the ILT waiting list	To be developed in qtr 1
5	Out of hours / weekend discharge and assessment	% of patients assessed out of hours by care central	To be developed in qtr 1
	Staffing to avoid delays in assessments and to facilitate	% increase in caseload of	To be developed in qtr 1

6	hospital discharge for clients into the community etc.	hospital discharge cases for older people with Dementia. % of patients who need a supported hospital discharge after stroke via Stroke OT	
7	Enhanced home care	% of patients referred for assessment for enhanced home care	To be developed in qtr 1
8	Home care hours for hospital discharge	% increase in hospital discharge referrals for home care resource	To be developed in qtr 1
9	Home care hours for prevention of hospital admission	% increase in Care central referrals for home care resource	To be developed in qtr 1
10	Residential / nursing home capacity for hospital discharge	% increase of new residential care placements (due to increase in capacity)	To be developed in qtr 1
11	Emergency residential / nursing admissions	% of patients referred for assessment for Emergency respite	To be developed in qtr 1
12	Linkline and telecare / telemedicine	% increase in deployment of Telemedicine units	To be developed in qtr 1
	Equipment	% increase of	To be developed in

13		patients with LTC who have had equipment deployed to prevent a hospital admission or aid discharge	qtr 1
14	Commissioning / Brokerage Teams staffing input	% increase in the numbers of care packages purchased	To be developed in qtr 1
15	LD demographics	% decrease in the number of LD clients admitted to hospital	To be developed in qtr 1
16	Speech and Language Therapy (SALT)	TBC	To be developed in qtr 1
17	CHC co-ordinator and add. Staff	% increase in the caseload of nurses assessments	To be developed in qtr 1
18	residential and home care capacity to match demographic trends and increased discharge activity	% of patients with Long Term conditions or Dementia in long term care	To be developed in qtr 1
19	Contribution to preventative day care and transport costs	% maintain of numbers of patients in specialist day care facilities	To be developed in qtr 1

Bexley NHS Care Trust

LONDON BOROUGH OF BEXLEY

20	Handyman service	% maintain number of hospital discharges supported by handyman service	To be developed in qtr 1
21	Children's / Transition	TBC	To be developed in qtr 1
22	Adult Safeguarding	% increase in the number of completed safeguarding cases	To be developed in qtr 1
23	Prevention	% increase preventative assessments completed by ILT	To be developed in qtr 1

The key benefits of the plans are;

- Anticipated reduction of inappropriate admissions/readmissions to hospital as patients undergo support and reablement through a multi-disciplinary planned programme .
- Ability to escalate packages of support to prevent inappropriate admissions/readmission to hospital through the extension of Care Navigation in the community.
- Improved case management approach for patients during the reablement phase and ensuring longer term support plan in place following reablement if needed .
- Provision of social care services to improve overall health and social care

outcomes by ensuring a joint and co-ordinated approach to heath and well being

- Increased numbers of patients leaving hospital in a timely manner
- Alleviation of Winter pressures on the whole system across health and social care and including emergency services.
- Maintain of existing care provision to meet on going demand in yr 2011/12

Timescales

Programme of planned activity to commence May 2011, the management operational planning will set timescales and deliverables in quarter one

Bexley NHS Care Trust LONDON BOROUGH OF BEXLEY	NHS Funding for Social Care 2011/12	**Ref:** **Current Stage:** *In Development* **Author:** *Sue Robinson and Dave Holman*

Appendix B

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 18 **LAMBETH PRIMARY CARE TRUST** **TRANSFER OF LAMBETH PCT & SOUTHWARK PCT COMMUNITY SERVICES INTEGRATION WITH GSTT**
DIRECTOR RESPONSIBLE: Andrew Eyres, NHS Lambeth Managing Director
AUTHOR: Una Dalton, NHS Lambeth Director of HR and Corporate Affairs
TO BE CONSIDERED BY: Lambeth Primary Care Trust
SUMMARY: See above
KEY ISSUES: See attached papers
INVOLVEMENT: See attached papers
RECOMMENDATIONS: The Board is asked to note Chair's Actions taken on the following: • To approve the final transfer to legal and commercial documentation regulating the transfer of Lambeth Primary Care Trust and Southwark Primary Care Trust Community Services Integration with GSTT.

DIRECTORS CONTACT:
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AUTHOR CONTACT:
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NHS Lambeth

Chair's Action

As set out in section 5.9.4 of the Lambeth PCT Controls Assurance Framework, the powers which the Board has retained to itself within the Standing Orders (section 5.7.5) may in emergency be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Officer members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Professional Executive Committee and the Board in public session for ratification.

Lead Director: **Andrew Eyres**

Rationale for Chair's Action

NHS Lambeth and NHS Southwark Community Services Integration with Guy's and St Thomas' NHS Foundation Trust

The March PCT Board received an update on progress on the transfer of Community Services to GSTT on behalf of KHP for 1st April. The Board approved Chair's Action to sign off final approvals. Attached is an update paper setting out progress to final transfer and seeking Board approval to the legal and commercial documentation to action the transfer.

Recommendation

The PCT Board is asked to note the above information and assurances and approve:

- The Community Contract
- The Business Transfer Agreement
- The Facilities Management Business Transfer Agreement *

Delegated ~~to~~ to Chief Executive of Lambeth BSH MD. Subject to approval by NHS London.

Further Action required:

The Transformation Partnership Board will oversee the first six months of the transfer past 1st April.

Confirmed with

Graham Laylee
Sue Gallagher

Sue Gallagher

31/03/11

Caroline Hewitt **Date**
Chair

ENCLOSURE 18

NHS Lambeth

Board Report

Report author: **Presented by:** **Queries to:**	Peter Coles, Independent Programme Director Andrew Eyres, Lambeth BSU, Managing Director Andrew.Eyres@lambethpct.nhs.uk direct line: 020 3049 4076
Relevant background papers:	• Previous reports to NHS Lambeth Board • JCPCT Papers
Also considered at:	Lambeth & Southwark JCPCT 17th March 2011
Title:	**Community Services Integration – Transfer of Lambeth Community Health to Guy's and St Thomas' NHS Foundation Trust**
What are the headline messages to consider from this paper?	• Progress continues to meet the planned transfer date of 1st April 2011. • A number of outstanding issues and risks remain.
Recommendation:	**The PCT Board is asked to note the information and assurances included within this report and approve:** • **The Business Transfer Agreement** • **The Facilities Management Business Transfer Agreement** • **The Community Contract**
Are there resource implications for revenue, capital, staffing? If yes, please explain.	• Resource assumptions are included within the draft Business Case, approved by the Board in January 2011.
Does this require an equality impact assessment (EIA)? If yes, what has been the outcome of the EIA to date? How have the issues raised been addressed in this paper?	• Equity and equality impact assessment screening are being completed focusing on the following elements of the programme: • TUPE consultation; • management structures for clinical and support services; • the overall business case including service development; • the work completed on stakeholder engagement. This has been done using a unified approach with the agreement of NHS Lambeth, NHS Southwark and GSTFT.
Will the proposals reduce health inequalities?	• This is one of the key objectives of the integration of community services

Please explain.	
What has been the scope of PPI in this work? How has feedback been incorporated/actioned to date? **Have clinicians been engaged in this work?**	• There has been broad ranging stakeholder engagement as part of the transfer programme, lead by the Transformation Partnership Board. • Yes, through the Service Transformation Programme and the JCPCT.
What are the key risks to delivery of this work. Are there plans in place to address risks?	• These are contained in the report. • Yes
Set out the relevant commissioning competencies	These are contained within the aims and objectives of the programme
Are there legal issues to consider?	The PCT is being advised by Capsticks Solicitors in relation to matters of the transfer of LCH services to GSTT

NHS Lambeth

NHS Lambeth and NHS Southwark

Community Services Integration programme

Formal approval and signing of the Transfer Agreement and related documents

1. Purpose of report

This report confirms that it is now in order for the Board (in the case of Lambeth PCT) or Chief Executive (in the case of Southwark PCT) to approve and sign the Business Transfer Agreement (BTA) which confirms the terms of the transfer of community services to Guy's and St Thomas' NHS Foundation Trust from 1 April 2011. Delegation of responsibility to the Chief Executive of NHS Southwark was confirmed by the PCT Board at its January 2011 meetings.

2. Progress to date

In January 2011 the Boards of both PCTs and GSTT approved the draft Business Case for the transfer of community services from Southwark Provider Services and Lambeth Community Health to GSTT, acting on behalf of King's Health Partners, on 1 April 2011.

The Transfer was also approved by NHS London at its Capital Investment Committee meeting on 25 March. In order to achieve that agreement there had been detailed discussions between the local parties on a number of key aspects of the Transfer Agreement and contract terms. These aspects are now agreed as per Appendix 1 to this report, and have been incorporated into the BTA and Community Contract as appropriate.

