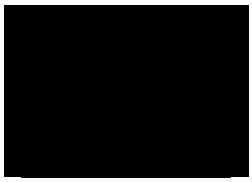
South East London

NHS SOUTH EAST LONDON PCT/ CARE TRUST BOARDS

Thursday 21st July 2011, 3.00pm-6.00pm

Council Chambers,
Bromley Civic Centre,
Stockwell Close,
Bromley BR1 3UH



All Boards / SEL (Black)

Bexley (Yellow)

Bromley (Blue)

Greenwich (Green)

Lambeth (Purple)

Lewisham (Red)

Southwark (Orange)

TAB COLOUR INDEX

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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 21st July 2011, 3.00pm-6.00pm at the Council Chamber, Bromley Civic Centre, Stockwell Close, Bromley BR1 3UH.**

Board members are requested to send questions or clarification requests to the Board Secretary by 12.00pm on Monday 18th July 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

	Time	Item	Papers	Presented by
BM/028/11	3.00	**Welcome & Introductions**		Caroline Hewitt
BM/029/11	3.05	**Apologies for Absence**		Caroline Hewitt
BM/030/11		**Declaration of Interests*** *Members should discuss any potential conflicts of interest with the Chair prior to the meeting.*		All
BM/031/11	3.10	**Minutes of previous meeting held on 19th May 2011** To agree the minutes of the previous meeting.	ENC 1	Caroline Hewitt
BM/032/11	3.10	**Matters Arising not on the agenda**		Caroline Hewitt

LEGACY				
ACTION BY: All Boards				
BM/033/11	3.15	**Quality Assurance Report** To agree further areas for review to improve assurance on provider quality	ENC 2	Dr Jane Fryer
BM/034/11	3.35	**Safeguarding Arrangements** To receive a briefing and endorse action on the SE London Safeguarding Arrangements.	ENC 3	Donna Kinnair
BM/035/11	3.50	**Primary Care Improvement Plan** To receive a discussion document on developing a Primary Care Improvement Plan for the next 18 months.	ENC 4	David Sturgeon
~ COMFORT BREAK (10 MINUTES) ~				
DELIVERY				
ACTION BY: All Boards				
BM/036/11	4.15	**Performance Report** To receive for information and agree actions as required.	ENC 5	Sean Morgan
BM/037/11	4.25	**Finance Report** To receive for information and agree actions as required.	ENC 6	Marie Farrell
BM/038/11	4.35	**NHS SEL Business Plan** To note revisions made to NHS SEL Business Plan. Corporate Objectives are available for Board members review via the website.	ENC 7	Gill Galliano
REFORM				
ACTION BY: All Boards				
BM/039/11	4.45	**NHS Commissioning System Reform** • **Future Forum and Government Response** To note the Future Forum report and command document. • **Commissioning Support Services** To note the development of Commissioning Support Services.	ENC 8	Simon Robbins Gill Galliano

REFORM				
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/040/11	4.55	**Pathfinder Development & Delegation** To agree recommendations for delegation to commissioning consortia • Lambeth PCT • Bexley Care Trust • Southwark PCT Note updates relating to progress toward pathfinder development and delegation • Bromley PCT • Greenwich Teaching PCT • Lewisham PCT	ENC 9	Simon Robbins
GOVERNANCE				
ACTION BY: All Boards				
BM/041/11	5.15	**Joint Boards Assurance Framework** To agree the Joint Boards Assurance Framework and note the indicative NHS SEL Risk Register pending adoption of the framework.	ENC 10	Gill Galliano
BM/042/11	5.25	**Delivering Equalities** To agree the implementation of the Equality Delivery System.	ENC 11	Gill Galliano
BM/043/11	5.35	**Standing Orders/Standing Financial Instructions** To receive changes to the Standing Orders/Standing Financial Instructions.	ENC 12	Simon Robbins
BM/044/11	5.37	**Register of Sealed Documents** To receive a register of Sealed Documents across South East London PCTs/Care Trust.	ENC 13	Caroline Hewitt
BM/045/11	5.40	**London Specialised Commissioning Group** To agree Chairs Action being taken to adopt a revised Establishment Agreement for the London Specialised Commissioning Group.	ENC 14	Sean Morgan

AGENDA

GOVERNANCE				
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/046/11	5.45	**BROMLEY PRIMARY CARE TRUST** To ratify Chair's Action regarding "Any Willing Provider" arrangements for community gynaecology and community dermatology services.	ENC 15	Meredith Collins
BM/047/11	5.50	**GREENWICH TEACHING PRIMARY CARE TRUST** To endorse the Greenwich Pharmaceutical Needs Assessment.	ENC 16	Annabel Burn
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/048/11		**Chair's Report**	ENC 17	Caroline Hewitt
BM/049/11		**Chief Executive's Report**	ENC 18	Simon Robbins
BM/050/11		**Human Resources Update**	ENC 19	Gill Galliano
BM/051/11		**Local Clinical Commissioning Committees** To note the minutes of the Local Clinical Commissioning Committees (LCCC): • Bexley • Bromley • Greenwich • Lambeth • Lewisham • Southwark	ENC 20	Dr Howard Stoate Dr Andrew Parson Dr Hany Wahba Dr Adrian McLachlan Dr Helen Tattersfield Dr Amr Zeineldine
BM/052/11		**Audit Committee** To receive for information the draft minutes of the Audit committee held on 6 June 2011.	ENC 21	Steven Corbishley
BM/053/11		**Performance, Finance & QIPP** To receive for information the draft minutes of the Performance, Finance & QIPP committee held on 30 June 2011.	ENC 22	Graham Laylee

BM/054/11		**Quality & Safety** To receive for information the draft minutes of the Quality & Safety committee held on 30 June 2011.	ENC 23	Susan Free
ANY OTHER BUSINESS				
BM/055/11	5.55	Any other business.		
BM/056/11	5.55	To receive questions from the public (if time allows).		Caroline Hewitt
DATE OF NEXT MEETING				
BM/057/11		Thursday 22nd September 2011, PART I 3.00pm-6.00pm, PART II 6.10pm-7.00pm, Venue to be confirmed.		
BM/058/11		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

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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 was held on Thursday 19th May 2011, 3.00pm-6.00pm at the Council Chambers, Lewisham Town Hall, 1 Catford Road, London SE6 4RU.

DRAFT MINUTES

Present:

Non-Executive Members	**Executive Members**
Caroline Hewitt, Chair, NHS SEL	Dr Angela Bhan, Managing Director, Bromley BSU
Steven Corbishley, Non-Executive Director	Andrew Bland, Managing Director, Southwark BSU
Paul Cutler, Non-Executive Director	Annabel Burn, Managing Director, Greenwich BSU
Cllr John Davey, Non-Executive Director	Dr Ann-Marie Connolly, Director of Public Health, NHS SEL
Jeremy Fraser, Non-Executive Director	Pamela Creaven, Joint Managing Director, Bexley BSU
Susan Free, Non-Executive Director	Andrew Eyres, Managing Director, Lambeth BSU
Sue Gallagher, Non-Executive Director	Marie Farrell, Director of Finance, NHS SEL
Richard Gibbs, Non-Executive Director	Jane Fryer, Medical Director, NHS SEL
James Gunner, Non-Executive Director	Gill Galliano, Director of Development, NHS SEL
Harvey Guntrip, Non-Executive Director	Dr Hilary Guite, Director of Public Health, NHS Greenwich
Graham Laylee, Non-Executive Director	Dr Nada Lemic, Director of Public Health, NHS Bromley
Rona Nicholson, Non-Executive Director	Dr Adrian Mclachlan, Clinical Lead, Lambeth BSU
Cllr Eileen Pallen, Non-Executive Director	Dr Joanne Medhurst, Joint Managing Director, Bexley BSU
Robert Park, Non-Executive Director	Dr Andrew Parson, Clinical Lead, Bromley BSU
David Whiting, Non-Executive Director	Simon Robbins, Chief Executive, NHS SEL
Keith Wood, Non-Executive Director	Dr Danny Ruta, Director of Public Health, NHS Lewisham
	Jane Schofield, Director of Operations, NHS SEL
	Dr Howard Stoate, Clinical Lead, Bexley BSU
	Dr Helen Tattersfield, Clinical Lead, Lewisham BSU
	Dr Hany Wahba, Clinical Lead, Greenwich BSU
	Dr Ruth Wallis, Director of Public Health, NHS Lambeth
	Martin Wilkinson, Managing Director, Lewisham BSU
	Dr Amr Zeineldine, Clinical Lead, Southwark BSU

Board Membership		Quorate	Board Membership		Quorate
	All Boards/South East London	YES		Lambeth PCT	YES
	Bexley Care Trust	YES		Lewisham PCT	YES
	Bromley PCT	YES		Southwark PCT	YES
	Greenwich Teaching PCT	YES			

In Attendance
Ebenezer Akinsanmi, Lambeth LINk
Graham Church, Genus Pharmaceuticals
Una Dalton, Director of Human Resources, NHS SEL
Michael English, Lambeth LINk
Sarah Gardner, Deputy Director, Governance, NHS SEL
Frances Hook, Greenwich LINk
Havi Hothi, Member of the Public
Oliver Lake, Director of Corporate Affairs, NHS SEL
Yvette London, Deputy Director, Communications, NHS SEL
Miriam Long, Lewisham LINk
Sean Morgan, Director of Performance, NHS SEL
John Nawrockyi, London Borough Greenwich
Joanna Nurse, Media Relations Manager, NHS SEL
Tony Read, Director of Strategy & QIPP, NHS SEL
Jeanette Threadgold, Lambeth LINk
Ben Vinter, Integrated Governance Manager, NHS SEL
Jane Walker, Head of Corporate Office/Board Secretary, NHS SEL
Alastair Whitington, SEL Cancer Network

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BM/001/11	**Welcome & Introductions** Ms Hewitt welcomed members to the first meeting of the Joint Boards of NHS South East London and particularly welcomed members of the public. The Chair assured members that at future meetings the volume of papers and the number of process items, necessary on this occasion, would be greatly reduced. Ms Hewitt also stated that following submission of a number of advance questions and points of clarification from board members - responses had been circulated electronically and also tabled at the meeting. These would also be appended to the minutes. Due to the scale of business to be covered, opportunity for the public to ask questions would be limited. Requests had therefore been made that wherever possible these are submitted in advance. The Chair also stated that in advance of future meetings she would host an hour pre-meet for members of the public and their representative bodies to raise questions. The outputs of such discussions would be minuted and published with the minutes of the boards' meeting.	
BM/002/11	**Apologies of Absence** There were no apologies received from Board members. Apologies were received from members of the executive team including Dr Kinnair, director of nursing, Ms Cottingham & Ms Masters, joint directors of acute contracting and Ms Selby, director of workforce transformation.	
BM/003/11	**Declarations of Interests** The Chair stated that she had not been notified of any potential conflicts of interest from members prior to the meeting and asked members to raise any declarations of interest prior to each item. The Board noted that a declarations register was being circulated.	
BM/004/11	**Matters Arising not on the agenda** There were no matters arising to discuss not already included on the agenda.	

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BM/005/11	**Governance** Governance Framework Ms Hewitt thanked Ms Galliano and her team for the comprehensive paperwork and thanked colleagues for their input and stated that there would be a need to keep the governance framework under review as the organisations moved forward. The Chair asked members to refer to the Page 68 of the board papers, Bexley Care Trust, board membership and informed members that a number of iterations of legal advice had been received. The documentation sets out two Councillor representatives, Cllr Eileen Pallen and Cllr John Davey, to share a vote (0.5 & 0.5). The latest advice indicated that this could not be the case and she had therefore had asked Mr Gunner to stand down as a member of the Bexley Care Trust Board in order to allow the Councillor representatives to have a vote each. Ms Galliano introduced the governance framework and highlighted areas where approval was required, stating that work continued to refine and apply consistency of language. Members were also asked to note that comments had been received from board members on the draft terms of reference; where practical these had already been incorporated. A full list would be referred to the committee chairs. Ms Connolly informed members that she would ensure that the Public Health function, within the Bexley Care Trust Board membership, would be covered, until their vacancy had been filled. Moreover the Joint Boards reflected upon the arrangements in place for Director of Public Health representation at the Joint Board meetings and understood the arrangements to be that Ms Connolly would represent the public health view unless a local issue arose at which time the local Director of Public Health would contribute. **RECOMMENDATIONS** **The Joint Boards noted the contents of the governance framework and approved the draft terms of reference for the Joint Committees of the Board, delegating final drafting to the committee chairs and vice chairs. Any amendments would need to be brought back to the board for approval.** Ms Hewitt asked members to NOTE the proposed membership of the Boards' Joint Committees:	**Committee Chairs /Vice Chairs**

	Audit: Chair, Steven Corbishley, appointed by the Audit Commission Members: Keith Wood, Harvey Guntrip, Jeremy Fraser, Graham Laylee, Rona Nicholson, Robert Park **Quality & Safety**: Chair, Susan Free, Vice Chair, Robert Park. Members: Paul Cutler, Cllr Eileen Pullen, Harvey Guntrip, Sue Gallagher, David Whiting , Caroline Hewitt **Finance/QIPP/Performance** : Chair, Graham Laylee, Vice Chair, Keith Wood Members: Cllr John Davey, Jim Gunner, Jeremy Fraser, Rona Nicholson, Richard Gibbs, Caroline Hewitt **Remuneration and Employment**: Chair, Caroline Hewitt Members: Paul Cutler, Keith Wood, Harvey Guntrip, Jim Gunner, Jeremy Fraser, Susan Free, Sue Gallagher, Graham Laylee, David Whiting, Rona Nicholson, Robert Park, Richard Gibbs <u>Standing Orders/Standing Financial Instructions/Scheme of Delegation</u> Ms Farrell introduced the common Standing Orders, Standing Financial Instructions and Scheme of Delegation for NHS South East London . Ms Farrell informed the Board that these had been based on the Department of Health models and amended to reflect the specific needs of the Cluster. They may be subject to further review as the organisations evolve. The Chair confirmed that any changes made would be tracked and be brought back to future Board meetings for ratification. **<u>RECOMMENDATION</u>** **The Joint Boards approved the standing orders, standing financial instructions and schemes of delegation and noted that LCCCs and BSUs will, going forward, also be subject to the guidelines, procedures and processes encompassed within the suite of documentation.**	**All Directors**

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	Adoption of the Principles of Public Life Ms Hewitt introduced the Nolan Principles on Standards for Public Life and asked Board members reflect upon their importance in view of the populations they serve. **RECOMMENDATION** **The Joint Boards endorsed the adoption of the Nolan Principles on Standards for Public Life.** Adoption of NHS SEL Boards' Contract Ms Hewitt asked board members to endorse the adoption of the NHS SEL Boards' Contract and agree shared responsibility for adherence to the contact and implied way of working. **RECOMMENDATION** **The Joint Boards adopted the NHS SEL Boards' Contract and agreed the way of working.** Adoption of lead officer roles Ms Galliano introduced the list of PCT statutory duties and responsibilities together with lead officer roles for each PCT/Care Trust. Ms Galliano asked Board members to note a number of changes since the submission of the paper. These included: • The cluster Senior Information Responsible Officer would be Marie Farrell with BSU leads being those designated. • The Lewisham BSU lead Senior Information Responsible Officer would be Martin Wilkinson, Managing Director. • The cluster Caldicott Guardian would be Jane Fryer, Medical Director, with BSU leads being those designated. Ms Galliano stated that the Boards had also received an update on safeguarding circulated in advance of the meeting which would be appended to the minutes. It was **AGREED** that an update against London Safeguarding Board recommendations would be presented at the July meeting. A list of statutory PCT functions was included for Board members' information which would be kept under review.	**Ms Galliano** **Dr Fryer**