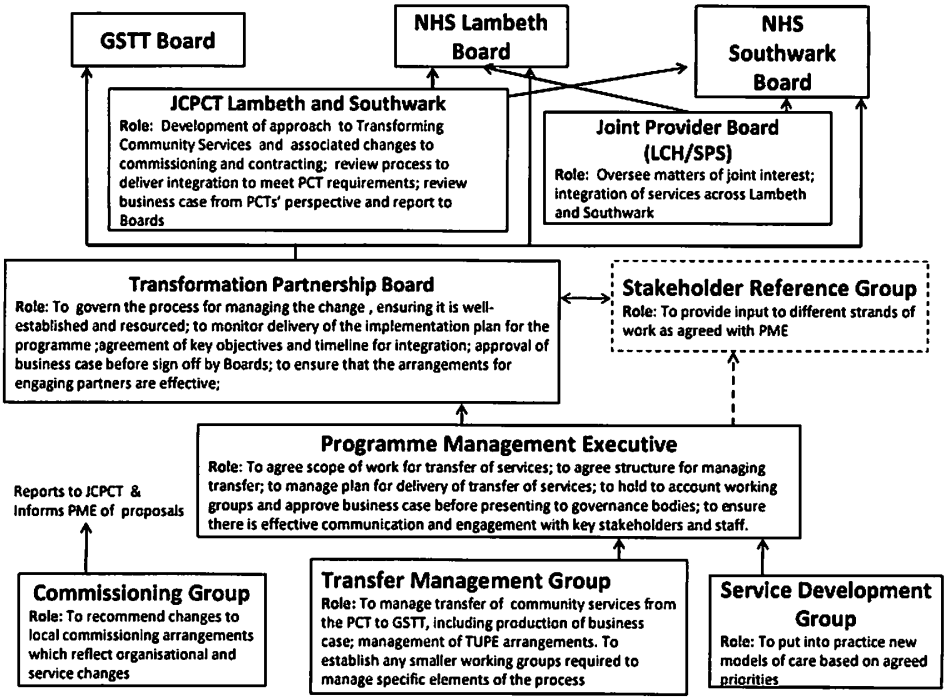
NHS London's approval was confirmed on 28 March (see letter from Ruth Carnall attached as Appendix 2) and is subject to:

- NHS Lambeth, NHS Southwark and GSTFT final sign-off of the Contract and Transfer Agreement (these are attached for signature);
- NHS Lambeth and NHS Southwark ensuring that the process of registering the services with the Care Quality Commission is completed by GSTFT prior to transferring the Community Health Services to GSTFT (CQC have confirmed that GSTT's application for registration of the community services and premises has been approved);
- Commissioners ensuring robust market testing of services over the course of the contract (this has been confirmed through the Commissioning Group and JCPCT); and
- Commissioners ensuring robust performance contract arrangements are in place post transaction to ensure delivery of the Quality, Innovation, Productivity and Prevention Plans (to be actioned through the relevant contract and performance mechanisms)

The transfer has also been approved by the Co-operation and Competition Panel and (for GSTT) by Monitor.

3. Programme governance

The transfer programme has been managed through an inclusive process, with a comprehensive governance structure, shown below:



These programme governance arrangements have been overseen by an Independent Chair and Programme Director. Angela Dawe, Chief Operating Officer for Lambeth Community Health, has been seconded to GSTT into the role of Director of Community Services Integration and Andrew Eyres has been the SRO for the programme.

The Business Case for the integration was approved by the Transformation Partnership Board and JCPCT in January 2011 and both bodies have subsequently played an active role in discussions about the detailed provisions within the Transfer Agreement and clinical services contract. There has been a detailed programme of stakeholder engagement and GP leads, in particular, have been involved throughout the process and have confirmed their support for the business case and transfer.

4. Key legal agreements and contracts

There are a number of related legal documents and contracts which are being agreed between the parties at the same time in order to enact the transfer to GSTT. These are as follows:

- The Business Transfer Agreement. After considerable discussion and negotiation between the parties, input by NHS London in relation to the key clauses referred to above and approval by the legal advisers to all parties, this document is attached for signature.

- The contract for community services. This is a joint contract between Lambeth and Southwark PCTs and GSTT, using the new national template for community contracts. It has been agreed by all parties and is presented here for signature.
- Transfer Agreement and Contract for the transfer of facilities management services to GSTT. These services and staff have been separated from the main BTA in order that there is flexibility in the event of changes to the ownership or use of properties in line with SHA and DH guidance. This has also been agreed between lead directors and legal advisers and is presented here for signature.
- Contract for the provision of IT services to GSTT by the PCT shared service. The key standards and terms and conditions of this are agreed, however the price of the service and the contract documentation are not completely agreed. Despite this not being signed off by all parties by 31 March, the overall community services transfer can still go ahead on 1 April, subject to the IT these issues being agreed by 30 April 2011 at the latest. (This point is reflected in the main BTA)
- Contracts or SLAs for the provision of a number of relatively small services back to the PCTs by GSTT after 1 April 2011. These services include Infection Control, HR advice, Continence service and Safeguarding advice. The nature of these services has been agreed, but the necessary documentation will not all be in place by 31 March. The overall transfer of community services can still go ahead on 1 April, but these agreements must also be signed off by 30 April 2011 at the latest. (This point is also referenced in the main BTA).

As a consequence of these approvals Lambeth Community Health and Southwark Provider Services and associated corporate and support staff will transfer to GSTT on 1 April 2011. 1037 Lambeth staff (783 WTE) and 884 Southwark staff (629 WTE) will transfer with the service and GSTT will thereafter be responsible for the provision of community services locally.

5. Due diligence, warranties and indemnities

During the summer of 2010 GSTT undertook a due diligence exercise direct with the PCTs, which was approached constructively and openly by all the parties. The findings of this exercise were then reviewed by KPMG who provided an External Due Diligence report to all three organisations. The key findings of this review have been addressed and incorporated into the Business Case, Post-Merger Integration and Implementation Plan and BTA.

Section 14 of the BTA details the warranties which are being provided by the PCTs. These cover the following areas:

- Actions which the PCTs have undertaken in 2010/11 to deliver recurrent QIPP and CRES savings and to deal with the reductions in Local Authority funding
- The ongoing actions which are being implemented by GSTT to complete these obligations
- Information provided under the due diligence inquiries

These warranties provide for GSTT to claim recompense for any unforeseen costs incurred by them through not receiving a balanced budget as agreed, or through

discovering hidden costs not previously declared. This liability is limited to 15 months post transfer.

There are reciprocal warranties provided by GSTT to the PCTs relating to PCT losses arising from errors or omissions by GSTT staff after the transfer.

There are also standard clauses relating to indemnities, for example in the case of clinical negligence claims dating from the period before 1 April 2011, which would fall to the PCTs and costs incurred by GSTT in inheriting any staff not identified beforehand on the TUPE transfer lists.

6. New organisational structure for community services

Significant efficiencies and savings have been made through the establishment of integrated management and support services arrangements for the new service, which have also contributed significantly to the achievement of management cost reduction targets. Appointments to these structures (which have been shared with the JCPCT) have been taking place over the last three weeks and most positions have now been filled. The remaining interviews will be taking place during the first week in April, after which it will be clear exactly how many staff are going to be at risk of redundancy. At the moment and subject to the remaining interviews and redeployment processes etc the figure is expected to be a maximum of 17. (This figure does not include any staff potentially at risk due to implementation of CRES/QIPP/LA budget reduction measures).

7. Ongoing service transformation and performance management arrangements

The integration is closely linked to the King's Health Partners Integrated Care Programme which is under development. The early priority which has been identified is to improve services for frail elderly people and this will involve in a number of key community services. The Service Development Group chaired jointly by Dr Adrian McLachlan and Professor John Moxham will continue to meet.

As there are a number of implementation issues which will run into the new financial year, it has been agreed that the Transformation Partnership Board will continue to meet for a period of approximately six months to oversee these areas. This arrangement will not interfere with the formal contract and performance review arrangements which are in place, or with GSTT's own Board sub committee for oversight of community services. In addition it is likely that the Health Overview and Scrutiny Committees and Health and Wellbeing Boards will wish to take an interest in the new integrated service. Extending the life of the TPB should however ensure that the excellent partnership working which has been evident during the programme continues.

8. Action Required

The PCT Board is asked to note the above information and assurances and approve:

- The Business Transfer Agreement
- The Facilities Management Business Transfer Agreement
- The Community Contract

NHS
Lambeth

Peter Coles
Independent Programme Director
30 March 2011
Version 4

NHS Lambeth, NHS Southwark, Guy's and St Thomas' NHS Foundation Trust

Community Services Integration programme - Transfer Agreement

Provisional agreement in relation to outstanding clauses

1. Contract duration

The PCTs have confirmed that the contract is for three years duration with effect from 1 April 2011. An option to extend for a further two years has been built in.

2. Services to be market tested

Group 1. There is an agreed list of services, to the value of approximately £7m pa, which the PCTs will market test or re-commission during the life of the contract. These are primarily rehabilitation services and continuing care.

Group 2. The PCTs intend to re-commission other services to the approximate value of £9m pa during the life of the contract. The services to be included in this group will be discussed with GSTT and the PCTs have confirmed that it is not necessarily their intention to carry out full market testing and competitive tendering exercises for this group. They will seek to work with GSTT and partners to redesign and re-engineer these services where possible in order to obtain quality and efficiency improvements. However market testing for this group could be an option. These will be discussed with GSTT prior to serving notice.

Thus, up to 20% of the c.£80m clinical services budget (by value) can be re-commissioned during the life of the contract.

The PCTs also wish to reserve the right to re-commission small elements of services – for example relating to individual posts or particular initiatives. Such initiatives would be discussed in advance with GSTT and would amount to no more than £250k by value in any financial year. At least six months notice of any such change would be provided by the PCTs.

3. Timing of market testing/re-commissioning

The PCTs have agreed that they will provide a minimum of 12 months notice of any service being de-commissioned from GSTT through market testing. In order for all parties to plan effectively the following time frames are also agreed:

- Notice will not be served on any service in the first six months of the contract
- From six months onward the PCTs may serve notice in relation to any of the services in Group 1 above.
- From 12 months onwards the PCTs may serve notice in relation to any of the services in Group 2 above. The PCTs have confirmed that decisions about further re-commissioning or market testing of services in Group 2 will be taken in the context of the Integrated Care Pilot being developed across King's Health Partners. Under this initiative, significant collaborative work is taking place to redesign a range of services. Such services would not be

subjected to market testing initiatives without prior consultation with GSTT/KHP.

4. Other notice periods

The PCTs confirm that they will not serve notice on any other services in addition to those referred to above during the life of the contract. The exception to this (and to sections 1, 2, and 3 above) would be in the event of significant service failings (as defined in the community contract) which could lead to notice being served on the relevant services if measures to address the service failings had not been taken or had not been successful.

5. Transfer of services to another provider

If, following market testing, the contract for the provision of a particular service is transferred to another provider, the PCTs and GSTT will work together to ensure that the relevant costs of that service are transferred to the new provider. It is assumed that in these circumstances TUPE would apply.

Where there are "overhead" or support services costs which cannot be transferred to the new provider, the PCTs will to pay up to 80% of these to GSTT for a period of 12 months after the service is transferred. This will allow more time for GSTT to reduce these costs through internal restructuring and efficiencies.