	RECOMMENATION **The Joint Boards noted the updated designations previously taken forward by Boards through Chair's Action.** Indicative Corporate Risk Register Mr Robbins introduced the Indicative Corporate Risk Register and asked members to note the summary of risks provided to the Board from across SEL. An assurance framework would also be developed for consideration by the Board at the July meeting. Following discussion it was agreed that the indicative risk register did not yet capture strategic risks. The Joint Boards requested the Audit Committee provide assurance as to the fitness for purpose of the assurance framework and report back to the Joint Boards. **RECOMMENDATION** **The Joint Boards noted the Indicative Risk Register, taking into account an assurance framework and a comprehensive picture of risk would be submitted to the July board meeting.**	**Mr Corbishley/ Ms Farrell** **Mr Lake**
BM/006/11	**NHS SEL Business Plan & Corporate Objectives** Mr Robbins introduced the paper stating that the Business Plan & Corporate Objectives build on work discussed at the recent Board awayday where three high level objectives had been developed: **Delivery** - sustain an effective grip on Finance, Performance and delivery of the QIPP programme - delivery of national Operating Framework priorities **Reform** - proactively manage the transition to the new commissioning system **Legacy** - improve health, quality and maintain safety of local services Mr Robbins suggested that future Board meeting agendas should be structured around the three identified objectives. The aim of the business plan was to clearly set out the key actions required by SEL cluster with associated KPIs to provide the Boards with a method of assurance. While the document would remain live	

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	and be kept under continual review progress would be monitored on a monthly basis through both the Delivery and the Operations Groups. Ms Galliano confirmed that the document had been produced in liaison with all Directors, identifying objectives common across all BSUs together with individual Borough objectives. Further development would take place over the next few weeks with the Board briefed on any changes. Ms Hewitt agreed the structure for future Board meetings and stated the Business Plan would identify the Boards will hold Executive Directors accountable for. A number of key points were raised by members: • It was important as a priority that BSUs learnt from each other • Primary Care issues including pharmacy and prescribing need greater prominence • When finalised the document requires a final review for consistency and overall narrative Ms Hewitt agreed to ask Mr Sturgeon and Dr Fryer to reflect on how to develop Primary Care indicators and population health indicators, and to involve Chairs of Committees and Directors of Public Health in this process. **<u>RECOMMENDATIONS</u>** **The Joint Boards agreed the NHS SEL Business Plan and Corporate Objectives.** **The Joint Boards agreed for GP Commissioning Consortia to define the vision for NHS SEL by July 2013 (to be coordinated by the BSU MDs).** **The Joint Boards endorsed the stated three core corporate objectives and the priorities listed under each core objective.** **The Joint Boards noted the work plans/objectives for each of the cluster directorates.** **The Joint Boards agreed the KPIs for 'measuring success' and the need for further work.**	**BSU MDs** **Mr Sturgeon** **Mr Read** **Mr Strugeon** **Dr Fryer** **Dr Connolly** **BSU MDs**

	The Joint Boards noted that the documentation represents work in progress and the plan would continue to be developed and that the business plan would be reviewed and updated on a quarterly basis.	
BM/007/11	**Integrated Plan** Ms Galliano introduced the paper which provided the Board with a summary overview of the financial position for the five SEL PCTs and Bexley Care Trust, illustrating the key drivers in the financial case for change, each PCT/Care Trust spend by QIPP category and the potential QIPP savings. Ms Galliano informed the Board that this would be monitored throughout the year and regular reporting would be provided. **RECOMMENDATIONS** **The Joint Boards noted that the six SEL PCTs/Care Trusts had submitted Operating Plans for 2011/12 in line with the Operating Framework guidelines and NHS London financial planning guidance.** **The Joint Boards noted the planning assumptions, impact of QIPP and the results of the cluster challenge process.**	
BM/008/11	**Emergency Planning & Business Continuity** Dr Connolly introduced the Emergency Planning and Business Continuity Policy for approval by the Boards and updated the Boards on the work being undertaking in liaison with BSUs with regards to an on-call rota and major incidents plan. This programme of work was required to ensure that the PCTs/Care Trust continue to be Category 1 responders under the Civil Contingencies Act. A new Emergency Planning and Resilience Steering Group would be established and report through the Quality and Safety Committee. The approval of the policy would contribute to the assurance process and completion of assurance returns to NHS London to demonstrate that the new organisations were compliant with their statutory responsibilities.	

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	Board members sought assurance that work previously undertaken continued at a local level. In response Dr Connolly confirmed that the Emergency Planning and Resilience Steering Group would oversee the work being undertaken at local level within each PCT/Care Trust who continued to work with Acute Trusts/Category 1 responders and London Ambulance Service. Dr Connolly also confirmed that work was going on across London with regards to the Olympics which was currently identifying what resources were required across London by working in conjunction with a number of boroughs. It was therefore **AGREED** that the Joint Quality & Safety Committee would oversee work to ensure the respective roles of individual PCTs/Care Trust is clear, determine resilience levels and assess levels of preparation for individual BSUs and the cluster as a whole . **RECOMMENDATIONS** **The Joint Boards approved the policy and noted the actions progressed to date and planned to secure robust emergency planning and resilience arrangements for the Joint Boards.**	**Ms Free/ Dr Fryer** **Dr Connolly**
BM/009/11	**Minutes of previous PCT Board meetings** The Chair asked the Boards to receive and approve the minutes of each of the last meetings' of SEL PCTs/Care Trust from 2010/11, noting actions taken since the last meeting: **Bexley Care Trust** The minutes of the meeting held on 15 March 2011, were **AGREED** as a correct record. There were no matters arising outstanding. **Bromley Primary Care Trust** The minutes of the meeting held on 17 March 2011, were **AGREED** as a correct record. **Greenwich Teaching Primary Care Trust** The minutes of the meeting held on 23 March 2011, were **AGREED** as a correct record noting the following: Dr Guite identified two omissions. The first from item 213/2011, 2011/12 Budget, to be amended with regards to the significance of	**Dr Guite** **Mr Robbins**

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	the red rated items in the QIPP programme risk assessment. Mr Robbins requested that Dr Guite write to him with the amendment and he would action via the Chair. It was further noted that the minutes did not record the Board's decision made at the meeting that the Director of Public Health would remain a Board member. There were no matters arising outstanding. **Lambeth Primary Care Trust** The minutes of the meeting held on 17 March 2011, were **AGREED** as a correct record. Mr Eyres reported that there were no outstanding matters arising and noted the outstanding action to bring the integrated care pilot at KHP to the meeting of the joint boards. **Lewisham Primary Care Trust** The minutes of the meeting held on 23 March 2011, were **AGREED** as a correct record. Mr Wilkinson reported that items 11/36 and 36.2 under matters arising were being picked up via the Development Group. **Southwark Primary Care Trust** The minutes of the meeting held on 24 March 2011, were **AGREED** as a correct record, with two amendments previously submitted by Richard Gibbs (appended to these minutes). Mr Bland reported that both items under matters arising, 1055/11 and 1060/11 had been completed and the paperwork would be supplied for appending to the minutes.	**Mr Eyres** **Mr Bland** **Mr Bland**
BM/010/11	**<u>Pathfinder Development & Delegation</u>** Ms Galliano introduced the paper and asked the Joint Board to consider the proposal for delegated responsibilities to Pathfinders in South East London, through the Local Clinical Commissioning Committees (LCCCs) which are now committees of each Board. The proposals require each Pathfinder to submit a Pathfinder Delivery Plan, and the paper outlined what this should entail in order to provide assurance both to the Board and NHS London.	

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	Mr Hall, in preparing the report, had met with all six BSUs, and held on-going discussions with NHS London and a workshop where development priorities and the delegation framework were discussed. This included discussion around how to spend the £2.00 per head, the process of allocation for which would be approved over the next couple of weeks. While it was understood NHS London were in the process of developing an assurance process on who would need to sign off delegated responsibilities. Mr Robbins stated that as Accountable Officer it was his responsibility to make the final decision around delegation. NHS London would ask the Accountable Officer to demonstrate support from Boards and the assurance that can be provided by BSUs and pathfinders. The Board **NOTED** the need for each LCCC to adopt a clear approach to management of conflicts of interest in LCCC and GP Pathfinder development which would be dealt with under the next item. **RECOMMENDATIONS** **The Joint Boards noted progress with the development an 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 £2.00 per head from April 2011.** **The Joint Boards noted 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).** **The Joint Boards agreed 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. The Boards agreed to the devolution of commissioning responsibilities for each of the Pathfinders via the Local Clinical Commissioning Committees.** **The Joint Boards agreed 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.**	**BSU MDs**

	The Joint Boards agreed 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. **The Joint Boards agreed 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.**	**Ms Galliano**
BM/011/11	**<u>Local Clinical Commissioning Committees (LCCCs)</u>** The Chair asked the individual Boards to agree the terms of reference of the Local Clinical Commissioning Committees: **Bexley** Members of the Bexley Board **AGREED** the terms of reference for the Bexley LCCC. **Bromley** Members of the Bromley Board **AGREED** the terms of reference for the Bromley LCCC and **NOTED** that they would remain under regular review. **Greenwich** Members of the Greenwich Board **AGREED** the terms of reference for the Greenwich LCCC. **Lambeth** Members of the Lambeth Board **AGREED** the terms of reference for the Lambeth LCCC, recognising there was a need to strengthen its approach to management conflict of interest, the need to review the Nurse member and Local Authority voting rights. **Lewisham** Members of the Lewisham Board **AGREED** the terms of reference for the Lewisham LCCC, noting there was currently a vacancy for the Nurse member. **Southwark** Members of the Southwark Board **AGREED** the terms of reference for the Southwark LCCC, stating that there was a process in place	

	to appoint the Nurse member. It has also been agreed to review the terms of reference during April 2012. **RECOMMENDATION** **Mr Robbins agreed to coordinate a standardised approach to development and management of conflict of interest across all SEL LCCCs.**	**Mr Robbins**
BM/012/11	**Performance & Quality** Ms Schofield introduced the 2010/2011outturn performance report, which provided details of 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. 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. Ms Gallagher raised the issue of relationships with providers and suggested positive feedback be given, when appropriate, via the Chair. **RECOMMENDATION** **The Joint Boards noted the contents of the report.**	**Ms Hewitt**
BM/013/11	**Finance Report** Ms Farrell presented the finance report which outlined the financial outturn performance for the cluster in 2010/11, and updated the Board on the settlements associated with acute contracts 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 the Boards are asked approve use of funding from the identified 2% non recurrent funds. The paper also outlines the significant increase in QIPP delivery requirements and the processes adopted to secure delivery. **RECOMMENDATION** **The Joint Boards noted:** • **The 2010/11 financial performance of the cluster (based on unaudited positions)** • **The overall budget for the NHS SEL cluster previously agreed by PCT Boards** • **The impact of acute contract settlements**	

	• **The commitments in the use of the 2% non recurrent funding** • **The overall financial savings anticipated from the cluster QIPP programme** **The Joint Boards agreed to delegate authority for adoption of the audited accounts to the cluster Audit Committee and to authorise the Chairman, Chief Executive and Director of Finance to sign off the accounts on behalf of the Board.**	
BM/014/11	**Quality Report** Dr Fryer introduced a report on quality and safety – historical issues & current arrangements, for the Board to note. The paper provided 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. Ms Free welcomed the report as the new Chair of the Joint Quality & Safety Committee and felt it was important, in looking forward, to develop and secure universally high standards across the cluster. The Chair stated that at future Board meetings, quality would be a standard item under the heading 'delivery'. **RECOMMENDATION** **The Joint Boards noted the contents of the report.**	**Dr Fryer**
BM/015/11	**London review of Cancer Services** Mr Eyres, in his role as Chair of the South East London Cancer Network, introduced a report to update Board members on the work being undertaken to implement the national *Improving Outcomes: A Strategy for Cancer* and the London Review of Cancer Services. Mr Eyres reported that the purpose of the paper was to increase the level of engagement across the cluster and ask LCCCs to review the proposals. An event for all GPs locally has been arranged for the 11 June 2011 to discuss ways of early detection and diagnosis. Mr Eyres also stated that the paper provided details of timetable and how we would commission across South East London.	

	Dr Connolly and Ms Burn noted the importance of prevention both prior to developing cancer (primary prevention) and screening for the early detection of cancer or pre-cancerous lesions (secondary prevention) as part of the cancer care pathways. **RECOMMENDATIONS** **The Joint Boards noted:** • ***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.** **The Joint Boards endorsed the expectation that;** • **The six borough Clinical Commissioning Committees 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.**	
BM/016/11	**Pharmaceutical Applications Panel** Mr Sturgeon presented a paper detailing proposals to establish a Pharmaceutical Applications Panel, in order to have suitable arrangements in place to consider pharmacy applications received under the NHS Pharmaceutical Services Regulations 2005 and it subsequent amendments. The paper detailed proposals for consistent decision making arrangements on behalf of the six PCTs/Care Trust within South East London. Mr Sturgeon stressed the urgency of establishing the Panel as there was already two cases outstanding. Membership required a Non Executive Director, with legal experience preferable but not necessary.	

	The Joint Boards preference was stated to be for a current NED to sit on the panel. However in recognition of current capacity challenges, it was suggested, as the guidance required, replacing a NED membership requirement with a Lay member so as to allow for flexibility and potential use of the former NHS SEL NED pool. Mr Whiting **AGREED** to act as interim Lay member in order for the outstanding panels to be heard. **RECOMMENDATION** **The Joint Boards approved the proposed configuration of and scope of responsibilities of a Panel which will consider pharmacy applications received by the six PCTs under the NHS Pharmaceutical Services Regulations 2005 and its subsequent amendments.** **The Joint Boards approved 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.** **The Joint Boards approved the proposed arrangements via the Joint Quality & Safety Committee for reporting decisions of the Panel to the Boards.** **The Joint Boards approved the proposed full membership of The Panel, taking into account the amendment from a NED member to a Lay Member.**	**Mr Sturgeon** **Mr Sturgeon** **Mr Sturgeon**
BM/017/11	**BEXLEY CARE TRUST – Progress on the QMS Campus Outline Proposal** Dr Medhurst introduced a paper which provided a summary of the proposals for the development of a Health and Wellbeing Campus on the site of Queen Mary's Hospital in Sidcup. This was an outline proposal, developed jointly by Bexley Care Trust and the London Borough of Bexley. Dr Medhurst stated that it was the aim of Bexley Care Trust and the London Borough of Bexley to provide a mix 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 aging population and the rising incidence of long term conditions.	

	Dr Medhurst advised the Board that the statement of intent attached to the board paper demonstrated the Borough wide agreement to the approach. Dr Bhan stated that Bromley welcome the direction of travel and asked for a wider understanding of the finances before the final business case. Mr Robbins personally endorsed the intent of the proposal and was keen to see the business case produced. Dr Medhurst thanked the cluster for their support and agreed to take on board the comments raised. **RECOMMMENDATIONS** **The Board noted the content of the Bexley Health and Wellbeing Campus and wide stakeholder agreement on the local area.** **The Board endorsed the development of a Bexley Health and Wellbeing Campus Outline Business Case.** **The Board endorsed work commencing to identify funding to take forward the development of the Bexley Health and Wellbeing Campus.**	
BM/018/11	**BEXLEY CARE TRUST – To ratify Chair's Action for the business care and transfer of £2.4 million to the Local Authority for Social Care** Both Cllr Davies and Cllr Pallen declared an interest and abstained from voting on this item as both are Bexley Council members. **RECOMMENDATION** **Bexley members endorsed the Chair's Action.**	
BM/019/11	**LAMBETH PRIMARY CARE TRUST - To ratify Chair's action for Lambeth PCT Community Services Integration with GSTT** Southwark agreed to supply paperwork for appending to the minutes to confirm Chair's action had been agreed previously by the previous Southwark Board. **RECOMMENDATION** **Lambeth members endorsed the Chair's Action.**	**Mr Bland**

BM/020/11	**BROMLEY PRIMARY CARE TRUST – To ratify Chair's Action for Local Pharmaceutical Service Continuation of Designation** Ms Hewitt asked member to note that Chair's action was taken on 1 May 2011 and not 8 May 2011 as stated in the documentation. **RECOMMENDATION** **Bromley members endorsed the Chair's Action.**	
BM/021/11	**Chair's Report** The Chair's report was received for information only.	
BM/022/11	**Chief Executive's Report** The Chief Executive's report was received for information only.	
BM/023/11	**Director of Public Health Briefing** The Director of Public Health briefing was received for information only.	
BM/024/11	**Any Other Business** Register of Sealed Documents The Chair informed members that a list of sealed documents across the six PCTs/Care Trust from 1/4/11 had been tabled. This would, in future, be included in Board papers, for information only. Board Survey Ms Hewitt asked members to complete a survey that would be e-mailed to them following the meeting, to evaluate the first meeting of NHS South East London PCT/Care Trist Boards, in order to gain views for the management of future meetings. Future Meetings –Pre-meeting for members of the Public The Chair confirmed that for all future meetings of the South East London PCT/Care Trust Boards, an hour pre-meet, would be arranged for members of the public to raise questions with the Chair and members of the Board. The outputs of these meetings would be recorded and appended to the formal minutes of the meeting.	**Governance team** **All**
BM/025/11	**To receive questions from the public** Transition Mr Robbins agreed to reply to Michael English in writing outside of the meeting, in response to the question raised around the number of jobs lost as a result of changes within South East London.	