6. De-commissioning of services

Where, for example as a result of service review and re-commissioning, particular community services cease to be purchased by the PCTs the following conditions shall apply:

- A minimum of 12 months notice to discontinue the service will be given by the PCTs unless to a value of less than £250k when 6 months notice would apply.
- The notice period will be used by GSTT, the PCTs and partners to re-deploy staff, utilise staff on fixed term contracts and in other ways reduce the costs of that service at the date of termination as much as possible.
- If at the end of this process there are staff who cannot be redeployed the PCTs and GSTT will consider the optimal way in which those costs can be dealt with and reach a local agreement on the most appropriate way in which these costs should be picked up.
- For overhead costs associated with the decommissioned services the second paragraph of point 5 above would apply.

Peter Coles
Programme Director
23 March 2011

Appendix 2

Ref: 201103-231

NHS London

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Interim Chief Executive
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1 Lower Marsh
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Susanna White
Chief Executive
NHS Southwark
Southwark Health and Social Care
160 Tooley Street
London SE1 2TZ

Ron Kerr
Chief Executive
Guy's and St. Thomas' NHS Foundation Trust
Guy's Hospital
Great Maze Pond
London
SE1 9RT

28 March 2011

Dear Andrew, Susanna and Ron

APPROVAL OF TRANSFER OF NHS LAMBETH'S AND NHS SOUTHWARK'S COMMUNITY HEALTH SERVICES TO GUY'S AND ST. THOMAS' NHS FOUNDATION TRUST

I am writing to confirm that NHS London has approved the decision to transfer NHS Lambeth's and NHS Southwark's Community Health Services to Guy's and St. Thomas' NHS Foundation Trust (GSTFT) subject to the conditions listed below:

- NHS Lambeth, NHS Southwark and GSTFT final sign-off of the Contract and Transfer Agreement;
- NHS Lambeth and NHS Southwark ensuring that the process of registering the services with the Care Quality Commission is completed by GSTFT prior to transferring the Community Health Services to GSTFT;
- Commissioners ensuring robust market testing of services over the course of the contract; and
- Commissioners ensuring robust performance contract arrangements are in place post transaction to ensure delivery of the Quality, Innovation, Productivity and Prevention Plans.

I look forward to seeing the benefits that will arise for patient care as a result of this new way of integrated working and welcome the commitment of GSTFT in ensuring full stakeholder engagement in overseeing the delivery of the Post Merger Implementation Plan.

Thank you for your and your teams' hard work in moving this project forward.

Yours sincerely

Ruth Carnall
Chief Executive, NHS London

cc: Simon Robbins, Sector Chief Executive
Peter Coles, Programme Director for the Integration
Paul Baumann, Director of finance, NHS London
Sara Coles, Director of Performance, NHS London
Hannah Farrar, Director of Strategy and Commissioning Development, NHS London
Trish Morris-Thompson, Chief Nurse, NHS London
Dr. Simon Tanner, Director of Public Health, NHS London
Dr. Andy Mitchell, Medical Director, NHS London
Mark Davies, Regional Director of Provider Development, NHS London
Andrew Woodhead, Head of Mergers and Acquisitions, NHS London
Deodita Fernandes, Programme Manager, Mergers and Acquisitions, NHS London

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 19 **Continuation of the LPS Neighbourhoods Designation in Bromley**
DIRECTOR RESPONSIBLE: David Sturgeon, Director of Primary Care
AUTHOR: Tushar Shah, Community Pharmacy Advisor
TO BE CONSIDERED BY: Bromley Primary Care Trust
INVOLVEMENT REQUIRED FROM THE BOARDS: Ratification of Chair's Action taken on 1 May required.
SUMMARY: Caroline Hewitt, Chair of the Joint Bromley PCT Board took chair's action, after consulting Bromley non executive directors Jim Gunner and Harvey Guntrip, to endorse the continuation of the LPS Neighbourhoods Designation in Bromley, without change, following the six month review required by the NHS (Local Pharmaceutical Services etc.) Regulations 2006 (SI 552). This action was taken on the advice given in the attached memo from David Sturgeon, dated 28 April 2011, in response to the paper (also attached) from Tushar Shah supporting extension of the LPS Neighbourhoods Designation, as agreed by the Bromley PCT Board on 2 November 2010.
KEY ISSUES: Continuation of the 3 designated LPS areas (Beckenham and Penge, Bromley and Orpington) is required to enable Bromley PCT to work up an LPS proposal for Bank Holiday pharmaceutical services cover. The consequences of not renewing the designation are described in David Sturgeon's attached memo.

South East London

INVOLVEMENT

- Bromley Community Pharmacy Liaison Group (to date)
- South East London Pharmacy Panel (when constituted)

RECOMMENDATIONS:
The Board is asked to ratify Chairs Action taken on 1 May 2011 to continue the LPS Designation without change.

DIRECTORS CONTACT:
Name: David Sturgeon
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Telephone: 020 3049 3950

AUTHOR CONTACT:
Name: Tushar Shah
E-Mail: tushar.shah@bromleypct.nhs.uk
Telephone: 01689 853339 Ext 3663

South East London

Memo to: **Caroline Hewitt**

Date: **28th April 2011**

From: **David Sturgeon**

Subject: **Continuation of the Local Pharmaceutical Service (LPS) designation for Bromley**

Action required: **Chair's action to approve the continuation of the LPS designation for Bromley based on attached paper**

For the LPS designation to continue for Bromley for ***'the provision of pharmaceutical services in specified out-of-hours periods covering the three Primary Care Hub areas'***, it needs to be reviewed before **2nd May 2011**, 6 months after it was agreed to put it place by Bromley PCT Board on 2nd November 2010.

The LPS Regulations state that a LPS designation can be continued for a further 6 months but a review of the need for it **must** be conducted before the end of a period of six months beginning with the date of designation or the date of the last review.

If the LPS designation is not renewed before the end of the six month period the designation will expire, and one of the important consequences of this is new pharmaceutical applications that were deferred (because the designation was in place) will need to be processed. This is likely to result in additional financial implications for the PCT budget prior to having worked up a specification for the LPS, the latter of which has been delayed as a result of the organisational change that has been ongoing over the last six months or so.

As NHS SE London Board is now acting on behalf of its constituent PCT Board, and it is clearly impossible for the Board to be convened before 2nd May 2011, I am requesting that you consider taking Chairman's Action to avoid the potential for challenges and/or for the designation to be cancelled at this stage.

The LPS Regulations and their related Guidance do not stipulate how the review of a Designation should be carried out. But given Bromley's designation was made at a meeting of the PCT Board, legal advice has confirmed that a new Board (or its Chairman) should also take responsibility for considering the case for continuation of the designation.

If the SE London Pharmacy Panel (which has not yet been constituted and will be the subject of a separate e-mail exchange) or senior officers within the PCT/NHS SE London carry out the review and make a decision to continue the Designation, without express authority from the Board, I am advised that there is a risk that the decision could be challenged as having been made without appropriate authority.

I would further recommend that if you are happy to take Chairman's action to continue the Designation, you may wish to require for a further report on progress to be presented in two months time to either the SE London Board, or, if they are given appropriate authority, the yet to be constituted Pharmacy Panel, given the Board may reasonably wish to delegate this detail.

It would be most helpful, by way of an audit trail to have your response before 2nd May, albeit I fully appreciate we have intervening Bank Holidays before us.

Many thanks

David

South East London

To:	**NHS South East London Board**
Title of paper:	**Review of Designation of Local Pharmaceutical Services (LPS) Neighbourhoods**
From:	**Tushar Shah, Community Pharmacy Adviser, NHS SE London**
Date:	**27 April 2011**
Action Required:	**The Board is asked to continue with the designation of the LPS neighbourhoods in Bromley.**

Summary

This paper recommends the continuation of the designation of the three LPS neighbourhoods in Bromley.

Background

The original designation was approved by Bromley PCT Board on 2 November 2010 for the purposes of Local Pharmaceutical Services (LPS) as defined in the NHS (Local Pharmaceutical Services etc.) Regulations 2006 (SI 552), for the provision of pharmaceutical services in specified out-of-hours periods covering the three Primary Care Hub areas:

1. Beckenham and Penge
2. Bromley
3. Orpington

The aim of the designation is to allow time for an LPS proposal to be worked up, processed or implemented. Once an area has been designated as an LPS area, this must be reviewed before the end of six months from the date of designation. The review may vary the designation, continue with the designation or cancel the designation at any time.

Since the designations, the Pharmaceutical Needs Assessment (PNA) for Bromley has been approved by the PCT Board at its meeting on 27 January 2011. The PNA did identify to explore the use of LPS to secure the provision of pharmaceutical services on Bank Holidays in Bromley and in particular to ensure that there is pharmaceutical services cover for the Urgent Care Centres which open between 8am and 8pm 365 days a year.

Since the designations were published, the PCT has received comments, as part of the PNA consultation, from one of the contractors in Bromley. The comment received suggested that it is not a requirement for an LPS to cover pharmaceutical services on Sundays and Bank Holidays.

The PCT will consider the representation received by considering all commissioning options to include LPS that provides flexibility to build local contracts, which support local delivery of improved health services designed to address local healthcare priorities, specific or unique situations without restriction on location.

At the Bromley Community Pharmacy Liaison Group (CPLG) meeting held on 15 March 2011 which includes representation from the Local Pharmaceutical Committee (LPC), local pharmacy contractors and the Local Medical Committee (LMC), it was agreed to progress the work to develop and procure the option of an LPS for Bank Holiday pharmaceutical services cover.

To enable the PCT to work up an LPS proposal and process it, the Panel is asked to continue the designation of the LPS Neighbourhoods in Bromley.

Recommendation

The Board is asked to continue with the designation of the LPS Neighbourhoods in Bromley.

Next steps

If the designation is continued, the PCT will notify a range of stakeholders of the outcome of the review.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 20

CHAIR'S REPORT

Welcome to NHS South East London

Since my appointment as chair of the six trusts was announced, I have spent as much time as possible getting round the patch and meeting with key staff and stakeholders. My initial impressions focus on the breadth of talent and experience we have in South East London.

We should not underestimate the scale of what we need to deliver over the coming months. The passion and commitment of all those involved gives me confidence that we can more than meet the challenge and seize the opportunity to improve health and health care for our communities.

Thank you and farewell to Non-Executive Colleagues

I would like to start my first Chair's report with a thank you to all Non-Executive Directors and chairs who have recently left South East London Primary Care Trusts and Bexley Care Trust boards. Many colleagues had served on local boards for a number of years and had helped the local NHS successfully navigate through the challenging issues of service reconfiguration, organisational change and reinvigorating our focus on quality and safety.

I would like to particularly thank Michael Richardson for chairing the South East London Joint Committee of Primary Care Trusts for the past two years and providing leadership to the initial governance arrangements for NHS South East London.

The Health Sector and reducing violence against women and girls

The NHS is often the first point of contact for women who have experienced violence, although they may not disclose the violence directly. It can play an important role in preventing violence against women by intervening early, providing treatment and information and referring women on to other services. Bearing this in mind, in April 2011 NHS South East London participated in the London Health and Violence Against Women and Girls Survey.

The request came from Professor Sir George Alberti, Chair, London Health and Violence Against Women and Girls Group. The NHS SEL survey reported that the majority of the six PCTs run specialist Violence Against Women and Girls programmes, actively encourage the early identification and referral of women and girls that have experienced violence and run Violence Against Women and Girls training for staff and clinicians. We also confirmed that non-executive leads Rona Nicholson and Susan Free are the NHS SEL leads who will hold us to account on our activities preventing Violence Against Women and Girls.

The results of the survey will be used to map work carried out by the health sector in London agree recommendations to be put to the Department of Health.

Joint Boards Away time – 5th May 2011

We held a board away day on Thursday 5th May. It was a productive session where members of the joint boards of the five PCTs and Bexley Care Trust came together to agree how to work with each other over the next two years. This was the first time that many board members had met in person and was an opportunity for new colleagues to acquaint themselves and share their skills and experience.

There was agreement on taking forward the proposed governance model, discussion and input to the board contract (presented to the Joint Boards on 19th May 2011) and agreement that collaboration on key work areas would be required.

Caroline Hewitt
caroline.hewitt@lambethpct.nhs.uk
020 3049 4067

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 21

CHIEF EXECUTIVE'S REPORT

Vote of thanks to staff and staffside

I would like to thank all staff and managers for their engagement in the change process over the past six months and I would like to wish everyone well who has left us recently, either through voluntary or compulsory redundancies.

I would like to particularly thank our staffside colleagues from across the six PCTs for their engagement and contribution to the management of the HR process.
We have now completed the first round recruitment for all vacant posts and these have been advertised using NHS Jobs to all at risk staff across London. The Cluster Management team have agreed to establish a vacancy review panel and all vacancies will be reviewed by this panel before we move to wider recruitment. The purpose of the panel is to ensure that we are consistent in our approach to recruitment. We hope to set up the first Cluster recruitment panel over the next week.

All staff appraisals and objective setting will take place by end June 2011. We will collate all personal development plans to create a sector wide training proposal. To support this we will establish a Cluster Training and Development review panel to co-ordinate all requests for funding for training.

BSU Performance stocktakes

It was agreed at the Cluster Management Board that the Cluster would develop a performance management framework for the delivery of the operational aspects of the 2011/12 Integrated Plan. It was agreed that central to this process would be quarterly 'stocktakes' for each borough that would bring together all the senior staff contributing to the delivery of that borough's Plan.

These 'stocktakes' will draw together all the latest headline performance information on finance, QIPP delivery and service performance, and will consider key risks to delivery and agree action to mitigate these risks.

The initial set of 'stocktake' meetings to establish the performance review process across each borough are being held between 11-20 May. These meetings will focus primarily on ensuring accountability for QIPP delivery is clear for each initiative, following the organisational re-structuring, and that the scale of QIPP plans is sufficient given the financial challenge in 2011/12. Thereafter, meetings will be held each quarter.

Development of Commissioning Support

NHS London is leading a piece of work to prepare a commissioning support system for post-2013. Commissioning Support is based around the management support that we currently give around commissioning cycle and corporate services. In the future, clinical commissioners will be able to purchase their commissioning support from a range of providers.
The first part of preparing to be a commissioning support organisation (CSO) will be for us to undertake a diagnostic exercise, which we will be commencing in the next month. This will confirm the skills we currently have, establish where there are gaps and help us produce a plan (called a 'roadmap') to either improve through development and/or decide where appropriate to consider developing partnerships. By undertaking this process, this will be in a strong position to be able to support clinical commissioning in the future.
This is a rapidly developing area which is changing regularly in line with the national debate around the future of the NHS. I am committed to involving staff and keeping them up to date with new information as we have it.

Development of Clinical Commissioning

A leadership and organisational development framework is in the process of being procured for Pathfinders by NHSL. Pathfinders can identify their needs in relation to eight development domains from a London Pathfinder Road Map, rating themselves in terms of level of confidence and priority for each domain. Providers from the framework, once selected, can then carry out interventions to respond to identified need. Currently there is a delay in procuring providers for the framework so a series of masterclasses across the cluster are being offered once the needs assessment by pathfinders has been completed.
All 6 Pathfinders in South East London attended a workshop on 4th May to hear about a leadership and organisational development support framework being procured for Pathfinders by NHSL. Pathfinders can identify their needs in relation to eight development domains from a

London Pathfinder Road Map (diagnostic tool), rating themselves in terms of level of confidence and priority for each domain.

Providers from the framework, once selected, can then carry out interventions to respond to identified need. From the workshop it was clear that Pathfinders were keen to use resource collectively when the development need was common, so although there is a delay in procuring providers for the framework, we would like to propose offering a series of master classes across the cluster once the needs assessment from the diagnostic tool by pathfinders has been completed.

Simon Robbins
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South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 19th MAY 2011

ENCLOSURE 22 **DIRECTOR OF PUBLIC HEALTH BRIEFING**
DIRECTOR RESPONSIBLE: Dr Ann Marie Connolly – Director of Public Health
AUTHOR: Dr Ann Marie Connolly - Director of Public Health
TO BE CONSIDERED BY: All
INVOLVEMENT REQUIRED FROM THE BOARDS: This paper is presented to provide a summary for the Board of the key health issues of cluster area.
SUMMARY: This paper sets out a summary of the key health issues for SEL. It identifies some key facts and figures and allows new members of the Board to gain a broader understanding of the comparative differences between the different PCT areas in demography and major health problems. It summarises the Staying Healthy elements of the QIPP that apply across the cluster. It presents the current health priorities of each local area and signposts each of the Public Health departments and their activities.
KEY ISSUES: Background to the issue : Significant changes have occurred in the recent restructuring of the 5 PCTs and Care Trust across South East London leading to the establishment of the 6 Business Support Units as part of the Cluster. During these changes the Public Health departments have not been a part of the re-structuring as a different trajectory for public health functions was first presented in the White Paper 'Liberating the NHS' and set out in more detail in the Public Health White Paper 'Healthy Lives Healthy People'.

The proposal for public health is that the functions and accountabilities move to a number of other organisations, namely Public Health England and to local authorities. The proposed functions, finances and accountabilities for these organisations in relation to public health have been set out in a series of consultation documents for which the closing date for response was the 31st March 2011. The proposed timeframe for these mooted changes is April 2012 for establishment of Public Health England and April 2013 for the transfer of public health responsibilities to the local authorities.

Guidance on the establishment of clusters has set out that Public Health departments be retained at local level so as to facilitate a smooth transfer to local authorities and not to be aggregated or absorbed into cluster bodies. At the same time clusters are asked to ensure that they have expertise to address health inequalities for their areas.

The recent 'pause' in the passage of the health and social care bill has postponed the proposed dates for change by three months. Nevertheless the general guidance is to continue to plan for the implementation of the White Paper.

For the Public Health departments in South East London, currently remain accountable to the NHS and remain aligned alongside the BSUs. All are in discussion with their local authority about interim transfers of staff and functions and at various stages of progressing to secondment arrangements using section 75 agreements (NHS Act 2006).

However even as this happens the NHS and the cluster remain accountable for health improvement, public health targets, finances and outcomes at least until April 2013.

For this purpose this paper sets out the key health problems for the population of South East London, how the QIPP Staying Healthy will address key public health targets. More detailed summaries of each area is attached including how the local public health department will work.

For future meetings of the board it is proposed that there will be an update on public health matters covering:

- specific actions to improve health,
- highlights of any key public health concerns
- update on issues of transition of public health to new organisations

INVOLVEMENT:
COMMITTEE INVOLVEMENT:
- This report has been discussed by the Directors of Public Health

IMPACT ASSEESMENT:
- Addressing health inequality is central to the work of all the public health departments

RECOMMENDATIONS:
The board (s) is asked to:-
- Note the contents of the report as a summary for the Board of the key health issues of cluster area.

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ENCLOSURE 22

South East London

Briefing for Joint PCT/Care Trust Boards

Health and Public Health Issues

from across South East London

ENCLOSURE 22

Briefing on Public Health Matters

This briefing paper summarises

- Major health issues for South East London
- Key QIPP Staying Healthy areas
- Major health issues for each borough
- Functions of PH Teams and current partnership arrangements

1. Demographics

1.1. Population size

South East London has a population of 1,568,000 people. The population size in each borough ranges from 216,012 in Bexley to 299,359 in Bromley (2009 estimates). The total population is projected to grow to 1.7 million by 2018. Greenwich is predicted to see the largest increase in population, with a growth over the next five years of 10%; Southwark will have the second highest at 8%. The populations of Bromley and Bexley are not expected to increase.