	A member of the public sought clarification as to why the PCTs were continuing to merge when the Government had launched a 'listening exercise'. *In response the Chair stated that the PCTs and Care trusts of NHS SEL had begun working as a cluster in order to respond to the need for management cost savings. The Government's 'listening exercise' related not to the requirement for management efficiencies but to wider reform proposals. NHS SEL did not believe it was doing anything that contradicted with the current pause.* A member of the public sought clarification as to the perceived low number of commissioned services from Dartford and Gravesham Hospitals. *The Board undertook to provide a response in advance of its next meeting.* A member of the public observed and queried the absence of any BME representation on the Joint Boards. *In response the Chair advised that the process for appointment to the Joint Boards was undertaken by the Appointments Commission and appointments could only be made from amongst those NEDs who both wished to apply and from within the existing cohort of NEDs from NHS SEL PCTs and Care Trusts. The Chair stated that she personally would have preferred a more representative grouping but this had to be balanced with the need to work within the rules.* A member of the public referred to high number of incidents of cancer within the BME communities amongst the 25 – 43 age grouping and sought to understand how such issues were being addressed *The Board undertook to provide a response in advance of its next meeting.*	**Ms Farrell** **Mr Eyres**
BM/026/11	**Date of Next Meeting** 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.**	

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 was held on Thursday 19th May 2011, 3.00pm-6.00pm at the Council Chambers, Lewisham Town Hall, 1 Catford Road, London SE6 4RU.

ACTION LOG

Reference	Action	Action Lead	Timescale	Status/Comment
BM/005/11	Governance Framework The Joint Boards noted the contents of the governance framework and approved the draft terms of reference for the Joint Committees of the Board, delegating final drafting to the committee chairs and vice chairs. Any amendments would need to be brought back to the board for approval.	Chairs/Vice Chairs	21 July 2011	Each Joint Committee has now met and considered its terms of reference. To date no amendments have been made.
BM/005/11	Standing Orders/Standing Financial Instructions/Scheme of Delegation The Joint Boards approved the standing orders, standing financial instructions and schemes of delegation and noted that LCCCs and BSUs will, going forward, also be subject to the guidelines, procedures and processes encompassed within	All Directors	On-going	BSU MDs & LCCC Chairs are members of their respective Boards and are aware of the Joint Boards' decision.

Reference	Action	Action Lead	Timescale	Status/Comment
	the suite of documentation.			
BM/005/11	Adoption of lead officer roles To append the update on safeguarding, circulated in advance of the meeting, to the minutes.	Gill Galliano	21 July 2011	Incorporated with the July Boards papers
BM/005/11	Adoption of lead officer roles An update against London Safeguarding Board recommendations to be presented at the July meeting.	Jane Fryer	21 July 2011	Included on the agenda
BM/005/11	Indicative Corporate Risk Register • An assurance framework and a comprehensive picture of risk would be submitted to the July board meeting. • The Audit Committee to provide assurance as to the fitness for purpose of the assurance framework and report back to the Joint Boards.	Oliver Lake Steven Corbishley/ Gill Galliano	21 July 2011 September	An NHS SEL Assurance Framework has been developed and is due for consideration at the July Boards meeting. When adopted the approach will be implemented. The Joint Audit Committees intend to review arrangements when they next meet.
BM/006/11	NHS SEL Business Plan & Corporate Objectives A number of key points were raised by members:			A revised excerpt from the Business Plan detailing each Directorate's objectives / workplans

Reference	Action	Action Lead	Timescale	Status/Comment
	• It was important as a priority that BSUs learnt from each other • Primary Care issues including pharmacy and prescribing need greater prominence • When finalised the document requires a final review for consistency and overall narrative Mr Sturgeon and Dr Fryer to reflect on how to develop Primary Care indicators and population health indicators, and to involve Chairs of Committees and Directors of Public Health in this process. The Joint Boards agreed for GP Commissioning Consortia to define the vision for NHS SEL by July 2013 (to be coordinated by the BSU MDs).	BSU MDs David Sturgeon Tony Read David Sturgeon/ Jane Fryer/ Ann-Marie Connolly BSU MDs		is included on the July Boards agenda.
BM/008/11	<u>Emergency Planning & Business Continuity</u> the Joint Quality & Safety Committee would oversee work to ensure the respective roles of individual PCTs/Care Trust is	Susan Free/ Jane Fryer		Emergency Planning is within the remit of the Joint Quality and Safety Committee.

Reference	Action	Action Lead	Timescale	Status/Comment
	clear, determine resilience levels and assess levels of preparation for individual BSUs and the cluster as a whole . The Joint Boards approved the policy and noted the actions progressed to date and planned to secure robust emergency planning and resilience arrangements for the Joint Boards.	 Ann-Marie Connolly		
BM/009/11	<u>Minutes of previous PCT Board meetings</u> Greenwich Teaching PCT - Mr Robbins requested that Dr Guite write to him with the amendment to the minutes of the meeting held on 23 March 2011 and he would action via the Chair. Lambeth PCT – To bring the integrated care pilot at KHP to the meeting of the joint boards. Southwark PCT – To append	 Hilary Guite/ Simon Robbins Andrew Eyres Andrew Bland	 21 July 2011 21 July 2011 21 July 2011	Proposed amendments were submitted and consulted upon. The Chair of the NHS G meeting has resolved to retain the stated record and receive the comments submitted as an advisory note. Service integration has been flagged as a potential future agenda item. Included within

Reference	Action	Action Lead	Timescale	Status/Comment
	amendments previously submitted by Richard Gribbs to the minutes. Items under matters arising, 1055/11 and 1060/11 had been completed and the paperwork would be supplied for appending to the minutes.	 Andrew Bland	 21 July 2011	meeting papers Included within meeting papers
BM/010/11	<u>Pathfinder Development & Delegation</u> Each LCCC to adopt a clear approach to management of conflicts of interest in LCCC and GP Pathfinder development. Chair's action to 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.	 BSU MDs Gill Galliano	 21 July 2011	BSU MDs & LCCC Chairs are members of their respective Boards and are aware of the Joint Boards' expectation The Joint Boards are due to be offered updates on these issues at the July Boards meeting
BM/011/11	<u>LCCCs</u> To coordinate a standardised approach to development and management of conflict of interest across all SEL LCCCs.	Simon Robbins		BSU MDs & LCCC Chairs are members of their respective Boards and are aware of the Joint

Reference	Action	Action Lead	Timescale	Status/Comment
				Boards' expectation. Support is available upon request from the Governance team,
BM/012/11	Performance & Quality Positive feedback be given to providers, when appropriate, via the Chair.	Caroline Hewitt		Noted as an NHS SEL way of working
BM/014/11	Quality Report Quality would be a standard item under the heading 'delivery' on all future Board agendas.	Jane Fryer		Quality is listed as an agenda item (Legacy) at the July Boards
BM/016/11	Pharmaceutical Applications Panel The Joint Boards approved 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. The Joint Boards approved the proposed arrangements via the Joint Quality & Safety Committee for reporting decisions of the Panel to the Boards.	David Sturgeon David Sturgeon		Panel met for the first time on 6/7/11 taking decisions on current applications and noted actions by officers on two minor changes. The backlog of applications has been addressed. A summary report will be made available to Joint Quality & Safety committee. A further panel meeting will be

Reference	Action	Action Lead	Timescale	Status/Comment
	The Joint Boards approved the proposed full membership of The Panel, taking into account the amendment from a NED member to a Lay Member.	David Sturgeon		held at the end of month to consider applications due to be decided in early August. David Whiting attended as NED and will attend meeting at end of July. Thereafter a lay Chair is being sought. Securing LiNK representation is pending.
BM/019/11	LAMBETH PRIMARY CARE TRUST - To ratify Chair's action for Lambeth PCT Community Services Integration with GSTT To supply paperwork for appending to the minutes to confirm Chair's action had been agreed previously by the previous Southwark Board.	Andrew Bland	8 July 2011	ACTIONED
BM/024/11	Any Other Business Register of Sealed Documents – To be included in future Board papers, for information only.	Governance Team	21 July 2011	Governance Team to collate across the six PCTs/Care Trust

Reference	Action	Action Lead	Timescale	Status/Comment
	<u>Board Survey</u> Members to complete a survey that would be e-mailed, to evaluate the first meeting.	All	27 May 2011	Comments collated and circulated. Points noted for future meetings.
BM/025/11	<u>Questions from the public</u> Mr Robbins agreed to reply to Michael English in writing outside of the meeting, in response to the question raised around the number of jobs lost as a result of changes within South East London.		21 July 2011	A workforce report has been produced for the consideration at the July Boards meeting.
	A member of the public sought clarification as to the perceived low number of commissioned services from Dartford and Gravesham Hospitals. *The Board undertook to provide a response in advance of its next meeting.*	Marie Farrell	21 July 2011	A clerical error during report production resulted in an omission, from annex 2. Bexley Care Trust commissions from the identified trust with a contract value is £21,545k.
	A member of the public referred to high number of incidents of cancer within the BME communities amongst the 25 – 43	Andrew Eyres		Appended

Reference	Action	Action Lead	Timescale	Status/Comment
	age grouping and sought to understand how such issues were being addressed *The Board undertook to provide a response in advance of its next meeting.*			

Annex 1

Response to public enquiry re incidence of cancers
May 2011 Joint Boards meeting

'Unfortunately there is very little local historic data as ethnicity is not always recorded (up to 40% of cases in some tumour groups) and although the Cancer Registry is now collecting data on ethnic minorities it will be sometime before we are able to undertake further analysis. However a report of the National Cancer Intelligence Network (NCIN) and CRUK, provides a national perspective on cancer in the BME communities, which it would not be unreasonable to accept as the same for our local population.

The key highlights from this report are that in comparison to the white ethic group:-

- Black people have a higher rate of myeloma & stomach cancer
- Black men have a higher rate or prostate cancer
- Asian women have a higher rate of mouth cancer
- Black and Asian women with breast cancer have poorer survival
- For many other cancers there are reduced levels BME groups.

At a recent workshop the SEL Cancer Network brought together stakeholders (GPs, Public Health, Hospital Doctors, Nurses and commissioners to consider how early awareness and detection of cancers could be improved locally. From this work a strategy is being developed including ways in which key messages can be spread to hard to reach groups including ethnic minorities - such as training local champions, expert patient groups and other local groups such as churches and community groups in Lambeth, Southwark, Lewisham and Greenwich'.

Andrew Eyres, Chair, South East London Cancer Network

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 1

MATTERS ARISING FROM 19TH MAY 2011 BOARD MEETING AND / OR TABLED PAPERWORK

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Ben Vinter, Integrated Governance Manager

TO BE CONSIDERED BY: All

SUMMARY:
The following information was made available late or tabled at the May 2011 meeting of the NHS SEL Joint Boards and is published as a public record

a) Questions submitted in advance of the meeting
b) Transforming Community Services CQC registration – position statement
c) Safeguarding – position statement
d) Register of sealed document to 19th May 2011
e) Southwark PCTs Chairman's action log

RECOMMENDATIONS:
The Boards have already received this information. No action is required

ENCLOSURE 1

DIRECTORS CONTACT:
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South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

Thursday 19th May 2011, 3.00pm-6.00pm

Advance comments / questions on Board papers and corporate response

Board Member	Comment / Question	**Response / Action** (via Executive Director)
Points of accuracy and / or clarification		
Richard Gibbs	In the first paragraph at the top of page 397 the sentence: "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." should be replaced by: "Existing non executive directors will stay until the end of April and RG will be the acting PCT Chair from 1st April until the new governance arrangements come into force as MLN's contract cannot be extended again for a further period."	To be agreed at the meeting
	And in the second paragraph on page 399 the phrase: "SPCT overspend is the lowest in SE London……." Should be replaced by: "SPC's acute overspend is the lowest in SE London….."	To be agreed at the meeting

ENCLOSURE 1

Comments / questions on paperwork		
Keith Wood	This will be a meeting in public & I think that the public's understanding of how we operate would be greatly enhanced if there was clarity on certain Defined Terms. In particular there does not seem to be a consistent term to describe the Board of an individual PCT/CT nor the forum where those individual organisations meet to make joint decisions.	Following consideration by the Joint Boards meeting it is proposed that a final review of the governance documentation will take place in order to ensure and facilitate consistency in both Terms of Reference and Standing Orders, SFIs and Schemes of Delegation etc. In referring to the cluster of PCTs and Care Trusts meeting or acting together the term Joint Boards will be used. When referring to an individual PCT or Care Trust or multiples of those bodies the term Board, Boards or PCTs / Care Trusts will be referred to. A list of defined terms can be developed at the Boards request
	P5. Please confirm that although decisions are made by "the six Boards operating jointly", each individual PCT/CT Board is accountable for that decision & it is not made collectively by the 32(?) people present.	Statutorily this statement is correct and can therefore be confirmed. Practically it is intended that an assessment exercise will take place in the preparation of each Board agenda with indicative allocations between 'all' and a 'PCT Board' being designed to aid smooth operation of a sizeable and public meeting of 6 statutory organisations. The suggestion of dissent or disagreement within any particular Board's membership during such an item may require each Board to take a decision individually. In such an event the members of such a Board would usually raise any such anticipated matters with the Chair in advance
	P7, P66,P78 The " *2" should be against Bexley, not Greenwich?	The *2 is not intended to designate attachment to any PCT / Care Trust other than Bexley Care Trust. The delineation contained within the table is not consistently applied vertically hence the perceived non continuance of allocation

	P9 What please is the authority for the statement that LCCCs cannot "double delegate"?	Legal advice provided by Capsticks to NHSL with relation to the implementation of cluster arrangements stated; *"Where PCTs delegate responsibilities, they must be sure: (i) to make any required amendments to their standing orders; (ii) only to delegate lawfully (i.e. in accordance with the provisions of the 2002 Regulations); and (iii) to avoid double delegation (i.e. PCTs must avoid a further delegation of delegated functions, whether through intermediary bodies/ committees or otherwise)"*.
	P23. What are the arrangements for ensuring that individual Boards are "kept on top" of their finances & financial risks on a prompt, monthly basis is this the responsibility of the BSU financial staff or the Director of Finance?	Financial reporting is the responsibility of the statutory Director of Finance at the Cluster. Finance reports will be produced on a monthly basis by the financial management teams supported by the Heads of Finance in the BSUs. The Cluster team is currently prioritising the implementation of an integrated reporting system aligned to Board and Committee timetables to achieve this.
	P26 I'm not clear how the Joint Q &S Committee will relate to the equivalent local Committees nor how it will be "nimble" enough to provide prompt assurance to Boards.	A quality workshop is planned by the Medical Director and Director of Nursing for June 15th where the role of the Joint Quality and Safety Committee and its interrelationship with acute contracting and local / BSU quality committees / groups is expected to be further defined. The principal of subsidiarity will apply with the aim being for local decisions making and scrutiny to be progressed where appropriate, with the Joint Committee ensuring that assurance exists as to the rigour of the processes being applied. It will be important to have clear ownership regarding quality while also securing appropriately inclusive participation for monitoring of quality in acute commissioning
	P100 How (frequently) will the use of the Seal be reported to the relevant Board?	Arrangements for the storage and use of the Seals are being reviewed. Reports can be provided to Boards or their membership at requested frequency. It is proposed such reports would be generated quarterly for review by the

		Joint Boards
	PP151 -179 There needs to be absolute clarity on what decisions are reserved to the Boards acting Jointly ("The Joint Boards") & those which have been delegated to individual Boards("Joint Boards" - eg P162)	A meeting of the Joint Boards is a meeting of each Board at the same time, a decision of the Joint Boards will only take place where that matter is of relevance and impacts upon all Boards. The statutory powers and responsibilities of PCTs continue to rest with each Board and have not therefore been delegated to them or vice versa. The schemes of delegation remains a live document and will be revised and reviewed at each stage that a decision or recommendation is made relating to delegation to Local Commissioning Committees / GP Pathfinders. The scheme of delegation in particular will be fluid and the SFIs SOs will also no doubt need amending as we develop ways of working
	P209 What is the timetable for establishing a robust Assurance Framework.	It is proposed an Assurance Framework will be considered by the July meeting of the Joint Boards
	P210 The risks seem to have been arrived at on "bottom up" basis. When can The Joint Boards expect assurance (from Internal Auditors via the Joint Audit Committee?) that the process for doing this is robust.	In developing a cluster risk assurance framework (timescales above) the views of Internal Auditors will be sought. The Audit Chair intends for the Joint Audit Committee to consider the approach to risk at its 2nd meetings. The outputs of this process will be reported to the Board
	There does not appear to be a "holistic top down" assessment of risk; for instance, I am surprised that there appear to be no specific risks in relation to the financial position of South London Healthcare.	The documentation presented to Board represents an indicative list based upon preliminary work undertaken by the newly established directorates and BSUs. Going forward all risks will be reviewed by the Cluster Management Board who will together own the process for identification and treatment of risks while also ensuring system wide risks are identified and managed.
	There should be timelines for addressing the gaps in control, particularly as one of them is potentially "catastrophic" (P219 and may not be addressed until the end of September -P288). I'm	The Board paperwork aims to present an indicative set of risks. As both teams and systems remain in the process of development the documentation and templates shared with the Boards do not yet fully incorporate all of the sections

	not sure that I am comfortable being told that a risk is "almost certain" to materialise with "catastrophic" consequences without evidence that urgent action is being taken to minimise the impact.	that will be applied going forward which will include timelines and actions plans to address any gaps in controls. The Governance team is taking forward a programme of work with all Directorate's and/or service heads to ensure appropriate controls, action plans and evidence are available for reporting to the Board. An SEL IG Framework has been circulated and has now been adopted by all BSUs therefore substantially mitigating and increasing the controls against the identified risk
	P242. In my opinion the development of commissioning intentions from Sept 2011 through Jan 2012 is far too late; work in QIPP for next year needs to start now.	The language of the identified action will be improved. Commissioning intentions for 12/13 will be developed as soon as we have confirmed the QIPP programme for 11/12 (i.e. ASAP). The action should read in a way that emphasises "informing the acute contracting round" as Sept to Jan is the timescale on that. I'm happy to reword the action to make clearer.
	P295 Does "the reduction of operating costs" to "address £15-£18m of this gap" mean that there will be further reductions in management capacity for 2011/12 over & above those already incorporated in budgets?	Required reduction of operating costs to address the current £15-£18m gap does not necessarily mean that there will be further reductions in management capacity although this cannot be guaranteed. We need to release costs from rationalisation of estate and by ensuring we deliver the efficiencies anticipated from doing some things once rather than six times (eg Internal Audit) and from the increased purchasing power of the cluster with a budget of over £3 billion
	P311 - Was the QIPP impact of £7.562m achieved re SLHT in 2011/12; The QIPP impact on SLHT in 2011/12 looks frightening; 2012/13 slightly less so. How do these numbers compare with those in the APOH plan & to what extent are the dependent upon the successful implementation of APOH?	Contract with SLHT is not yet finalised so not possible to confirm at this stage. It should be noted that the QIPP total schemes for SLHT in terms of the BBG commissioners is equivalent to those for LSL in terms of Lewisham Guys and Kings. The main impact is on SLHT for BBG as this is where the majority of BBG activity is commissioned - LSL commission across a wider range of

		providers. The focus on QIPP has been on 11/12 to deliver financial targets in what will be a very tight year. It is acknowledged that we need to accelerate our ability to deliver transformational QIPP and effort should be invested with BSUs in doing this throughout the year. It should also be noted that if QIPP does not deliver in 11/12 then there will be a much higher requirement for delivery in 12/13. APOH predicted savings were c £17m but most of this was from increased productivity at SLHT. There have been delays in delivering savings due to the additional SoS review and also the timing of the A&E closure. As this was done in the winter, the APOH reduction of the medical admissions beds at QMS has not yet happened therefore the Trust has not been able to reduce costs. Cluster is working with the Trust to deliver this
Supplementary information for the Boards to note from Chief Executive		
Simon Robbins	Notice of expectations for PCT Clusters during transition received from London Safeguarding Board Position statement of each BSU and local arrangements has been compiled. Work now being undertaken to provide further assurance and NHS SEL approach.	**NOTE** the update provided and appended to this note
Simon Robbins	NHSL have contacted all clusters to advise DH have requested the current position in respect of the CQC registrations that PCTs were previously required to hold. Where PCTs/sectors no longer retain any responsibility for service provision NHSL expect that clusters are in the process of organising deregistration. However indication has been sought of any situation that might require a PCT to remain registered with the CQC	**NOTE** submitted table to NHSL / DH

South East London

Contact in case of further queries: ***Sarah Gardner, 020 7206 3340, s.gardner@nhs.net***

PCT	Have transferred services been deregistered? (Y/N)	Indicate any service continuing to be provided post 1 April	Current registration status (Registered/ De-registered)	Details of solution being pursued for services still provided (e.g. tender, social enterprise)	Planned date of implem-entation
Bexley	No	The community provider services that have been transferred to Oxleas (I.7.10) have been registered in Oxleas FT,s name. Bexley Care Trust will begin the deregistration process immediately.The services are as follows: Step Up, Step Down Unit, Queen Mary's Hospital (Treatment of disease, disorder or injury)Urgent Care Centre, Queen Mary's Hospital (Treatment of disease, disorder or injury) Bexley Community Services Headquarters (Nursing car, Treatment of disease, disorder or injury) Bexley Youth Advice, 233 Broadway, Bexleyheath, (Family planning) Erith Health Centre, 50 Pier Road, Erith, (Family planning)The Oval Clinic, Sherwood Park Avenue, Sidcup, (Family planning)			Deregistration to be completed May/June 2011
Bromley	Yes	Transferred services (Bromley Healthcare) have registered separately. PCT registration continues for Learning Disability Residential Services	Registered	Residential reprovision exercise being undertaken by the London Borough of Bromley	November 2011
Greenwich	Yes		De-registered from 1 April 2011	N/A	N/A
Lambeth	Yes	None	De-registered from 1 April 2011	GSTT amended their registration to include Lambeth Community Services	N/A
Lewisham	Yes	None	Deregistered		
Southwark	Yes	None	De-registered from 1 April 2011	GSTT amended their registration to include Southwark Community Services	N/A

Briefing Note to Board 19th May 2011

Author: Jane Fryer, Medical Director
Sarah Gardner, Deputy Director Integrated Governance

Current Safeguarding Arrangements

Key Issues

- Recruitment to designated roles
- In light of the governance intention to move safeguarding adults at risk to a similar statutory footing as children, adult at risk systems need further development to ensure they are compliant.
- Need to continue to seek assurance that systems remain robust in this period of transition; supported through implementation London Safeguarding Board recommendations.

Cluster Arrangements

The NHS SE London Director of Nursing is the Executive Lead for Safeguarding. She will take the lead for the cluster in working through the implications of the Munro Review for the SEL Health care System and review adult safeguarding arrangements.

The action plan in response to NHS London Safeguarding Board recommendations will be developed and a report brought to the next board meeting.

1. Southwark PCT

The Managing Director of the Southwark BSU is the overall Safeguarding Lead

Child Safeguarding:

- There is a full time designated nurse in post who reports to Deputy Director of Client Group Commissioning and through her to the Managing Director
- The GP Clinical Lead for Children's Safeguarding has been appointed.
- There is a Designated Dr in post
- Managing Director Southwark BSU, Deputy Director for Client Group Commissioning and Designated Nurse all attend the Southwark Safeguarding Children Board Safeguarding Children's Board.
- Commissioning JD for both children's and adults include safeguarding responsibilities

Safeguarding Adults at Risk:

- The responsibility for safeguarding adults with the Southwark BSU has been located in the Assistant Director Adults Older People and Dementia role with the Continuing Care Commissioning manger acting as a Deputy.
- The Health Authority lead for Adult Safeguarding sits with the Safeguarding Adults Manager.
- The Southwark BSU and Local Authority work closely together to ensure robust and joined up processes around adult safeguarding
- The BSU will be represented at the Southwark Adult Safeguarding Partnership Board by the Assistant Director of Adults, Older People and Dementia
- GP Clinical lead for Safeguarding is currently the End of Life Care Lead – roles across client group commissioning are currently being confirmed
- Commissioning JD for both children's and adults include safeguarding responsibilities

2. Lambeth PCT

Child Safeguarding:

- There has been the interim appointment of the DPH as designated board lead and through a designated doctor and a designated nurse who provide expert child safeguarding oversight across health services.
- The interim AD for children's commissioning is a member of the Lambeth Safeguarding Committee, which oversees the implementation of the action plan following the SIT visit in 2010, monitors safeguarding processes for commissioned services, including the health element of serious case reviews.
- The PCT is recruiting a GP to provide 2 sessions per week into local safeguarding work and act as a safeguarding champion across primary care.
- Children's commissioning is now part of the integrated services directorate, and a senior commissioning lead will be recruited.
- Lambeth sends senior representation to the Lambeth Safeguarding Children's Board and is represented on its sub groups.
- Lambeth DPH is chairing a working group across Lambeth and Southwark to review the current arrangements for child death reviews.

Safeguarding Adults at Risk:

- Adult safeguarding is led by the Lambeth Safeguarding Adults Partnership Board (LSAPB).
- The terms of reference set out the requirements for representation across all interested parties and specifically that of statutory partners such as the PCT and the police.
- To-date representation from the PCT has been twofold, the Medical Director or Chair of the PEC
- The three main hospital trusts, GSTFT, SLaM and Kings, are represented on the Board, primary care providers are not.

- The Lambeth BSU Managing Director is the executive director responsible for safeguarding in the PCT.
- Management responsibility is delegated to the Director of Integrated Commissioning, who will attend the LSAPB as the Lambeth PCT representative.
- It is proposed that the Assistant Director – Disabilities, a London Borough of Lambeth employee, takes a coordinating responsibility for the operational management
- It is proposed that the Clinical Board nominates a clinical lead for adult safeguarding who could continue to act as vice-chair for the LSAPB, if acceptable to the LSAPB.

3. Bromley PCT

Overall designated functions have been retained with the public health department and the line management and professional accountability arrangements will work through the consultant in PH and the DPH. The Managing Director of Bromley BSU retains some DPH functions and is the overall Safeguarding Lead for children and adults in the BSU

These current arrangements will remain in place though the team understands the need to have this link with the sector, including the sector medical and nursing director.

As Public Health moves across to the local authority under a section 75 agreements (this will be in place from June), there will be an SLA back to the BSU detailing the functions the PH dept will perform for the BSU. Safeguarding (and infection control) will be part of that SLA with the recognition that the arrangements will continue for a maximum of two years.

Child Safeguarding:
- There is a full time designated nurse in post who reports to the Consultant in Public Health and through her to the DPH/MD for BSU
- There is a GP Clinical Lead for Children's Safeguarding.
- There is a Designated Doctor in post working 2 PAs per week
- There is also a Designated Doctor for Child Deaths
- The Consultant in Public Health, Designated Doctor and Designated Nurse all attend the Bromley Safeguarding Children Board.

Safeguarding Adults at Risk:
- The Bromley Safeguarding Adults Executive is presently chaired by the Director of Adult and Community Services of London Borough of Bromley.
- Terms of reference set out requirements for representation across all interested parties for e.g Police and Health providers.

- South London Healthcare Trust and Bromley Healthcare Provider services are represented on the Board as is Oxleas NHS Foundation Trust.
- There is a safeguarding manager and a safeguarding coordinator. NHS Bromley contribute to the running of the Board and half of the safeguarding manager's salary.

4. Greenwich PCT

Child Safeguarding:

- There is a full time designated nurse in post who reports to the Managing Director
- We have recently appointed a GP with a special interest in Safeguarding Children who is shortly to come into post
- We have a vacant post for our designated doctor for safeguarding children which is a considerable concern to the PCT. We have tried over the last 15 months to appoint to this post without success. The post remains vacant in the management structure. If recruitment is not successful, we have an agreement with SLHT that they will include this responsibility in the JD of a vacant paediatrician's post which they are to advertise shortly. As you will know it can take many months to appoint a consultant so we are anticipating a gap in service. If the post is vacant following phase 2 we will be approaching other BSU MDs to ask whether there is any opportunity for cross cover into this high risk area.
- JDs for commissioners for children's services and the Head of Non-Acute Commissioning and Partnership include safeguarding as a responsibility including attending partnership meetings and assuring quality of providers in this area.
- The MD of the BSU will attend the Safeguarding Children's Board and the Children's Trust Board which are both important partnership forums for coordinating safeguarding children.

Safeguarding Adults at Risk:

- The responsibility for safeguarding adults has been located in the Continuing Care Manager's role description.
- JDs for commissioners for adult's services and the Head of Non-Acute Commissioning and Partnership include safeguarding as a responsibility which includes attending partnership meetings and assuring quality of providers in this area.
- The BSU will be represented at the Safeguarding Adults Multi-agency Group - possibly me but we are yet to work through detailed roles and responsibilities in this area

5. Lewisham PCT

Child Safeguarding:

- The designated doctor and designated nurse functions for Lewisham will be hosted by the Lewisham BSU. The Designated Doctor will be returning from a brief spell of compassionate leave, and will be resuming full duties on a phased basis.
- The DPH will act as local lead director for Safeguarding in the NHS and will advise the BSU, the Federation and the Joint Boards of the SE London PCTs on issues relating to Safeguarding, as necessary.
- The Deputy DPH will line manage the designated doctor and nurse functions as before.
- The designated nurse will be the main point of contact with all local NHS trusts, referring issues, as she feels necessary, to the Deputy DPH.
- NHS Lewisham Safeguarding Committee will continue to meet, combining both Adults at Risk and Children.
- The designated doctor function in relation to child deaths will be covered by a consultant at Lewisham Hospital and the Deputy DPH.
- The designated nurse and a GP, as named doctor for Primary Care, are helping as much as they can to cover the designated doctors training and teaching commitments
- Designated doctor for Southwark and the designated doctor for Lambeth have both very kindly agreed to advise named doctors in Lewisham when an urgent opinion of a designated doctor is necessary.

Safeguarding Adults at Risk:

- Commissioners are represented on the multi agency Safeguarding Adults at Risk Board
- The BSU is developing a multi agency Health Action Plan to comply with the Mental Capacity Act.

6. Bexley Care Trust

Child Safeguarding:

- There is a Designated nurse in place
- There is a Designated Doctor in place
- The executive lead is the MD of the BSU
- All named professional posts are filled in SLHT (subject to agreeing job plan) and Oxleas NHS Trusts.
- There is full engagement from all the designated and named professionals at Bexley LSCB

Safeguarding Adults at Risk:

- The lead is the Assistant Director of Public Health within the BSU
- Since 2006 Bexley has had multi-agency policy and procedures in place led by London Borough of Bexley (LBB).
- There is a Safeguarding Adults Partnership Board that meets on a quarterly basis, chaired by the Director of Adult Social Services.
- Safeguarding Adults training is delivered to staff members across a full range of organisations, including staff from Bexley Care Trust.
- As Local Authorities have lead responsibility for safeguarding adults, LBB have a small team led by a Safeguarding Adults Manager, who deal with all safeguarding adults alerts.
- Safeguarding adults is included in all key contracts such as community health services with Oxleas NHS Foundation Trust contains a number of key points related to adult safeguarding

London safeguarding children board

Chairs & CEs of PCT Cluster

Contact: Ian Dean
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Date: 6th May 2011

Dear Chairs & Chief Executives of London Cluster PCTs

We are writing in relation to children's safeguarding and the current proposed changes in the NHS.