	Total Population size				*Percentage*		
	0-15	*15-64*	*65+*	*Total*	*0-15*	*15-64*	*65+*
Bexley	42,468	140,540	33,004	216,012	20%	65%	15%
Bromley	56,777	194,990	47,591	299,359	19%	65%	16%
Greenwich	52,442	158,060	27,100	237,601	22%	67%	11%
Lambeth	55,366	209,737	23,707	288,810	19%	73%	8%
Lewisham	54,625	187,066	24,163	265,855	21%	70%	9%
Southwark	55,868	193,577	24,994	274,439	20%	71%	9%

Table 1. Population size and age for South East London by borough in 2009

1.2. Age Distribution

Bromley (15%) and Bexley (16%) have relatively high proportions of older people compared with Lambeth (8%) and Lewisham and Southwark (9%). In contrast Southwark and Lambeth have relatively high proportions of people of working age (71% and 73% compared with Bromley with 65%).

1.3. Ethnicity

70% of the population is white British, and 30% from Black and Ethnic Minority groups (BME). Black Africans, Black Caribbeans and Black 'other' minorities form the largest combined ethnic minority in the South East London sector, accounting for 67% of the total minority population in 2009. Black Africans form the largest single group amongst the ethnic minorities (33% in 2009). Southwark has the largest population of Black African people of 43,000 people, while Lewisham and has the largest Black Caribbean population in the sector 35,000.

1.4. Deprivation and Wealth

There is a well established link between deprivation and ill health with increased incidence and prevalence of disease amongst most deprived population groups with increased risk of early death and shortened life expectancy. As can be seen in Fig 1 deprivation is concentrated in the boroughs in the north and east of the cluster area.

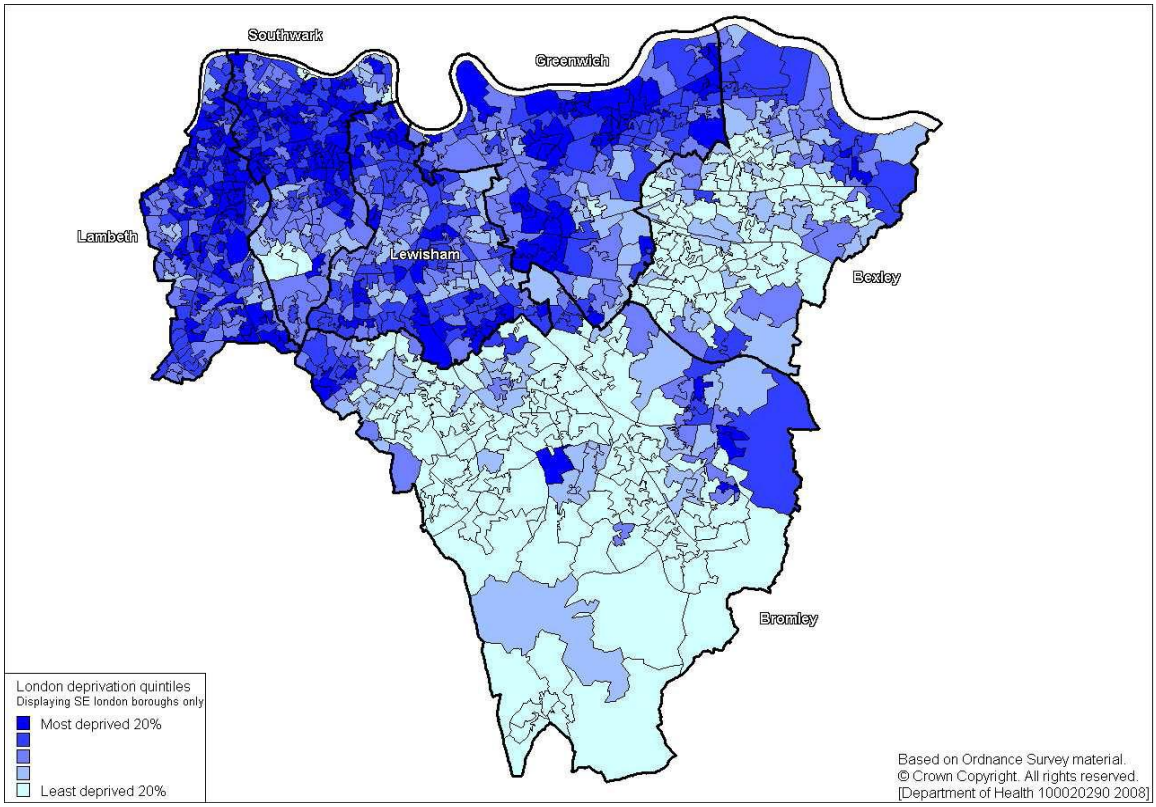

Fig 1. Index of Multiple deprivation by super output area, SEL, 2007 (Source: Index of Multiple Deprivation 2007)

2. Major Health issues for South East London

2.1. Major Causes of ill health and premature mortality

The major causes of death and premature death are cancer, respiratory diseases and circulatory diseases particularly coronary heart disease and stroke. Many residents of south east London also experience significant mental ill health which is responsible for most of the lost years of healthy life in SEL. More than 25% of the total HIV cases in England live in this sector with a particular concentration in Lambeth and Southwark.

2.2. Cancer

Cancer affects one in three of the population and is responsible for a quarter of all deaths. Each year, over 6,000 people are diagnosed with cancer in SEL, with incidence proportionately increasing with age. Cancer mortality in SEL is higher than both London and nationally, although there has been a recent decrease in this gap. While treatments for many cancers are improving there remain significant differences in the expected survival from each cancer

- Breast cancer has amongst some of the best survival rates. Incidence is highest in Bexley and Bromley. Mortality is highest in Lewisham.
- Lung cancer incidence and mortality rates are high compared with national figures. In Lewisham lung cancer accounts for 22% of deaths.
- Colon cancer – the incidence of colon cancer has remained stable, with the highest rates in Greenwich and Lambeth. However mortality is highest in Bromley.
- Prostate cancer – there is a higher incidence in more deprived areas, but also high mortality in Bexley.

2.3. Circulatory disease – Hypertension, Stroke and Coronary Heart Disease (CHD)
Heart and circulatory disease is the UK's biggest killer and cause of premature death. For both of these disorders the death rate trends have been improving over that past 15 years.

CHD Particular issues in SEL:

- Bromley and Bexley have better mortality rates in people under 75 than either London or England. Lambeth Southwark Lewisham and Greenwich PCTs have higher mortality rates than London and the national average
- The actual percentage of patients who are registered with GP practices varies with much higher numbers in Bromley and Bexley (due to the much larger number of older people).
- In contrast while the actual numbers of people with CHD in Lambeth and Southwark are lower than the national average but there are poorer outcomes.
- Control of blood pressure varies between areas with Bexley achieving the highest scores.

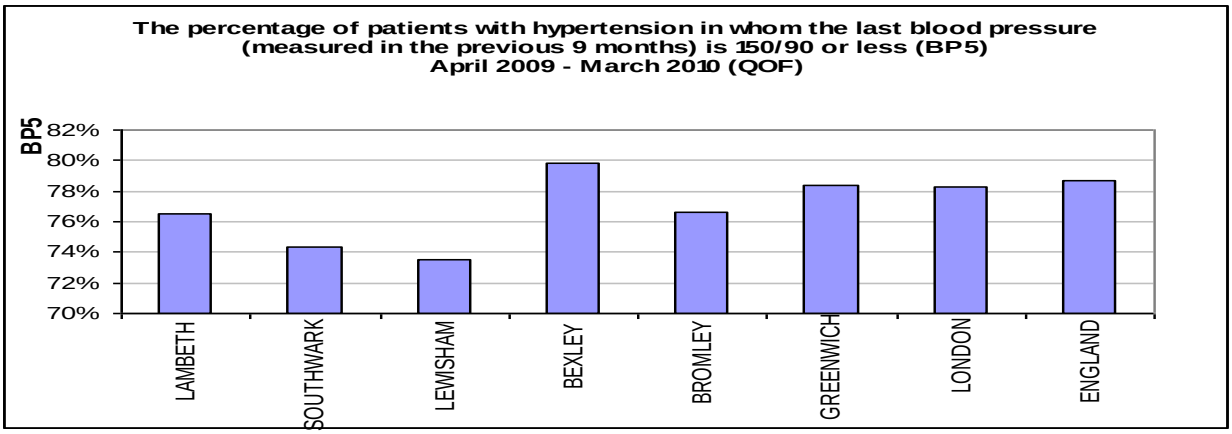

Fig 2. Outcomes of Blood pressure care: % of patients with hypertension whose blood pressure was 150/90 or less

For stroke:

- Stroke death rates in South East London are highest in the more deprived PCTs: Lambeth Lewisham and Greenwich, all of which have rates significantly higher than the London average. The death rates in under 75s, are significantly higher in SEL than for London or England but there is a general downward trend in death rates for stroke.

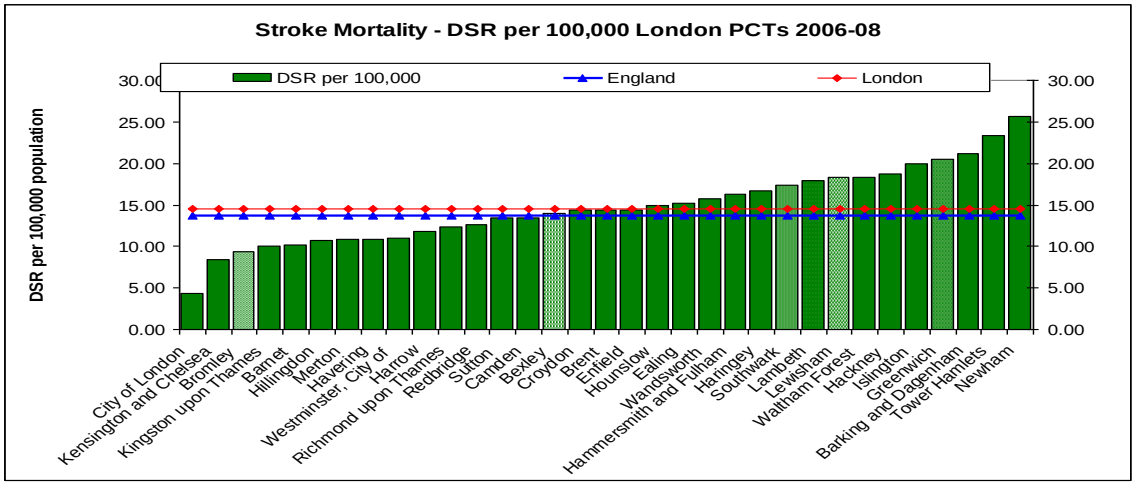

Fig 3. Stroke mortality in south London compared to London and England

- While Bromley and Bexley have comparatively low standardized death rates the actual numbers of deaths are amongst the highest in London, due to the number of older people in the boroughs
- Black African and African Caribbean people are at greater risk of high blood pressure and hence stroke while men of Asian origin are at higher risk of cardiovascular disease

2.4. Long Term Conditions (including Diabetes, COPD and HIV)

2.4.1. COPD

The most prevalent respiratory diseases are asthma and Chronic Obstructive Pulmonary Disease (COPD). Smoking is the most important risk factor for Chronic Obstructive Pulmonary Disease (COPD).