At the London Safeguarding Children Board members discussed proposals relating to changes to NHS arrangements for children and young people and how the NHS engages with partners locally to deliver safeguarding arrangements. As a result of this discussion, we are writing to you on behalf of the London Board with its views at this stage of the implementation of the changes in London.

NHS London safeguarding advisors, together with the designated and named professionals for safeguarding children in London, have worked with the London Board to identify implications of the recent proposals for the NHS on safeguarding children. The Board wishes to ensure that the safeguarding of children remains robust during transition and is not diluted as a result of the proposed changes.

Whilst the direction of greater accountability, transparency, increased focus on choice, patient experience and development of outcome measures is welcomed by the Board, there are many areas of risk associated with the changes which we would like to raise for attention.

At a general level, as I am sure you are aware, the significant organisational change taking place across London currently carries significant risk to arrangements for safeguarding children locally. Changes in key personnel, potential loss of expertise and capacity can all disrupt local partnership working arrangements, causing risks to safe information sharing and service delivery between key partners. It is important that organisations continue to give clear local strategic leadership to the safeguarding of children, maintain strong local partnerships and ensure operational delivery is sustained.

Specific issues that the Board wish to raise at this stage include:

- It is essential that NHS organisations across London retain the child protection / safeguarding expertise that links strategy to practice. The service should not suffer a reduction in capacity from what is currently available as the new organisations take shape.

- Chief Executives of new PCT clusters need to ensure that expertise for safeguarding children is retained at a senior commissioning and provider level through executive leads and designated and named doctor and nurse arrangements. The focus should remain on children and not shared, for example within a wider remit of safeguarding adults and children. This inevitably leads to reduced capacity for children's priorities.

- Chief Executives of new PCT clusters must ensure that the NHS is effectively represented on relevant local safeguarding children boards (LSCBs).

- Transferring the PCT statutory duty to safeguard and promote the welfare of children to GP commissioning consortia will enable GPs to increase their engagement in safeguarding. This will naturally lead to the identification of educational gaps for GPs, which PCT clusters need to prioritise the provision of training opportunities to fill. In addition, safeguarding arrangements should be addressed at an early stage in discussions with GP consortia. GP contracts will need to ensure adequate paediatric and safeguarding knowledge.

- GP consortia should be asked to each identify a GP lead for safeguarding who is a member of the RCGP, who sits on the RCGP child protection special interest group and can ensure an effective link between the GP Consortia and the LSCB locally.

- In addition, children and safeguarding need to continue be on the consortia development programme at the SHA, maintaining a similar weighting to other priority workstreams. Pathfinders with an interest in children's services should be identified and offered assistance from NHS London and partners.

- There is a need to ensure effective joint working approaches between PCT clusters and local authorities, and subsequently GP consortia and local authorities, particularly where arrangements may not be coterminous. Designated professionals should continue to be aligned to local authority areas to enable continuity and full and effective engagement with LSCB priorities.

- Support must be in place to ensure effective joint commissioning approaches to the provision of targeted and specialist services for children and young people. Engagement in local partnership approaches involving a range of providers should also be supported, including those best delivered by third sector organisations, ensuring these services lead to children and young people being safeguarded; including vulnerable children and the impact of services in specific areas, for example children at risk of sexual abuse, domestic violence or neglect.

- Chief Executives need to ensure that all contracted services by the NHS are compliant with safeguarding and child protection standards. Early work should be taking place to develop quality standards on safeguarding for consortia and frameworks to ensure they are adhered to.

- The role of public health and local authorities as strategic public health leaders for their local population needs to be considered in relation to local arrangements for commissioning on safeguarding children.

- The role and governance arrangements of the proposed Health and Wellbeing Boards (HWB) and their relationship to LSCBs must be considered carefully, as well as their respective roles in scrutinising safeguarding performance.

- The HWB should include independent NHS designated professional advice on safeguarding and child protection matters. The HWB should have a representative on the LSCB and be advised by the designated professionals. The LSCB annual report should report on the effectiveness of the HWB in relation to safeguarding children and young people.

- There is a need to ensure continued oversight and scrutiny of serious incidents and engagement in and learning from serious case reviews.

- The focus on the views of children and young people is welcomed, however Health Watch as a new body should be evaluated and subject to review to ensure it is effective and delivering for children and young people. NHS designated professionals, who understand the needs of

vulnerable children and those at risk of harm, should be enabled to engage with Health Watch to ensure that it will be a body that champions all children's issues.

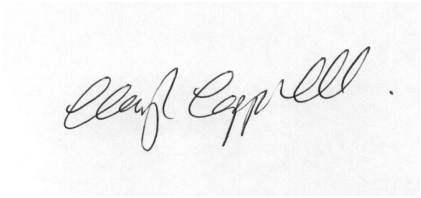
The London Board and individual LSCBs are ensuring continued oversight of the proposed changes across London as they occur, working to manage the risk of local working arrangements losing momentum on improvements in both safeguarding and looked after children's health and the potential loss of key clinical staff during the transition to new arrangements.

The board is working with NHS London on a number of areas to support this change, including;

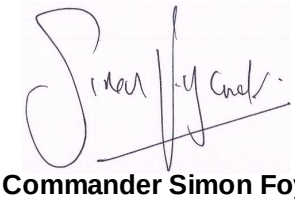
- Supporting a network of designated and named NHS safeguarding leads from across London;
- Drafting commissioning guidance on children's services for GP consortia;
- Developing training for PCT executive leads.

We would welcome ongoing dialogue with you, and look forward to a response from you in relation to the points raised above. We would be happy to meet with you to discuss these issues further if this would be useful.

Yours sincerely



Cheryl Coppell
Chair, London Safeguarding Children Board



Commander Simon Foy
Specialist Crime Investigation
Metropolitan Police

Prof Trish Morris-Thompson
Chief Nurse
NHS London

ENCLOSURE 1

NHS

South East London

REGISTER OF SEALED DOCUMENTS
From April 2011

DATE	DOCUMENT	SIGNATORIES	PCT / Care Trust
13/5/11	Section 256 transfer of funds to local authority for Social Care	Simon Robbins / Marie Farrell	Bexley
5/4/11	Transfer of title for 103 Bourne Way	Angela Bhan / Keith Fowler	Bromley
21/4/11	Novation Agreement for NHS Facilities Management Service SLA	Christine Caton / Una Dalton	Lambeth
21/4/11	Transfer Agreement for FMS Services to GSTT	Simon Robbins / Marie Farrell – Requestor Malcolm Hines	Southwark
11/5/11	S106 Planning Consent – Sheldon Building St Giles	Simon Robbins / Marie Farrell – Requestor Malcolm Hines	Southwark

ENCLOSURE 1

NHS Southwark

Chairman's Action Log from Board Meeting on 24 March 2011

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.

Action: 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.

Action: 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.

I authorised the above actions which were completed by 31st March 2011

31st March 2011

ENCLOSURE 1

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 2

QUALITY AND SAFETY REPORT

DIRECTOR RESPONSIBLE: Dr Jane Fryer- Medical Director NHS South East London

AUTHOR: Dr Jane Fryer- Medical Director NHS South East London and Sarah Gardner, Deputy Director of integrated Governance

TO BE CONSIDERED BY: All

SUMMARY:
This paper sets out the quality assurance processes that have been set up for the Acute Trust Providers, Mental Health Trusts, Community Service providers and Primary Care General Practitioners.

In addition this paper identifies some areas of particular focus over the next year that will form the basis of discussion at the NHS SEL Joint Quality and Safety Committee.

KEY ISSUES:
The Joint Board has a responsibility to assure itself that there are appropriate and robust systems of monitoring the quality and safety of health care providers for the residents of South East London.

We have been developing a framework that provides a consistent process across all providers and this paper details progress in this area.

We have also highlighted for each provider the areas we propose to focus in more detail over this year:

- **SLHT:** Pressure sores, Maternity services, Clinical Quality complaints, Never events
- **Lewisham Hospital:** Pressure sores, Patient experience of Maternity Services, Never events

- **GSTFT:** Never Events, Rate of Caesarian Sections
- **KCH:** Never Events, Maternity Services
- **SLAM:** Physical Health Care, Use of antipychotics in dementia, Staff safety
- **Oxleas – MH:** Physical Health Care; Use of antipychotics in dementia; Staff safety

COMMITTEE INVOLVEMENT:
- NHS SEL Joint Quality and Safety Committee

PUBLIC AND USER INVOLVEMENT:
- Engagement with public and users is done at individual provider level, CCB's and the SEL

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:
The board (s) is asked to:-

- **NOTE** the content of the report.
- **NOTE** the particular issues listed in paragraph 5 and **AGREE** these should form part of the work plan of the Joint Quality and Safety Committee.

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*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 21st July 2011

ENCLOSURE 2

Quality and Safety Report

DIRECTOR RESPONSIBLE: Dr Jane Fryer, Medical Director

AUTHOR: Dr Jane Fryer, Medical Director
Sarah Gardner, Deputy Director Integrated Governance

1. Introduction

A Quality Framework has been agreed across South East London Cluster to ensure that the Joint Boards can be assured that our commissioned services are providing safe and high quality care. This framework covers four main components to enable a matrix of Quality intelligence to be gathered;

- Governance Assurance Process
- Culture of Quality
- Contractual Performance
- Management of Risk

The purpose of this paper is to provide the Joint Boards with the first in what will be regular updates on current Quality issues that are emerging from across our commissioned services.

It should be noted that we are at an early stage of the reporting cycle with only a small sample of Quarter 1 data currently available. Our focus has therefore been to ensure we have robust quality assurance processes in place across all providers. Clinical Quality Groups have been established with providers with representatives from across Cluster including BSUs and Clinical Commissioners and these groups will act as the main source of local assurance that Quality issues are being addressed .

As future clinical quality groups meetings take place and quality monitoring is embedded in our contracting processes, we will be providing a richer picture of quality issues.

2. Quality Assurance Frameworks by Provider

2.1 All Acute Providers Quality Assurance Framework

The following provides a summary of Acute Quality Framework paper presented to Cluster Management Board and the Joint Quality and Safety Committee by the South East London Contracting team. (full version available by request)

2.1.1 Background

The acute contract portfolio, totalling over £1.3 billion, covers purchasing of acute hospital care (excluding designated specialist services) provided to the population of South East London. A key aspect of the contract management is the monitoring, management and improvement of quality standards. SE London discharges this responsibility in its role as Co-ordinating Commissioner for the four main acute contracts and as Associate Commissioner for the other 20 plus contracts, as described below:

2.1.2 Co-ordinating Commissioner

Ensures that they meet the national and locally quality requirements, as set out in the contracts for all services it provides for

- Guy's and St Thomas' Foundation Trust,
- King's College Hospital Foundation Trust,
- Lewisham Healthcare Trust
- South London Healthcare Trust.

2.1.3 Associate Commissioner (a further 24 acute contracts)

Ensures all 24 contracts, via PCTs' consortia agreement, that the quality standards for the Trust will be monitored and managed by the co-ordinating Commissioner on its behalf. The major non-local contracts include:

- Darent Valley
- St George's
- London Ambulance Service (LAS)

2.1.4 Principles

The key principles underpinning the proposed quality framework for the monitoring and management of acute contracts of SE London Trusts during 2011/12 are:

- Each acute contract will have a Clinical Quality Review Group (previously known as the Quality Group) which will form the central vehicle for the systematic ongoing monitoring by commissioners of quality standards, patient safety and patient experience.
- A core agenda of items will be common to all Clinical Quality Review Groups to ensure consistency of approach.
- The Clinical Quality Review Group will be chaired by a clinical commissioner, formally nominated to the role by the relevant GP consortia
- The Clinical Quality Review Group's membership will be multidisciplinary and will be drawn from senior clinicians within the consortia, and from within the Trust, where necessary the group will able to co-opt clinical members with specific expertise needed for a particular theme under review.
- The Clinical Quality Review Group will meet regularly – at least bi-monthly – with a specific focus on core quality standards;
- The Clinical commissioners on the Clinical Quality Review Group will report to the relevant Contract Management Board, as required by the National contract and will be responsible for taking contractual action, where appropriate. This will be overseen by the Cluster Director of Acute Contracting who report through to the Cluster Operations Group.
- The Clinical commissioners on the Clinical Quality Review group will report also to the relevant GP consortia through the local Clinical Commissioning Boards ensuring that they are both kept appraised of any matters of significant clinical concern and the actions being taken to address and that they can pro actively feed in matters of concern.
- SE London Governance oversight and assurance will be through the Board committee responsible for Quality and Safety.

2.1.5 Membership of the Clinical Quality Review Group

Chair - it is proposed that Clinical Quality Review Groups (CQRGs) are led by local clinical commissioners to ensure that the views of consortia are fully represented at the meetings. The Chair will therefore be formally nominated by the relevant main GP consortia

In addition to the Chair it is proposed that each of the main GP consortia has members on the CGRG. So it is proposed that:

- Guy's and St Thomas' Foundation Trust – Lambeth and Southwark GP consortia are core members; other GP Commissioning consortia can choose to attend
- King's College Hospital Foundation Trust –Southwark and Lambeth GP consortia are core members; other GP Commissioning consortia can choose to attend

- Lewisham Healthcare Trust – Lewisham GP consortia are core members; other GP Commissioning consortia can choose to attend;
- South London Healthcare Trust – Bromley, Bexley and Greenwich GP consortia are core members other GP Commissioning consortia can choose to attend

In addition to the Clinical commissioning leads as above each relevant main BSU will nominate a senior managerial lead to be a member to provide local managerial expertise.

South East London's Medical Director, Director of Nursing and Director of Public Health – will provide expert guidance to clinical commissioners on key aspects of quality – for example Serious Incidents, complaints, infection control, mortality trends. Also in the short term either the Medical Director or the Director of Nursing will attend each CQRG to provide further senior clinical input – this will be reviewed after six months.

2.1.6 Core Quality Review Areas

The formal national contract requirements do not stipulate specific quality areas that are mandatory to review. The national guidance recommends that commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the Quality schedules of the contract.

Given that the quality measures and standards by which the acute services could be monitored are immense and complex, in South East London, it is proposed, that there are systems in place to provide assurances for a set of core quality standards. In doing so the focus will be both on performance review and ensuring action is taken to address any performance issues.

The core quality indicators proposed that will be systematically monitored and addressed in respect of each acute Trust are:

- Safety - trends in Serious Incidents (SIs) and Never Events
- Mortality – trends in Hospital Standardised Mortality Ratio (HSMR), maternal deaths
- Complaints – trends in complaints relating to the provision of the services;
- Patient Experience –conclusions from national and local patient surveys; feedback from other external organisations eg LINk , Care Quality Commission (CQC)
- Infection Control – trends in MRSA, clostridium difficile (C.Difficile) infection (
- CQUINS - assessing progress on delivery
- Quality Accounts

In addition to these core agenda items, CQRG members will also review issues in accordance with specific local need arising from local concern [e.g. concerns raised by GPs in consortia] or local population need

2.1.7 Quality Monitoring

Core Quality Standards
The core quality standards will be incorporated into a performance dashboard covering all SEL NHS providers. These indicators will be monitored on a monthly basis and performance against them will be reported to the Joint Quality and Safety Sub-Committee and to the Operational Group.

Wider Metric of Quality Standards –
Further discussion is taking place to determine the appropriate quality monitoring systems and to ensure that responsibilities are clear within the South East London cluster.

2.2 Guys and St Thomas' Community Services (Southwark & Lambeth)

2.2.1 Background
The GSTFT CHS Contract and Quality Meetings will provide quality assurance and discussion. We have scheduled monthly contract meetings and quarterly Quality meetings with the provider. NHS Lambeth Chair these meetings and they are attended by representation from Lead Commissioner and Associate Commissioners including Clinical Commissioners.

Contract Duration: 1st April 2011 to 31st March 2014 with option to extend for another two years.

Annual Contract Values

	NHS Lambeth £	NHS Southwark £	NHS Lewisham £	NHS Wandsworth £	Total £
Lambeth Provider	42,147,792	976,834	867,137	351,992	44,343,755
Southwark Provider	2,954,000	32,776,373	3,074,000		38,804,373
Total	**45,101,792**	**33,753,207**	**3,941,137**	**351,992**	**83,148,128**

Lead Commissioner: NHS Lambeth
Associate Commissioners: NHS Southwark,
NHS Lewisham
NHS Wandsworth

2.2.2 Principles

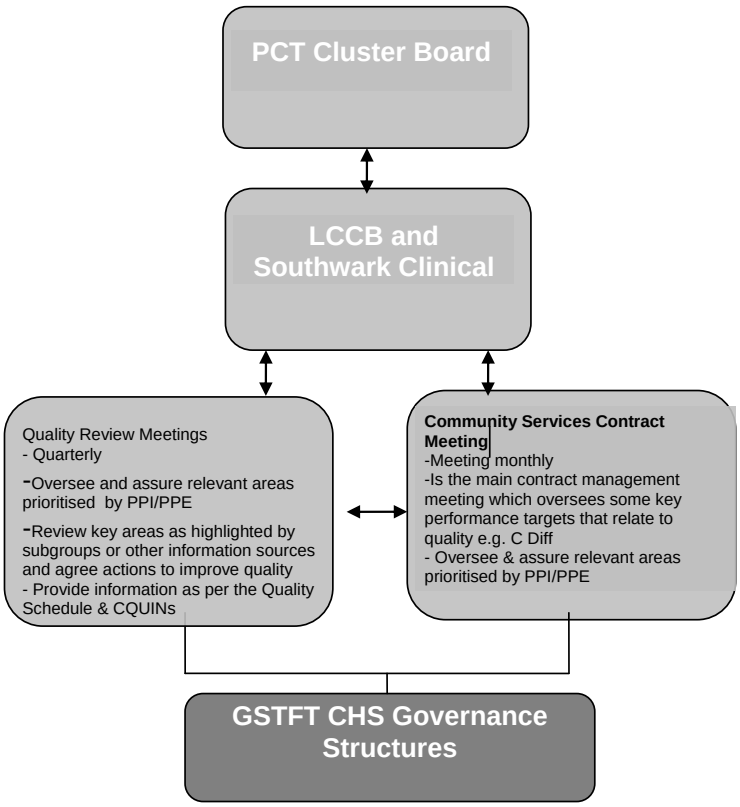
Role of Contract and Quality Group:

- Assure and review all information relating to local community services Quality including Governance, Safety, Effectiveness and User Experience
- Provide assurance, communicate with and address contract and quality community issues for NHS Lambeth, NHS Southwark, NHS Lewisham and NHS Wandsworth
- Receive and review reports from defined subgroups on specific aspects of community care
- Review and data assure quarterly GSTFT CHS Quality Report information for the NHS Lambeth Clinical Commissioning Collaborative Board.
- Support the improvement of community quality performance using a developmental and collaborative approach
- Manage quality issues relating to the contract Quality Schedules and CQUINs
- Inform the core contract monitoring meetings of the extent to which Quality Schedule requirements are achieved.
- Inform the core contract monitoring meetings of the extent to which CQUIN targets are achieved and indicate value of financial reconciliation linked to performance.
- Assure that new local or national quality guidance and recommendations are implemented, where appropriate
- Review and address any issues raised by external assurance processes or other clinical governance initiatives
- Review GSTCHS processes for public and patient involvement and ensure issues and actions prioritised by patients and clinicians via this route are addressed
- Ensure any commissioning issues arising from cross-provider complaints, serious incidents or clinical discussions are addressed
- Review and approve Quality Accounts
- Review and address any issues raised by Quality Alerts.

2.2.3 Membership of the Contract and Quality Group

- Director of Care Pathways, NHS Lambeth (Chair)
- AD of Primary and Community Care, NHS Lambeth
- Senior Commissioning Manager, NHS Southwark
- Operations Director, GSTFT CHS
- Director of Business, Finance & Performance, GSTFT CHS

- General Manager, Adults GSTFT CHS
- General Manager, Children GSTFT CHS
- Head of Performance GSTFT CHS
- Assistant Director, Older People, NHS Lambeth
- Assistant Director, Children's and Maternity, NHS Lambeth
- Clinical Commissioner, Lambeth
- Clinical Commissioner, Southwark



2.2.4 Core Quality Review Areas

2.2.5 Quality Monitoring

Areas of focus over the next year are as follows:

- District nurses & community matrons
- Health visitors
- Diabetes (Southwark only)
- Stop smoking (Southwark only)
- Sexual health
- Intermediate care
- School Nurses
- Early interventions (Lambeth only)
- Breastfeeding (Lambeth only)
- Child Immunisations
- Admissions Avoidance
- Telemedicine

CQUINS:

- Pressure Ulcers: Productive community services metric
- Falls: Productive community services metric
- End of Life Care
- To Encourage Effective Communication between Community Primary Care.
- Children's Immunisations
- To improve the responsiveness to personal needs of patients receiving community based and community based hospital healthcare

A full breakdown of CQUINS and Quality Requirement to of the contract and method of measurement is available on request.

2.3 Lewisham Hospital Community Services

2.3.1 Background

Lewisham Healthcare NHS Trust have been an integrated Trust (acute and community) since August 2010. They have made significant inroads in 2010/11 to integrate governance and contractual management processes across the Trust. However, commissioners (both adult and Children and Young People) have been reviewing community services separately. Currently, the lead Contract Manager is in Lewisham BSU, although this role is planned to move to

the Cluster Contracting team during 2011/12 as part of the overall contract management for Lewisham Healthcare

In addition in April 2011, the Trust absorbed the health promotion and community development team from Lewisham PCT Public Health.

The contract value is 35.7m

From September 2011, the process for acute contract and community contract will be aligned as some streams in the Quality Schedule for community are now integrated across the Trust (complaints, incident reporting, registration, CAS alert process etc.). The Community contract meeting following the acute quality and safety contract review meeting will be focused on the remainder of the Quality Schedule and CQUINs for community services.

There will be some timing issues to resolve as the Community Contract Quality and Safety process is quarterly, whereas the acute community contract is two monthly.

2.3.2 Principles

- There is a Quarterly Quality and Safety contract review. There is a monthly contract review, where any Quality and Safety immediate issues or follow up from the Quality and Safety report can be made.
- This covers performance and exception reporting against the Quality Schedule agreed for the year. The Quality Schedule covers the Patient Safety, Patient Experience and Clinical Effectiveness measures. It also covers CQUIN performance and any agreed payment. The Trust is required to produce a Quality report in advance of the meeting for review at the meeting covering performance and exceptions.
- The key Quality and Safety exceptions and performance are built into the Commissioning meeting.
- The Head of System Management attends the meeting to form the link to the Quarterly Quality and Safety report to the Lewisham Clinical Commissioning Committee's Quality and Safety Group that provides assurance for all commissioned services. Highlights will be provided from this to the Quality and Safety Subcommittee of the Board for further assurance and comparative issues between Community Services in South East London.
- The indicators included in the Quality Schedule for 2011/12 are set out below

2.3.3 Membership of the Clinical Quality Review Group

Led by the Contract Manager for Adult Services from Lewisham BSU.

The following attendees are also

- MD Lewisham BSU
- Senior Commissioning Manager Children and Young People Joint Commissioning
- Head of System Management
- Representative of the GP Federation as the Consortia. Following the election of the Executive Committee, attendance at Contract Meetings will need to be reviewed.
- Trust Contract and Performance Assistant Director
- Trust Clinical Governance Assistant Director.

2.3.4 Core Quality Review Areas

- Review of 10/11 CQUINS showed that having 9 CQUINS meant too broad an approach. 2011/12 is focused on 4 CQUINS.
- There has been a long term issue relating to waits within the assessment and planning approach for children's autistic spectrum disorder. A CQUIN is being agreed on this.
- Community services incident reporting fell in Q4. A refreshed approach across the Trust is planned.
- The alignment of acute and community quality and safety processes for September

2.3.5 Quality Monitoring

Patient Safety:

- Care Quality Commission Registration and any exceptions
- External Assurance – CQC or other statutory assurance bodies e.g. QA visits.
- Clinical Audits – agreed plan and implement recommendations.
- NRLS Incident Reporting
- SIs
- Infection control – NPSA Clean Your Hands compliance

Patient Experience:

- Complaints: Thematic review and learning
- Patient Experience. Annual surveys and Patient Experience trackers.

Other/Clinical Effectiveness

- Risk Register - Assurance and highlight to commissioners any concerns
- Equality Scheme

- Business Continuity
- Implementation of NICE guidance
- Deliver information on health choices.
- Effectiveness of health promotion and disease prevention initiatives are evaluated and reviewed.
- Develop positive partnerships and links across the health economy, with voluntary sector and local authority as appropriate.
- Data Quality
- NHS Staff Survey
- CQUIN achievement.
- Continuous Service Improvement Plans.

A full breakdown of CQUINS and Quality Requirement to of the contract and method of measurement is available on request.

2.4 Oxleas Community Services (Greenwich)

2.4.1 Background

Value of contract is	£35m approx.
Lead Greenwich Commissioner is	Head of Non-Acute Commissioning Assisted by Commissioning & Contract Manager

2.4.2 Principles

Quarterly Clinical Quality Monitoring Group meetings are led by the Designated BSU Medical Director. The main purpose of the meeting is to monitor clinical quality of services including CQUINS, Patient experience and Serious Incidents.

The purpose of the group is to maintain and continuously improve the quality of community health services delivered to the residents of Greenwich and to provide assurance to the PCT Board that high quality services are being provided through the monitoring of clinical quality.

This group will be used to ensure that GCHS and NHSG work together appropriately to deliver quality services, within a culture of mutual respect and a 'learning' framework, being mindful of the different roles of provider and commissioner.

The meetings will have a clinical focus rather than focusing on performance which is done elsewhere. Quality will be considered under the domains of safety, clinical effectiveness and patient experience.

2.4.3 Membership of the Clinical Quality Review Group

Members from:
Designated BSU Medical Director (Chair)
Greenwich BSU
Oxleas Greenwich Community Health Services Directorate
Clinical effectiveness and governance staff

2.4.4 Core Quality Review Areas

Areas you will want to be focusing on: –

- Patient experience – e.g. PALS, Complaints
- Clinical quality KPIs
- CQUINs
- Serious Incidents
- Patient Safety Incidents
- Regulatory issues – any information, notification or advice from any regulator with a bearing on the provision of services.
- Gaining an understanding of quality assurance systems within GCHS and how these link clinical service to the Board.

2.4.5 Quality Monitoring

- Monitoring agreed clinical performance indicators with an annual programme for focusing on: CQUINS, patient and staff survey results, national performance indicators and locally agreed clinical quality indicators set out in the contract.
- Considering significant clinical incidents i.e. SUIs, serious case reviews, etc. This is to provide assurance that incidents have been appropriately handled and that the risk of a similar incident recurring is reduced as far as is practicable.
- Considering concerns raised by patients, public, primary practitioners GPs or other clinicians. These concerns would come from a variety of sources.
- Monitoring the delivery of action plans where clinical concerns had been identified.
- Gaining assurance for NHS Greenwich from GCHS clinical governance and assurance processes that a culture of openness and safety is being adopted across all service areas.

A full breakdown of CQUINS and Quality Requirement to of the contract and method of measurement is available on request.

2.5 Oxleas Community Services (Bexley)

2.5.1 Background

The Clinical Quality Group for Bexley Community Health Services was established when Bexley Community services were transferred from Bexley Care Trust to Oxleas FT in July 2010.

The Quality Monitoring Group meets monthly. This meeting is preceded by a Contracts Meeting that examines purely contractual issues. Every other month the Quality Monitoring Group monitors the CHS Quality Dashboard and Quality KPI's. The Group has themed meetings for the other alternative months. These have recently covered patient experience and GP linkages.

Lead Bexley BSU commissioner: Community Commissioning Manager (interim)

Chair: Bexley BSU Clinical Quality Lead

Total Contract Value for 2011/12: £16,355,470

2.5.2 Purpose;

To monitor and support the continuous improvement of the quality of health care delivered to the residents of Bexley, and to provide assurance to both Oxleas NHS Foundation Trust Board and Bexley Clinical Quality Assurance Group and the Clinical Cabinet that high quality services are being provided through the monitoring of the domains of clinical quality: patient safety; clinical effectiveness; and patient experience.

2.5.3 Principles

This group is used to ensure that Oxleas Community Health Services and Bexley BSU work together appropriately to deliver quality services, within a culture of mutual respect, learning and transformation and a 'learning' framework. This includes considering:

- Implementation of national guidance and quality standards as appropriate
- Delivery of agreed local strategies and policies
- Assurance that systems and processes both within the BSU and across the CT/BSU interfaces are fit for purpose
- Raising ad hoc quality enquiries for the purpose of agreeing how they should be handled on an ongoing basis
- reviewing the development of new patient pathways
- reviewing quality themes relating to CHS as identified by Bexley BSU complaints and PALS.

2.5.4 Membership of the Clinical Quality Review Group –

- Bexley BSU Quality Lead (Chair)
- Bexley BSU Clinical Governance & Corporate Risk Manager
- Assistant Director OCHS
- Head of Governance OFT
- Medical Director - OFT
- Commissioning lead BCT

2.5.5 Core Quality Review Areas

The Quality Monitoring Group monitors specific KPIs and quality parts of the contract, and associated reports and reviews including :

- Complaints
- Serious Incidents
- HCAI
- Health Outcomes
- Audits
- CQUINs
- Focus areas
- Delivery of health improvement or promotion activity
- Any information, notification or advice received from NHS London or any other Regulator which relates to or has a bearing upon the local provision of the health and care services

2.5.6 Reporting

Quality & safety reports are prepared by Oxleas CHS for the Quality Monitoring Meetings. These include a Quality Dashboard that covers the principal domains of quality: patient safety; clinical effectiveness; and patient experience; as well as workforce. These reports are reviewed in detail by the commissioning representatives at these meetings. Further assurance is requested when commissioners are not satisfied with the controls or outcomes or further information is needed.

The reports from the Quality Monitoring Group are fed into the Bexley BSU Clinical Quality Assurance Group whose role is to review and ratify the reports and report to the Bexley Clinical Commissioning Cabinet and the NHS South East London Cluster Board sub-committee meeting on Quality & Safety. The Quality & Safety reports from the Quality Monitoring Group are used to inform the Bexley BSU Quality Report.

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2.6 Bromley Healthcare CIC Community Services

2.6.1 Background

Bromley Primary Care Trust [PCT] has a 5 year contract with Bromley Healthcare for the provision of community health services is from 1 April 2011 to 31 March 2016.

2.6.2 Principles

As part of the contract monitoring with Bromley Healthcare, Bromley PCT has a monthly Clinical Quality Review Group, which is a sub-group of the main Contract Monitoring Board, to gain quality assurance.

2.6.3 Membership of the Clinical Quality Review Group

The Clinical Quality Review Group is currently chaired by the Managing Director / Joint Director of Public Health of the PCT.

The other members of the Group are:
Consultant in Public Health, Bromley PCT
GP Lead, Practice Based Commissioning
Head of Non-Acute Commissioning, Bromley PCT
Commissioner for Non-Acute Services, Bromley PCT
Other PCT Clinical representatives as nominated by PCT
Representatives of other commissioners
Joint Clinical Director & Operations Director, Bromley Healthcare
Assistant Director, Bromley Healthcare
Up to 2 additional CPU nominated clinicians and managers as appropriate

2.6.4 Core Quality Review Areas

The Clinical Quality Review Group reviews the CQUIN schemes, service improvement outcome measures and KPIs, exception reports and any serious incidents.