- Respiratory diseases are responsible for a high proportion of deaths in the sector
- Mortality rates for COPD are significantly higher than the national average in all PCTs except Bexley and Bromley, with rates in Southwark being about 80% higher than the national averages
- For people living with COPD there are variable prevalence rates between PCTs and very different performances on measure of monitoring control (FEV1)

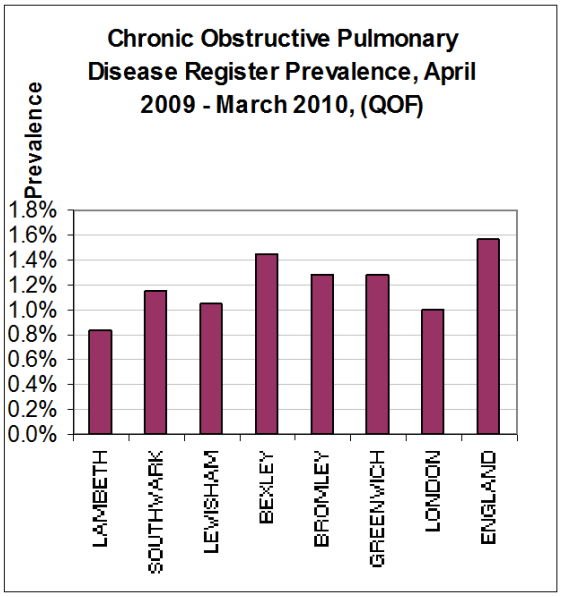

Fig 4 Chronic Obstructive Pulmonary Disease registers prevalence, April 2009 – March 2010, (QOF)

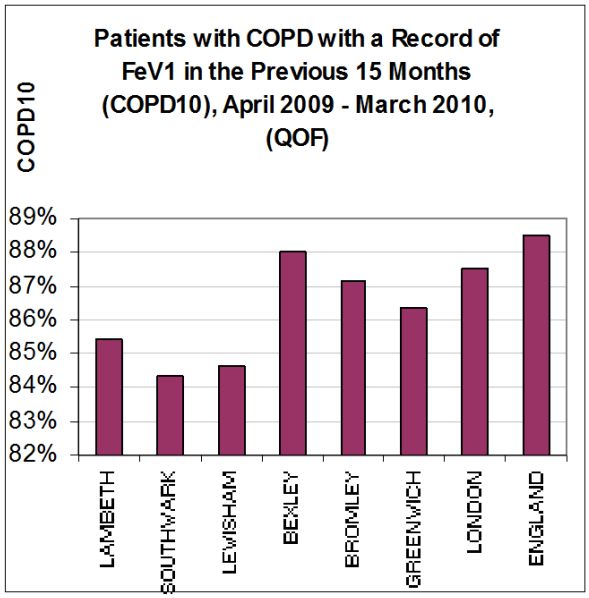

Fig 5 Patients with COPD with a record of FeV1 in previous 15 months (COPD10) (COPD10), April 2009 March 2010, (QOF)

2.4.2. Diabetes

- Diabetes is a long term condition that is responsible for considerable morbidity such as cardiovascular disease, kidney failure, peripheral vascular disease and blindness when not managed correctly. It is also responsible for considerable premature mortality.
- Populations such as Black African are at higher risk of developing diabetes and so a considerable percentage of SEL population have a greater risk of this disorder.
- There are considerable variations between practices in the level of control of diabetes achieved amongst their patients. There are also variations between practices and between PCTs in the proportion of patients that are classified as 'exceptions' to achievement of good blood glucose control

2.4.3. Sexual health (HIV)

Sexual health problems are a particular issue for Lambeth and Southwark and HIV is the most serious and life threatening of these conditions:

- The prevalence rate for HIV was 475 per 100,000 population in 2008- nearly 5 times that seen for the UK.
- The total numbers of cases across Lambeth and Southwark account for about a quarter of all the HIV cases in England.
- There were 702 new diagnoses in SE London in 2008, with the majority being amongst white males and African women. The ratio of case is about twice as many males as females being affected .The majority of cases are amongst are amongst those aged 25-44
- The proportion of new cases that were first diagnosed at an advanced stage has grown to 39% of new cases, but the target is 15%.

2.5. Mental health

Mental illness accounts for a large burden of disease and disability and significantly impacts on quality of life. On average, people with long term mental health difficulties die ten yeas younger than expected, because of poor physical health. Particular issues in SEL:

- The reported mental illness prevalence is higher than the national average in most PCTs. Prevalence is highest in Lambeth and Lewisham.
- Admissions to hospital for adults are higher than national average for Lambeth, Lewisham and Greenwich

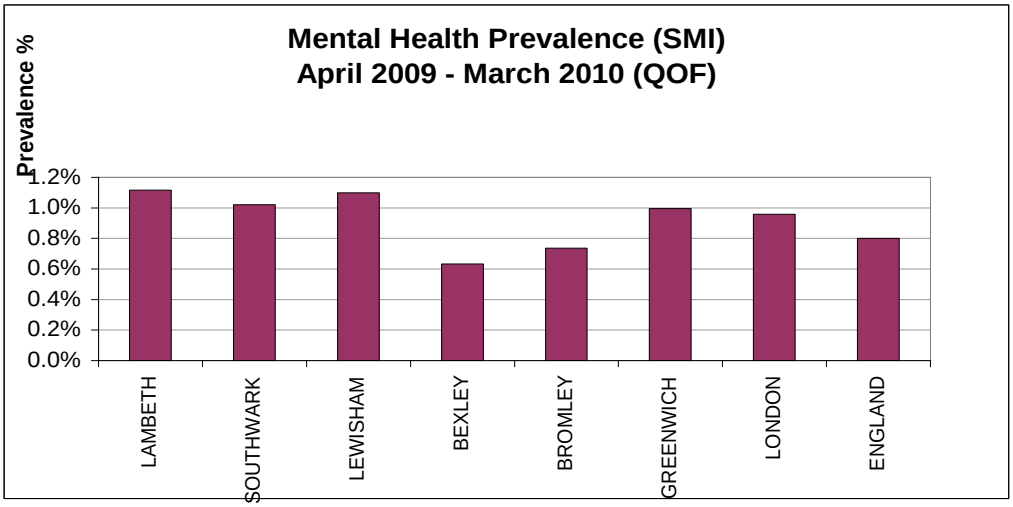

Fig 8. Mental Health Prevelance (SMI) April 2009 – March 2010 (QOF)

2.6 Staying healthy

2.6.1 Key issues affecting health

Much ill health is potentially avoidable, with lifestyle factors a significant cause. Lifestyle factors smoking, alcohol, poor diet and lack of physical exercise cause 140,000 preventable deaths a year in England and are important factors in the development of chronic disease. Avoidable ill health impacts unnecessarily on individuals and adds pressure and costs to NHS services.

- Smoking is identified as a leading risk factor for the top causes of early death in Greenwich (CVD, a number of different cancers, respiratory diseases)

- Death rates from alcohol related conditions in Lambeth are significantly higher than the rest of London for men (68 people compared to 52 in London and 50 in England per 100,000 population)
- In Southwark, there are high rates of obesity for young people both at Reception Year (14.4% second highest in the country 2007/08) and at Year 6 (26% the highest in the country)
- In Lewisham, areas with the highest proportion of people suffering from depression are also the areas in which the lowest proportions of people participate in physical exercise.
- Preventable infections continue to affect SEL residents e.g SEL has 5% of all of TB cases in the country; immunisation rates for children do not reach the necessary target levels to protect children from spread of disease

3. Staying Healthy QIPP activities – South East London

The QIPP Implementation Plan for Staying Healthy focuses on 3 sets of interventions: i) Interventions that the Public Health White Paper and consultation papers signal will be led by Public Health England and potentially led at a cluster level in the future; ii) Interventions where there is either new investment within the QIPP or a business case has been made by one or more PCTs/CTs; iii) Interventions where each PCTs/CTs public health priorities overlap and meet the shared health challenges.

This plan does not cover the totality of the work carried out in each borough by Public Health. There are many additional programmes already in operation across South East London to prevent avoidable ill health and early death and promote positive mental and physical health and well-being.

However, for some programmes working collaboratively across a few boroughs can be more effective and for a small number of areas the most effective approach has been recognised as sector wide. Therefore there is a three pronged approach to the Staying Healthy QIPP.

Staying Healthy Priority	Objectives
Sector wide approach	
Communicable disease (TB)	To improve the early detection and effective treatment of TB in SEL and reduce the burden of disease within the population
Immunisations	To improve the coverage of childhood immunisation across SEL and reduce the incidence of outbreaks and cases
Cancer screening	To improve the coverage of cancer screening programmes across SEL, increasing the early detection of treatable breast, cervical and bowel cancers within our population and improving survival rates
Borough level with collaboration between some boroughs	
Smoking cessation	To increase the numbers of people quitting smoking with NHS stop smoking services in SEL, reduce the prevalence of smoking amongst our population and reduce smoking attributable acute activity and premature mortality
Vascular prevention / Health Checks	To fully implement the new NHS Health Checks programme in SEL, reducing the major risk factors for vascular disease and reducing the prevalence of heart disease, strokes and diabetes within our population
Priority actions at borough level but with different projects chosen by borough	
Obesity	To slow down and aim to halt the rise in obesity amongst children and adults within our population, and reduce the prevalence of obesity-related mortality and morbidity
Sexual health	To improve population sexual health by reducing late diagnosis of HIV, reducing teenage conceptions, improving the early detection and treatment of chlamydia and improving access to sexual health and contraceptive services

PCT Population, Health and Public Health Profiles

ENCLOSURE 22

BEXLEY

Population profile:	**Health profile:**
• Bexley is an outer London borough with a northern boundary on the River Thames and is situated between Bromley, Greenwich and Dartford. • The estimates for 2010 show the Bexley resident population as 215,990. This population is predicted to increase to 217,910 by 2016. • Bexley has an ageing population. The proportion of residents over 65 has been projected to increase from 2006 to 2016, with a decrease projected for residents between ages 15-64. There will therefore be a higher need for services for diseases associated with older age: heart diseases, stroke and cancer. • Bexley Care Trust is in 111th position of relative deprivation out of the 152 Primary Care Trust areas in England, meaning it is amongst the most affluent communities in the country.	• There are known inequalities within Bexley. For example, the life expectancy of men living in the least deprived parts of the borough is nearly 6 years higher than for men living in the most deprived parts of the borough. For women the difference is over 4 years. • The five most common causes of death under 75 (defined as premature deaths) match the picture across the country in percentage terms: Cancers 28.8%, Ischaemic heart diseases 15.3%, Respiratory diseases 13.1%, Other circulatory diseases 10.9%, Digestive diseases 4.3% • Whilst cancers and circulatory diseases have the biggest impact in Bexley, the main causes of admission to hospital are for cardiac and respiratory conditions.
Key health priorities as identified in Bexley's 5 year strategic plan ○ Diabetes ○ Stroke ○ Mental Health – Dementia, Talking Therapies, home settings ○ COPD ○ Sexual Health ○ CVD ○ Childhood immunisations and vaccinations ○ Child health – emotional health and wellbeing ○ Childhood obesity	**Public Health Department** Bexley's Public Health and Health Improvement department is a combined commissioning and providing department. It works in partnership with and has good working relationships with a wide range of statutory and third sector organisations. The department works with partnership boards including Shadow Health and Wellbeing Board, Joint Management Board, DAAT, Children and Young People's Strategic Partnership, Sexual Health Roundtable

BROMLEY

Population Profile	Health profile:
• The population estimates for Bromley is 300,855 population which has risen by 5,280 since 2002. However the population is projected to fall to 299,492 by 2020. • The pattern of population change in the different age groups is variable between wards, with some wards such as Bromley town experiencing a large rise in the proportion of young people and Biggin Hill experiencing a large rise in the over 75s. • BME communities make up 12.3% of the population up from 8.4% in 2001, with the largest increase being amongst the Black African population. • Five wards have consistently poorer health outcomes than the rest: Penge & Cator, Crystal Palace, Mottingham & Chislehurst North. Cray Valley East, Cray Valley West	• Life Expectancy amongst Bromley residents is rising and is well above the national average with women living 1.58 years longer than the England average and men living 1.77 years more than the England average. • The gap between wards has reduced to 7.5 years for men and 7 years for women • The three main causes of death over the past five years (2005 to 2009) in Bromley have been cancer, circulatory disease and respiratory disease. However the prevalence of Coronary Heart Disease has fallen to less than half the 1993 level, in line with the national trend. • There are 12,509 people are on the diabetes register which reflects a rise in prevalence over the last 8 years from 1.6% to 4.75% • The prevalence of obesity is rising and is predicted to continue to rise with subsequent impact on prevalence of other diseases.

Priorities PH priority areas are programmes for: ▪ Healthy Weight ▪ Tobacco Control ▪ Vascular Prevention ▪ Cancer Screening ▪ Immunisation ▪ Sexual Health Additional priority areas are: ▪ Early years interventions ▪ Mental and emotional well being. the five wards with the poorest health outcomes have been targeted to receive additional health improvement support.	**Department of Public Health** The Bromley Public Health Directorate is primarily concerned with public health commissioning, but also acts as a provider for Chlamydia screening and NHS Health Checks in Bromley. In addition Bromley PH are the host commissioners for Diabetic Retinopathy Screening for Bromley, Bexley and Greenwich (BBG), and the lead cervical and breast screening commissioner for BBG. The provider service is commissioned from the Health Improvement Service in the recently established Bromley Healthcare social enterprise. Bromley Public Health team maintain very strong partnership relationships with the local authority, clinical commissioning and the voluntary sector. The PH team support clinical commissioning through health intelligence and needs assessments The majority of the PH priority programme boards include representation from the Local Authority and voluntary sector in their membership. PH has close working relationships with various teams in the Local Authority e.g. planning, environmental health, children's services, and PH is represented on the main strategic partnership groups e.g. older people, mental health.

GREENWICH

Population Profile	Health Profile
• There are 237,600 people living in Greenwich, 67% of whom are population are estimated to be aged between 16 and 64 year, 22% are under the age of 16, and11% are aged 65 and over. Greenwich has a similar population structure to London. It has a lower proportion of people of working age and more children in its population than London generally, but a similar proportion of older people. It has a younger population compared with England. • Population projections estimate that about 32.8% of the Greenwich population is estimated to be from BME (Black and Minority Ethnic) populations and 67% were estimated to be White. The next largest population group is the Black African population at 13%followed by the Indian population at 5% • Greenwich is a deprived borough. In 2007, it ranked as the 24th most deprived local authority (LA) in England (out of 354 Local Authorities) on the Index of Multiple Deprivation (IMD) and the 16th out of 152 PCTs. • Whilst Greenwich is in general more deprived than England, within Greenwich there is significant variation, with the majority of the most	Most causes of death are reducing in Greenwich whilst the numbers of people living with major conditions is increasing. Diabetes in particular is due to rise from 11,047 cases in 2008 to 15,320 in 2020 if the current levels of obesity continue. Common mental health problems will rise more over this time as they are more prevalent in younger adults and Greenwich is expected to grow mainly from migration of younger adults and from an excess of births over deaths. The major causes of death – cancer and coronary heart disease (CHD) Greenwich death rates are improving but not as fast as our deprivation comparators for cancers. For respiratory diseases, including COPD[1], rates are falling faster than London whilst for chronic liver disease the rates of death are actually rising for men in Greenwich. There are major inequalities in death rates with significant higher risk in those living in the most deprived quintile compared to the least. Local practice data versus disease prevalence estimates indicate that a

[1] COPD (Chronic Obstructive Pulmonary Disease), a term which groups together disorders of the lungs where there is difficulty breathing due to principally obstructive problems such as chronic bronchitis and emphysema.

deprived areas being in the North of the borough. • The age structure of the net migrants to Greenwich suggests that it is mainly families with children that are moving out of the area, while young people (16-24 years) are moving in. The population was expected to increase rapidly initially, and by 2015 a 13% increase in the population (i.e. over 31,000 additional residents) is projected.	sizeable number of people with a long term condition are not currently recorded as such on GP registers, particularly: High blood pressure, COPD, CKD , Dementia. For those who are recorded there is a need to better control these disorders. A comparison of effective prescribing for long term conditions shows that rates are improving but Greenwich remains at or near the bottom of its deprivation comparator group. Smoking and obesity are two significant risk factors for poor health for Greenwich residents, while much is being done more is needed for long term impact on health.
Priorities The PH and WB directorate has identified its priorities via the JSNA 7 main priorities; 10 root causes and 3 major challenges The major challenges arise from understanding of the gap in male life expectancy which is the second worse in London affecting men in the bottom 4 out of 5 quintiles of deprivation and the bottom 2 out of 5 quintiles of deprivation for women. The 7 main priorities are cardiovascular, cancers, respiratory disorders, mental health, falls and fractures, alcohol related harm and diabetes. The 10 root causes being addressed are smoking, alcohol, hypertension, physical inactivity and diet while addressing under recording in disease, the most deprived 40%, social isolation, anti-social behaviour and new populations	**Public Health Department** The Greenwich Public Health and Well-being directorate is a combined public health commissioning and providing directorate. It works in partnership with many different bodies through partnership groups such as: Health and Wellbeing Partnership , Children's and Young Peoples Strategic Partnership, Worklessness taskforce, Sports, Physical Activity and Health Group, Sexual Health, HIV and Teenage Pregnancy group.

NHS

South East London

NHS LAMBETH

A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

Chair: Caroline Hewitt

Chief Executive: Simon Robbins

ENCLOSURE 22

Population profile: • Lambeth's resident population is estimated at 283,300 in 2009. The resident population in Lambeth is estimated to grow to 305,236 by 2015 a rise of 11% from 2001. However the General Practice registered population in Lambeth was over 374,000 in March 2010. Lambeth has a relatively young population with over 50% population aged 20-44. Lambeth population is also ethnically diverse, with Black and Minority Ethnic (BME) community accounting for nearly 37% of the total population (109,416 people). • Lambeth is a borough with high levels of deprivation with some super output areas in wards amongst the most deprived in the country. The 2007 Index of Multiple Deprivation ranks Lambeth as the ninth most deprived borough in the country. • Lambeth is one of the most densely populated boroughs 11,796 people per Sq. Km (which is twice the London average).	**Health Profile** • Life Expectancy in Lambeth for men in 2006-08 was 75.7 years compared to England average of 77.9 years. The female life expectancy in 2006-08 was 81 years compared to England average of 82 years. While the LE for both is increasing year on year recent estimates shows that the gap for males is narrowing more than the gap in life expectancy for females in Lambeth compared to England. • Premature mortality in Lambeth, in the <75 year population from cardio-vascular disease and cancer is on the decline year on year • Key lifestyle factors that impact on health in Lambeth include Smoking, Obesity (especially childhood obesity), Alcohol and substance misuse • Coronary heart disease prevalence recorded in Lambeth practices is 1.4%, but estimates suggest that the figure may be as high as 3.3% with much undetected in adults. Diabetes prevalence recorded in Lambeth practices in the over 16 population is 3.9%, but with estimates suggesting the actual prevalence to be around 7.3% in adults. • Lambeth has the highest number of HIV positive individuals compared to other boroughs in London with almost 1,000 patients diagnosed per 100,000 population. • Severe mental illness as recorded in primary care QOF (Qualities and Outcomes Framework) register in Lambeth was 1.1% in 2008/09 compared to 0.9% in London. Mortality rate from suicide and undetermined injury is low and similar to the London and England average at 8.3 per 100,000.
Health Priorities Coronary heart disease Diabetes Smoking cessation Childhood obesity HIV and sexual health Severe mental illness	**Public Health Department** The department is organised into three teams, health intelligence, health protection and commissioning along with a business development and programme management function. The Department works closely with the Local Authority on a number of Partnership Boards. It also provides public health advice and support to primary and community care services in Lambeth.