2.6.5 Quality Monitoring

The CQUIN schemes include: falls, pressure ulcers, end of life care, patient experience, and public health data.

Examples of the service improvement outcome measures being monitored include:

i) Increase the quality of patient care in the District Nursing Service by increasing the number of patients on District Nurse caseloads who receive End of Life care in their preferred place; and increase the number of patients with Venous Leg Ulcers which within 12 weeks of commencement of treatment
ii) The Integrated Community Children's Nursing Team to improve on timely and safe early discharge from hospital, avoid re-admission and provide support in the community.

A clear issues log is held so that any concerns not addressed in the Clinical Quality Review Group meetings are dealt with in between meetings, with a clear audit trail.

2.7 Mental Health Providers Quality Assurance Framework
2.8 South London and the Maudsley Foundation Trust - Mental Health Services

2.8.1 Background

The SLaM contract is a bilateral contract between Lewisham, Southwark, Lambeth and Croydon. Though the contract is bilateral, all aspects of the contract that are not specific to one Borough are the same across all 4 Boroughs. The contract is therefore developed and agreed across LSLC.

10/11 Contract Values:

Lewisham - £60,482,350
Southwark - £65,727,540
Lambeth - £83,190,310

We do not have a lead commissioner arrangement across LSL and Croydon. We have an effective collaborative approach to working together for example around the development of the annual contract.

NHS Lambeth have been servicing and supporting this collaboration by hosting and servicing meetings together with coordinating the development of contract schedules, development of CQUIN and more recently established a pan borough Payment by Results steering group.

2.8.2 Principles

Monthly core contract performance meetings are held between BSUs and SLaM with a rolling care group focus at each, with every third majoring on quality or in some cases a separate focused quality meeting is held. The quality meetings focus on the quarterly quality reports provided by SLaM as part of the contract performance framework.

A quarterly quality report is provided by respective BSUs to their respective Clinical Commissioning Boards,

2.8.3 Membership of the Clinical Quality Review Group

Core membership includes:

SLaM :	Medical Director
	Director of Nursing
	Director of Patient Safety
	Respective CAG Service Directors
BSUs	AD Commissioning leads,
	Joint Commissioning Managers
	Leads from Local Clinical Commissioning Committees.

2.8.4 Core Quality Review Areas.

- Improving the secondary / primary care relationship (being addressed via CQUIN)
- CPA 7 day follow up target has been problematic - albeit now SLaM stating they are meeting it, the problem has been the data recording.
- HoNOS reports on a borough by borough basis
- Violence and aggression on acute wards continues to rise consistent with national trends, SLaM are developing a strategy and action plan to address this concerning trend.
- Reporting of serious incidents are also on the rise, a report on 2010/11 incidents is due July 2011 and will be the subject of specific review meeting
- SLaM made positive progress on the seven CQUIN targets during 2010/11; the personalisation and social inclusion targets were not met in full and have been incorporated within the revised CQUIN for 11-12.

2.8.5 Quality Monitoring

- Schedule 3 of the 11/12 contract - Quality & Performance
- Schedule 4 of the 11/12 contract - CQUIN schemes
- SLaM Quality Reports - e.g. CQC reports, health & safety, security, national requirements etc
- PEDIC - patient experience surveys and results
- Serious Incidents monitoring progress of live cases.

A full breakdown of CQUINS and Quality Requirement to of the contract and method of measurement is available on request.

2.9 Oxleas NHS Foundation Trust - Mental Health Services

2.9.1 Background

BBG Commissioners have been meeting jointly with Oxleas since the beginning of 2010/2011 on a Quarterly basis to review the Quality and Safety Improvement Plan and the CQUIN Plan included in the contract.

The Quality and Safety Improvement Plan and CQUIN Plan were agreed jointly with BBG.

The Quarterly monitoring meetings include commissioning and clinical representation from PCTs as well as clinical and management representation from Oxleas.

Oxleas provide quarterly quality reports to commissioners, within 28 days of quarter end, and the quarterly quality meetings are scheduled approximately two weeks later.

The contract is bi-lateral between Bexley, Bromley and Greenwich Business Support Units (with Lewisham BSU commissioning Forensic Services)

Bexley Care Trust Contract Value:	£23.4m
Bromley PCT Contract Value:	£35.46m CQUIN value up to a further 1.5% on full achievement of £532,026
Greenwich TPCT Contract Value:	£50m (main contract) £2m IAPT
Lewisham PCT Contract Value:	£4m

Lead Commissioner (Bexley):	Head of Mental Health Commissioning.
Lead Commissioner (Bromley)	Lead Commissioner, Mental Health & Learning Disabilities
Lead Commissioner (Greenwich)	Senior Mental Health
Lead Commissioner (Lewisham)	AD Joint Mental Health Commissioner

2.9.2 Principles

Commissioners gain quality assurance through the scheduled quarterly quality meetings with Oxleas NHS Foundation Trust. In addition, each Borough meets with Oxleas on a Monthly basis, specific Borough issues or concerns can be discussed in more detail.

Core Agenda Items are:

- Quarterly Quality Report Review – including any headlines
- Review of quality and safety improvement plan and achievements against target
- Review of CQUIN progress against each individual CQUIN vs set milestones – including agreement on whether any thresholds have been met or not regarding payment.

2.9.3 Membership

Deputy Medical Director, NHS South East London. (CHAIR)
Mental Health Commissioning, Greenwich
Mental Health GP Lead, Bexley
Mental Health Commissioning, Bexley
Assistant Director of Public Health, Bromley
Mental Health Commissioning Bromley
Medical Director, Oxleas NHS Foundation Trust

Associate Director, Strategic Business Development Oxleas NHS Foundation Trust
Head of Quality and Audit

In addition, it was agreed at the last meeting in May 2011, that the GP Clinical Commissioning Lead for Mental Health would be added to the Membership.

This will include:
Clinical Commissioning Lead, Bromley
Clinical Commissioning Lead, Greenwich
Clinical Commissioning Lead, Bexley (existing member)

2.9.4 Core Quality Review Areas

- Quarterly Quality Report – acts as an exception report for headlines
- Quality and Safety Improvement Plan (references the schedules of contract) – Agreed as per BBG for contractual year 11-12
- CQUINS and achievement to date of milestones – Agreed as per BBG for contractual year 11-12

2.9.5 Quality Monitoring

The contract includes a schedule of Quality Performance Indicators including local and national indicators to enable robust performance management of quality at Oxleas. These include:

- Increasing support for families and carers
- Enhancing Care Planning
- Improving the way we relate to both service users and carers
- Ensuring patient safety and risk reduction following discharge from inpatients
- Manage risk of HCAI
- To improve transition planning between our children and adult mental health services
- Standardising assessments and allocation of care pathways in line with nationally agreed Health of the Nation Outcome Scales (HoNOS) Payment by Results (PbR) tool and care clusters
- Ensuring multi axial diagnosis coding
- Providing better information for our users and carers
- Delayed discharges

There are also indicators included for:

- National Specified Events
- Never Events

- Quality Performance Indicators for CQUINS

A full breakdown of CQUINS and Quality Requirement to of the contract and method of measurement is available on request.

2.10 Prison Health Providers Quality Assurance Framework
To be provided to Joint Quality and Safety Committee in September 2011

3. Serious Incident Reporting and Assurance Process

3.1 Currently notification of Serious Incidents into Commissioners differs depending on whether the incident occurs within a Foundation or Non Foundation Trust. This is essentially because Foundation Trusts are not required to report Serious Incidents directly to NHS London via the national reporting system STEIS as are Non-Foundation Trusts.

3.2 For Foundation Trusts that means that agreement on incident notification to commissioners has had to be built into contracts and means of notification and signing off final reports agreed with BSU Governance Leads. For Non-Foundation Trusts such as Lewisham and South London Healthcare Trust (SLHT), this occurs through their use of STEIS whereby the Cluster we will automatically notified of SI's logged by these providers and NHS London will continue to sign off Final Reports as they have historically.

3.3 Based on the above reasons and local resourcing, each Business Support Unit has varying practices on how Serious Incidents are managed, monitored and followed up with providers but they all link into the contract quality monitoring process lead by the Cluster Contracting team.

3.4 The Cluster central corporate team acknowledges that effective working practices have been established by each BSU with regard to their host Acute and Mental Health Providers, through which the Cluster can gain an assurance that at a local level, Serious Incidents are being effectively managed.

Local Serious Incident Investigations

3.5 By the 1st April 2011, all community services had integrated with Acute or Mental Health Providers. With the provider element of PCTs now well established in Acute Providers, the most common source of Serious Incidents to be loaded by PCTs are now Primary Care.

3.6 The management of investigations remains unchanged since the establishment of the Cluster. This is because each BSU is responsible for management of investigations of incidents that occur inside their Borough. There needs to be further work on clarifying the working relationship with the Primary Care contracting team now that it is based at the Cluster.

New Arrangements

3.7 It is proposed that the Cluster Governance team will act as central point of notification for Serious Incidents that occur across all providers as detailed in the flow diagram below

3.8 Through this new centralised reporting arrangement the Joint Quality and Safety Committee will be able to provide the Joint Boards with assurance that it will:

- Gain an overall intelligence on Serious Incidents,
- Disseminate that intelligence to appropriate Cluster leads, particularly the Medical and the Contracting and Performance Directorates
- Ensure that Action Plans derived from final reports are completed by providers
- Analyses themes that may be forming across the cluster
- Ensure lessons learnt are disseminated across the cluster

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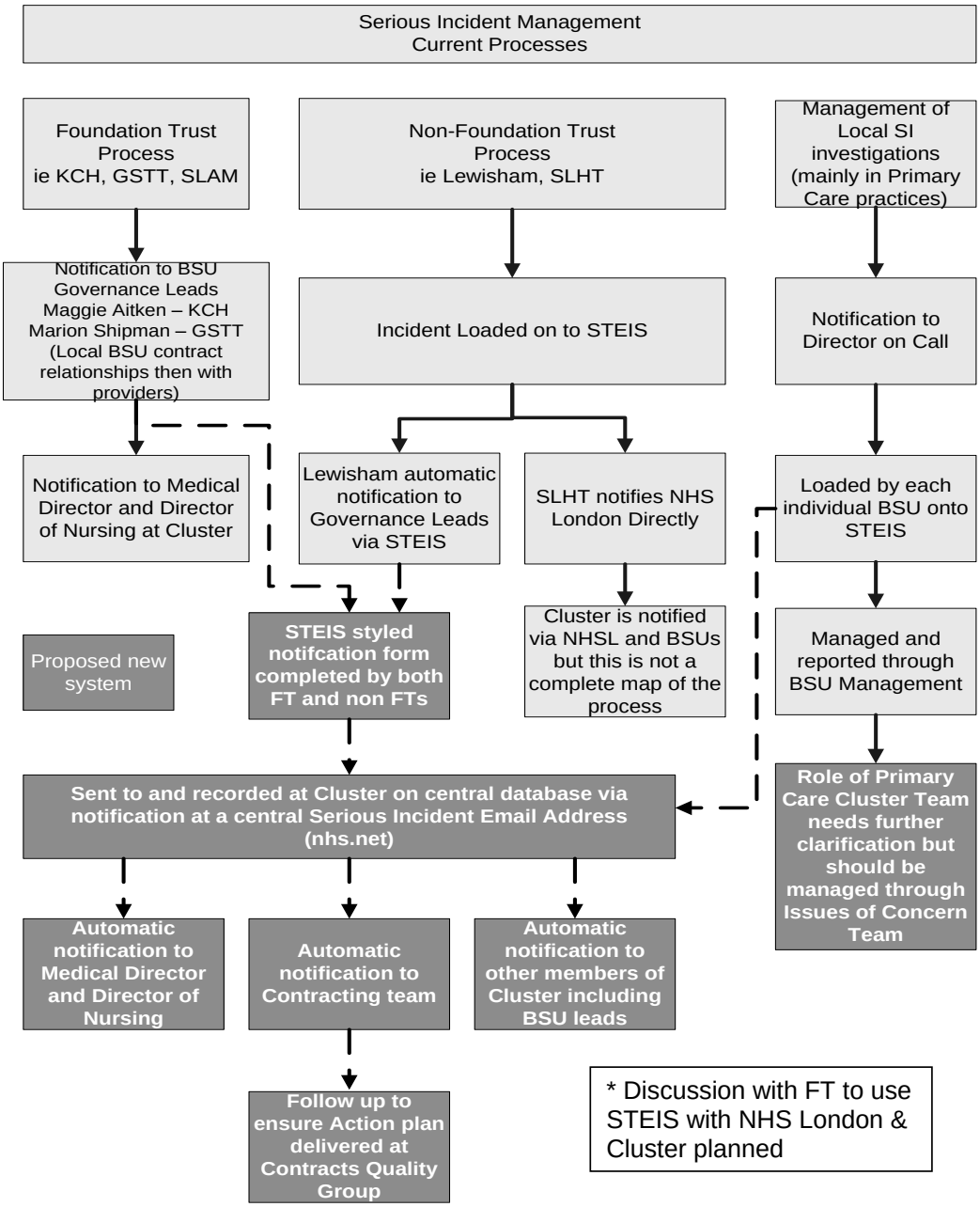

4. Primary Care – GP Quality Performance Framework

4.1 Key Issues:
Given the performance achievements reported in this paper, it is recommended that further investigation (in co-operation with GP Practice operational teams) is warranted particularly in the following areas:

4.1.1 Quality & Outcomes Framework

- Overall QOF achievement (all domains and exception reporting) in Greenwich and Lewisham.
- QOF Additional and Patient Experience achievement, as well as Exception reporting in Southwark.
- The steady reduction in QOF achievement over time in Bexley.

4.1.2 Access to Primary Care

- Access to primary medical services within 48 hours in Southwark, Bexley and Greenwich.
- Advanced access (i.e. booking beyond 48hrs) to primary medical services in Lambeth, Lewisham and Bexley.

4.1.3 Key Performance Indicators

- Smoking achievement in Lambeth and Greenwich (including the setting of individual GP Practice targets in Greenwich).
- Immunisation rates for children under two years and five years old in Lambeth.
- Immunisation rates for children under five years old in Greenwich.
- Cytology smear uptake in Lambeth, Southwark, Lewisham and Greenwich.
- Seasonal flu uptake across the Cluster.

4.14 Patient Complaints

- Further analysis as to the reasons of high numbers of patient complaints in clinical and communication/attitude across the Cluster.
- High rates of patient complaints as reported in Lambeth.

It is further recommended that the Business Intelligence Unit create a SE Cluster performance tool which includes (by working with public health colleagues) GP Practice profiles assessing demographic factors, (such as; IMD, sex, age and ethnicity breakdown). This will then be regularly reported to the Quality Committee together with GP Practice data as recorded by the NHS London Outcomes Dashboard.

A business case is developed by the Business Intelligence Unit to improve timely and efficient reporting of all independent contractor quality and performance measures. This will include proposals for the utilisation of automated electronic data extraction and returns by primary care providers, as well as (secure) on-line access to performance information by primary medical providers.

The Cluster primary care directorate share independent contractor quality and performance information with individual BSU Clinical Boards.

A full copy of the report is available from the Primary Care Business Intelligence Unit at the Cluster

5. Quality and Safety Issues

5.1 The Joint Quality and Safety committee will be paying particular attention to individual providers in the following areas:

SLHT
- Pressure sores
- Maternity services
- Clinical Quality complaints
- Never events

Lewisham Hospital
- Pressure sores
- Patient experience of Maternity Services
- Never events

Guys and St Thomas' NHS Foundation Trust
- Never Events
- Rate of Caesarian Sections

KCH
- Never Events
- Maternity Services

SLAM
- Physical Health Care
- Use of antipychotics in dementia
- Staff safety

Oxleas

- Physical Health Care
- Use of antipychotics in dementia
- Staff safety

6. Recommendations

6.1 To NOTE the content of the report

6.2 To NOTE the particular issues listed in paragraph 5 and AGREE these should form part of the work plan of the Joint Quality and Safety Committee.