NHS

South East London

A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

Chair: Caroline Hewitt

Chief Executive: Simon Robbins

ENCLOSURE 22

Lewisham

Population Profile	Health Profile
• The population is estimated as over 270,000. There are proportionally more pre-school children and younger working age adults, and fewer school-age and older age-groups than the England average. It is estimated to grow to 279300 by 2015 • There is a large BME population, with Black Caribbean and Black African being the largest groups: Black Caribbean 13%, Black African 11%, and White People making up 61% • It is the 39th most deprived borough in England.[2] • Lewisham population is growing and will become increasingly diverse, with a higher proportion of residents from BME communities. People from Black and South Asian ethnic groups are at higher risk of CHD, Stroke and Diabetes, thus leading to a greater demand on health services.	• There is a 7 year difference in life expectancy between most deprived and least deprived wards. • High premature death rates from cardiovascular disease - 31 % of life expectancy gap between Lewisham & England in men and 44% in women • The premature mortality rate of cancer for men is significantly higher than the London and England rates and for women higher than England. Lewisham has the second highest mortality for all cancers, all ages in London. Coverage for screening programmes do not meet the national targets. • The ethnicity profile means higher rates of diabetes than England average, but control of HbA1c is in the bottom quartile nationally level. • Mortality from respiratory diseases is higher than London and England. Emergency hospitalisation rates are high. • Improving care for children and young people – high childhood obesity rates; low take-up of childhood immunizations and high rates of teenage pregnancy.

2

Health Priorities:	Public Health Department
• Reducing premature mortality from cardiovascular disease • Improving mental health • Improving care for people with long term conditions, particularly diabetes and COPD • Improving the health of children and young people, particularly childhood obesity and immunisations • Reducing premature mortality from cancer • Reducing teenage pregnancy	The Department is engaged in commissioning health improvement and health services, and in health protection, and has transferred provider functions to Lewisham Health care NHS Trust from 1st April 2011. The DPH is a joint appointment, and the department will be co-located within Lewisham Council from June 2011. The department works closely with all LSP partnership boards, and is currently engaged in establishing a shadow Health and Wellbeing Board, which will meet for the first time in May 2011.

SOUTHWARK

Population Profile	Health Profile
• There are an estimated 285,000 residents in the London Borough of Southwark and 317,900 people registered with NHS Southwark's GP Practices. The resident population projected to increase by 5% from 2010 to 2014, mainly among those of working age. • Southwark has a very large young adult population, but this is similar to other London boroughs. 41.8% of the population are aged 25-44, 23.4% aged 5-24 and 18.7% aged 45-64. This younger population will have higher need for sexual, reproductive and maternity services. The management of long term conditions is still important, particularly due to our ethnic profile. • More than a third of people (35.2%) are from black and minority ethnic groups (compared to 31.0% for London). 12.2% are Black African, 6.6% Asian and 6.4% Black Caribbean. Proportions vary across the borough. Certain long term conditions are more common among black and minority ethnic groups, • More than half of the population (57%) live in the most deprived areas of England. Southwark is the 9th most deprived borough in London. 42.3% of the child population live in poverty. Deprivation is concentrated in the central parts of the borough.	• Significantly higher death rates for Chronic Obstructive Pulmonary Disease, Heart attacks and Stroke among those aged under 75 in Southwark. The all age all cause death rate for Southwark is reducing. This death rate is lower in both males and females in Southwark than the national rate. There are inequalities for life expectancy across the borough. There is also a high infant death rate. • Clear gap between modelled prevalence estimates and numbers recorded on GP registers. Variation in achievement of outcomes (eg blood sugar control for diabetics) and exception reporting exist across GP practices. • Significantly higher adult smoking rates and death rates from smoking compared to England. • Proportion of children in reception year who are obese is among the highest in England. The proportion of obese adults is similar to London, and lower than England.

• 10% of the population moves in and 10% moves out of Southwark every year making it difficult to maintain continuity of care. There is a need to maintain accurate GP practice lists for public health and health care interventions	
Health Priorities ▪ Cardiovascular disease ▪ Respiratory (COPD) in particular ▪ Diabetes ▪ Health inequalities , focussed on the most deprived 20% of the borough ▪ Childhood obesity ▪ Physical Activity ▪ Achieving improvements in screening and immunisation ▪ Reducing infant mortality	**Public Health department** The public health department is mainly a commissioner of services and works to develop health through analysis of issues, working in partnership, developing and implementing policy and engaging with as many relevant stakeholders as possible to achieve health outcomes. The department works with partnership boards such as Health and Wellbeing, Health and Social Care, Young Southwark, Southwark DAAT, Physical activity and Community Safety

SOUTH EAST LONDON HEALTH PROTECTION UNIT

Priorities South East London has high rates of a number of communicable disease including ▪ HIV ▪ Sexually Transmitted Infections ▪ Tuberculosis ▪ Viral hepatitis ▪ Malaria ▪ Low immunisation rates resulting in measles outbreaks in recent years The Unit prioritises response to acute cases and incidents. A wide range of cases and incidents occur in South East London requiring effective management to reduce spread and prevent further cases. Examples of the Unit's response during 2010 include ▪ Working with TB teams to manage over 30 TB incidents requiring screening in settings such as schools and colleges ▪ Over 200 suspected cases of measles requiring individual investigation and follow up. ▪ Eighteen cases of legionnaires' disease requiring investigation with Environmental Health Officers into potential environmental sources ▪ Over 30 cases of acute hepatitis B infection requiring provision of advice on prevention of spread and investigation into potential sources	**South East London Health Protection Unit (SELHPU)** SELHPU is a local unit of the Health Protection Agency (HPA) and is based at 1, Lower Marsh SE1. It serves the population of the six South East London boroughs and is part of the public health function in South East London. The Unit's core functions are: • Surveillance of communicable disease and environmental hazards; • Acute response to cases, incidents and outbreaks of communicable disease and environmental hazards; • Working with local partners to implement nationally or locally formulated strategies or policies to prevent and control communicable disease and environmental hazards. This includes a role in emergency planning. To deliver these functions the Unit works closely with a wide range of organisations and professionals including local authority environmental health officers, primary care organisations, hospitals and others in the wider Health Protection Agency. .

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

SUMMARY AGENDA
Thursday 19th May 2011

BM/001/11	3.00	**Welcome & Introductions**		Caroline Hewitt
BM/002/11	3.05	**Apologies for Absence**		Caroline Hewitt
BM/003/11		**Declaration of Interests**		All
BM/004/11	3.10	**Matters Arising not on the agenda**		Caroline Hewitt
BM/005/11	3.15	**Governance**	ENC 1-5	Simon Robbins
BM/006/11	3.30	**NHS SEL Business Plan & Corporate Objectives**	ENC 6	Tony Read
BM/007/11	3.40	**Integrated Plan**	ENC 7	Gill Galliano
BM/008/11	3.55	**Emergency Planning & Business Continuity Policy**	ENC 8	Dr Ann-Marie Connelly
BM/009/11	4.05	**Minutes of previous PCT Board meetings**	ENC 9	PCT MDs
BM/010/11	4.15	**Pathfinder Development & Delegation**	ENC 10	Gill Galliano
BM/011/11	4.35	**Local Clinical Commissioning Committees**	(See ENC 1)	LCCC Chairs
BM/012/11	4.45	**Performance & Quality**	ENC 11	Jane Schofield
BM/013/11	4.55	**Finance Report**	ENC 12	Marie Farrell
BM/014/11	5.05	**Quality Report**	ENC 13	Dr Jane Fryer
BM/015/11	5.15	**London Review of Cancer Services**	ENC 14	Andrew Eyres
BM/016/11	5.25	**Pharmaceutical Applications Panel**	ENC 15	David Sturgeon
BM/017/11	5.30	**BEXLEY CARE TRUST** To discuss progress on the QMS Campus Outline Proposal	ENC 16	Dr Joanne Medhurst/ Pamela Creaven
BM/018/11	5.45	**BEXLEY CARE TRUST** Business Case and transfer of £2.4 million to the Local Authority for Social Care	ENC 17	Dr Joanne Medhurst/ Pamela Creaven
BM/019/11	5.45	**LAMBETH PRIMARY CARE TRUST** Lambeth PCT & Southwark PCT Community Services Integration at GSTT	ENC 18	Andrew Eyres
BM/020/11	5.45	**BROMLEY PRIMARY CARE TRUST** Local Pharmaceutical Service Continuation of Designation	ENC 19	Dr Angela Bhan
BM/021/11		**Chair's Report**	ENC 20	Caroline Hewitt
BM/022/11		**Chief Executive's Report**	ENC 21	Simon Robbins
BM/023/11		**Director of Public Health Briefing**	ENC 22	Dr Ann-Marie Connolly
BM/024/11	5.50	**Any Other Business**		
BM/025/11	5.50	**Questions from the Public**		Caroline Hewitt
BM/026/11		**Date of Next Meeting**		
BM/027/11		**Close**		