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21st July 2011

ENCLOSURE 3

ENCLOSURE 3

ADULT AND CHILD SAFEGUARDING UPDATE REPORT

DIRECTOR RESPONSIBLE: Donna Kinnair , Director of Nursing

AUTHOR: Donna Kinnair , Director of Nursing

TO BE CONSIDERED BY: All

SUMMARY:
The purpose of this paper is to inform the board of the current processes and proposed future management of adult and children safeguarding processes across the SEL Cluster

To enable this to occur this paper sets out the following

- Proposed arrangements for child safeguarding reporting and monitoring
- Proposed arrangements to ensure a Board Assurance Framework for Adult and Child safeguarding is developed that will report to the Quality and Safety Committee.

KEY ISSUES:

Safeguarding Children Arrangements
All children and young people under 18 years of age, in particular those who are seen as vulnerable; are referred to health and social services and will be assessed for risks of potential significant harm or are suffering significant harm, have the right to protection by health and social services.

All boroughs with the exception of Greenwich have designated professionals in post, (these are both doctors and nurses). Greenwich has a designated nurse but does not have a designated doctor in post. Negotiations have been taking place with South London Healthcare Trust Clinical Director; SLHT will employ a paediatrician who will also hold the role of the designated doctor for Greenwich.

Across the cluster designated nurses are employed in the main by BSU's however the designated doctor who works as a paeditatrician is employed by a range of providers and it is important to secure the role of designated doctors, who work for the cluster. Hence a work is underway to ensure that the role, function and time component of Designated Doctors is specified through service level agreements with employing Trusts. SLA's to be in place by August 2011

Adult Safeguarding Arrangements
An adult at risk is defined as a person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness and is or may be unable to take care of himself/ herself or is unable to protect himself against significant harm or exploitation.

Whilst Social Services take the lead in adult safeguarding it is important that health services work with the local authority and therefore NHSSEL Cluster has a duty to quality assure the adult safeguarding services across the Cluster.

NHS London is undertaking a comprehensive assessment of clients in residential care, placed there, by the NHS with support by local commissioners in BSU's therefore all BSU's and Acute Trusts are in the process of undertaking a self-assessment of safeguarding in commissioning of services which will be sent into the cluster by 11th July 2011.

Acute Trusts
Currently there are a number of safeguarding cases at South London Health Care Trust that were a concern to the acute quality-monitoring group, as a number of them related to grade 3/4 pressure sores, which developed whilst in hospital. The Director of nursing has attended an Adult Safeguarding Case Conference held on 23 June 2011. A further meeting is being arranged to sign off the root cause analysis and recommendations and reviews are being planned to look at how education and training is being delivered to staff and learning disseminated to clinical staff.

New Arrangements
There will be an annual report to the Joint Boards that will.

- Ensure that the cluster safeguarding lead is notified of adult/ child safeguarding concerns alongside borough managing directors
- A network approach to manage and ensure dissemination and knowledge of safeguarding policies and procedures, education and training
- Stock take adult safeguarding through self assessment of adult safeguarding by July 11th 2011
- Analysis of themes that may be forming across the cluster. August 2011
- Reporting and serious cases review to the Quality and Safety committee, exception reporting to Joint Committee part 2.
- Board Assurance Framework for safeguarding to report to the quality and Safety Committee. Developed by July 2011.
- Client review and visits to residential units where patients /clients are placed to be undertaken by safeguarding leads.

Appendices

a) NHS SEL Adult Safeguarding Policy – to be considered by the Joint Boards as background information and is available electronically on request.

COMMITTEE INVOLVEMENT:

- The Operations Group
- Cluster Management Board.

PUBLIC AND USER INVOLVEMENT: N/A

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:

The board (s) is asked to:-

- NOTE the current key issues in relation to Child and Adult Safeguarding
- AGREE the proposed arrangements for the management of adult and children safeguarding across the Cluster and to note the timescales.
- AGREE for the Joint Quality and Safety Committee to monitor progress against the assurance framework and to receive an annual report on this.

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*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 21st July 2011

ENCLOSURE 3

Adult and Child Safeguarding Update Report

DIRECTOR RESPONSIBLE: Donna Kinnair, Director of Nursing

AUTHOR: Donna Kinnair, Director of Nursing

1. Introduction

1.1 The Cluster Board lead will need to assure itself that the child safeguarding arrangements are fit for purpose and the designated professionals are able to provide the appropriate level of assurance to the joint boards and to assure the board that we are discharging appropriate accountability to NHS London.

1.2 To enable this to occur this paper sets out the following

- Proposed arrangements for child safeguarding reporting and monitoring
- Proposed arrangements to ensure a Board Assurance Framework for Adult and Child safeguarding is developed that will report to the Quality and Safety Committee.

1.3 The purpose of this paper is to inform the board of the current processes and proposed future management of adult and children safeguarding processes across the SEL Cluster

2. Safeguarding Children Arrangements

2.1 The current children safeguarding arrangements were notified to the board by the paper written by Dr Jane Fryer, Medical Director at the last board meeting. These arrangements have been in place prior to the creation of the South East Cluster on the 1st April 2011 and the cluster has retained all designated professionals for child safeguarding that were in post prior to the creation of NHS SEL Cluster.

The role of the designated professionals is to quality assure the health economy.

2.2 All children and young people under 18 years of age, in particular those who are seen as vulnerable; are referred to health and social services and will be assessed for risks of potential significant harm or are suffering significant harm, have the right to protection by health and social services.

- Children 0-5 years old are seen as the most vulnerable group in this section; health and social care, along with parenting education is provided to support the development of children.
- Children 5-16 years are in the developing and most formative years and it is essential that health and social care services continue to monitor development and progress in partnership with education departments.
- Children and young people with mental health or learning difficulties present additional needs and therefore, through appropriate health, education and social care continue to be monitored through their development.

2.3 Therefore, NHS SEL Cluster seeks through its commissioning arrangements to ensure that:

- the provider services contracted, seek to make adequate provision that are supported by robust strategies, procedures and policies,
- to give assurance that all measures are taken to provide effective services.
- The designated professionals ensure the needs of children and young people are at the forefront of service planning and service delivery
- They ensure through commissioned contracts that health services contribute to multi-agency working and are accountable for ensuring that all providers work to clear service standards that safeguard and protect children.
- They monitor the implementation of safeguarding standards and quality assures services contracted by the cluster/ Clinical commissioning consortia for adequate safeguarding arrangements.
- They support and provide quality assurance for the health component of serious case reviews and ensure that any recommendations are implemented, appropriately across the health economy.

3. Key Issues - Safeguarding Children Arrangements

3.1 All boroughs with the exception of Greenwich have designated professionals in post, (these are both doctors and nurses). Greenwich has a designated nurse but does not have a designated doctor in post.

3.2 Negotiations have been taking place with South London Healthcare Trust Clinical Director; SLHT will employ a paediatrician who will also hold the role of the designated doctor for Greenwich. The post is currently awaiting sign off from the Royal College of Paediatrics and Child Health. Interviews are being planned for late July / early August. In the absence of a designated doctor the MD has been advised to escalate concerns and seek advice from the cluster nurse director and medical director

3.3 Across the cluster designated nurses are employed in the main by BSU's however the designated doctor who works as a paeditatrician is employed by a range of providers and it is important to secure the role of designated doctors, who work for the cluster. Hence a work is underway to ensure that the role, function and time component of Designated Doctors is specified through service level agreements with employing Trusts. SLA's to be in place by August 2011

3.4 The Director of Nursing has set up an overarching child protection network where all designated professionals are brought together to performance manage the Child safeguarding system, determine sector priorities, plan joint areas of working work and ensure that education and training is provided to primary care as providers and that good governance is set up in commissioning support. The meeting creates a supportive environment to share intelligence, enable peer supervision and facilitates a consistent approach to tracking serious case reviews and the implementation of any recommendations pertinent child safeguarding across the health economy and allows the planning for the safeguarding needs of clinical commissioning consortia. Terms of reference are being drawn up and meetings will be bi –monthly.

3.5 Currently notification of safeguarding incidents such as serious child injury or death or the need for a serious case review is notified to borough directors in the BSU's and to public health leads depending on where the role is line managed.

3.6 The Designated professionals also notify NHS London via the national reporting system STEIS. The reporting has been extended to the Director of Nursing, the board safeguarding lead who will inform the chief executive and chair of the NHS SEL cluster, and others as appropriate and we are then able to track investigations and ensure learning is shared where appropriate across all boroughs.

3.7 It is anticipated that issues of child safeguarding that require escalation to the board will be exception reporting to part 2 of the board meeting, due to the confidential nature of cases.

3.8 All PCT's and related Trusts were subjected to a Child Protection Service improvement visit in 2009/10, the designated professionals are currently tracking the implementation of recommendations across the system, and issues or concerns will be highlighted to the NHSSEL Cluster Board Lead.

3.9 The Designated professionals will be writing annual safeguarding reports for September 2011, this report will identify the current safeguarding issues in the system, priorities worked on or to be worked on and progress made throughout the last year. It will also assess health's compliance section 11 Children Act 2004. It is planned that an aggregated report is brought to the Quality and safety committee board meeting following the annual report.

4. Adult Safeguarding Arrangements

4.1 An adult at risk is defined as a person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness and is or may be unable to take care of himself/ herself or is unable to protect himself against significant harm or exploitation. (No Secrets 2.3)

4.2 The groups of people who may require adult protection are those who may have sensory impairment, physical disabilities, mental health needs, long term illness, those who misuse substance or alcohol, those who are physically frail or mentally frail and/or people with dementia.

4.3 Whilst Social Services take the lead in adult safeguarding it is important that health services work with the local authority and therefore NHSSEL Cluster has a duty to quality assure the adult safeguarding services across the Cluster.

These are to ensure that:

- In working with local authorities BSU's identify a senior lead for adults at risk to ensure their needs are at the forefront of local planning and service delivery

- There are clear standards for safeguarding and promoting the welfare of adults at risk in all commissioning arrangements.

- We are accountable for safeguarding processes and those undertaken by agencies with whom they have commissioning arrangements

- Clinical governance arrangements are in place to assure quality of services provided and contracted by the cluster and the boroughs monitor commissioned services

- All health agencies with whom they have commissioning arrangements are linked to interagency partnerships and that there is representation from the agency and at an appropriate level of seniority

5. Key Issues - Adult Safeguarding Arrangements

5.1 In the wake of concerns raised by the Panorama program on Castlebeck services at Winterbourne view in Bristol. The importance of ensuring the care of vulnerable clients in residential settings is both safe and free from abuse is a high priority for both health and social care commissioners.

5.2 NHS London is undertaking a comprehensive assessment of clients in residential care, placed there, by the NHS with support by local commissioners in BSU's. However it is important that local commissioners also undertake reviews of clients who are in receipt of care, such continuing care services.

5.3 Currently all Borough Managers have been asked to identify adult safeguarding leads, and most boroughs have done this.

5.4 Clinical commissioners have been asked to nominate a clinical commissioner with responsibilities for Safeguarding.

5.5 Currently all BSU's and Acute Trusts are in the process of undertaking a self-assessment of safeguarding in commissioning of services which will be sent into the cluster by 11th July 2011.

5.6 Commissioning guidance on Adult Safeguarding has been issued to all BSU's.

5.7 An Adult safeguarding network planning meeting is planned for the 8th July 2011, this is to ensure that the cluster is able to bring together adult safeguarding leads from primary care, acute and community services, mental health and those from care homes, adult safeguarding boards leads.

5.8 The plan is to ensure that the NHSSEL cluster is cognizant of adult safeguarding issues. It is hoped that by August 2011 we will have reviewed the safeguarding structures with particular attention to vulnerable groups, such as learning disabilities.

5.9 It is planned to improve the education and training of health service staff on Mental Health capacity issues, depravation of liberty (DOLS), Working with MARAC (Domestic Violence) and using the Memorandum of understanding to investigate harm to patients /clients. There will also be a planned visits to establishments where elderly frail / clients with continuing care needs are residing.

6. Focus on Acute Trusts

6.1 Currently there are a number of safeguarding cases at South London Health Care Trust that were a concern to the acute quality-monitoring group, as a number of them related to grade 3 /4 pressure sores, which developed whilst in hospital. The Director of nursing has attended an Adult Safeguarding Case Conference held on 23 June 2011. A further meeting is being arranged to sign off the root cause analysis and recommendations and reviews are being planned to look at how education and training is being delivered to staff and learning disseminated to clinical staff.

6.2 Meetings have taken place with Adult and child executive board leads a Guy's and St Thomas', Kings College Hospital, South London and Maudsley Foundation Trust Hospitals. Assurance has been sought that they have robust Child safeguarding mechanisms in place and established escalation procedures.

A copy of their self-assessment for adult safeguarding has been requested by 11th July 2011.

7. Focus on Nursing Homes or residential units / campuses

7.1 A plan number of reviews and audits to be defined and undertaken by BSU' professionals and nursing a medical director, where possible in collaboration with local authority.

8. Summary of new arrangements

8.1 The work outlined above will be pulled together by the adult and children safeguarding network and a NHSSEL Cluster Board

Assurance Framework and will be monitored bi- monthly by the Joint Quality and Safety Committee.

8.2 There will be an annual report to the Joint Boards that will.

- Ensure that the cluster safeguarding lead is notified of adult/ child safeguarding concerns alongside borough managing directors
- A network approach to manage and ensure dissemination and knowledge of safeguarding policies and procedures, education and training
- Stock take adult safeguarding through self assessment of adult safeguarding by July 11th 2011
- Analysis of themes that may be forming across the cluster. August 2011
- Reporting and serious cases review to the Quality and Safety committee, exception reporting to Joint Committee part 2.
- Board Assurance Framework for safeguarding to report to the quality and Safety Committee. Developed by July 2011.
- Client review and visits to residential units where patients /clients are placed to be undertaken by safeguarding leads.

9. Recommendations

The Board is asked to NOTE the current key issues in relation to Child and Adult Safeguarding and AGREE the proposed arrangements for the management of adult and children safeguarding across the Cluster and to note the timescales.

The Board is asked to AGREE for the Joint Quality and Safety Committee to monitor progress against the assurance framework and to receive an annual report on this.

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21st July 2011

ENCLOSURE 4

DEVELOPING A PRIMARY CARE IMPROVEMENT PLAN FOR THE NEXT 18 MONTHS- A DISCUSSION DOCUMENT

DIRECTOR RESPONSIBLE: David Sturgeon, Director of Primary Care

AUTHORS: David Sturgeon Director of Primary Care, Rylla Baker and Jill Webb, Assistant Directors of Primary Care

TO BE CONSIDERED BY: All

SUMMARY:
The formation of the Cluster Primary Care Directorate provides a period of 18 months to improve both the access and quality of primary care services within South East London. This document identifies the need to consolidate and improve services for patients over the transition period to ensure a robust and sustainable legacy of primary care services. The paper highlights a number of suggested solutions to achieve these aims. There is a need to ensure that the proposed courses of action align to the vision of the emerging local clinical commissioning consortia (LCCC). Discussions at the Board and wider will determine the way forward for the Primary Care Directorate over the next period.

KEY ISSUES:
There is an opportunity to improve both access and quality of primary care services throughout South East London over the next 18 months. Differing approaches have been adopted across the boroughs and the cluster arrangement for primary care commissioning provides the ability to develop a consistency of provision for patients by ensuring the delivery of a common core of high quality services through contractual arrangements.

Resources are limited in terms of commissioners to lead improvements and development monies. Therefore a prioritisation of what can be achieved in the timeframe needs to be made. The paper sets out key areas of improvement and development together with commissioning intentions.

The paper sets out greater provision of primary care services through re-negotiation of existing contracts delivering better value for money and new contracts being linked to delivery of required outcomes. Use of information is promoted to drive up quality and performance working with the emerging LCCCs. The provision of patient user friendly information on practice performance and outcomes is proposed to inform choice of provider.

Addressing poor performance of contractors and premises issues will have short term costs but will be beneficial in the medium to long term. The financial consequences of these plans need to be finalised.

While concentrating on general medical services, similar approaches will be undertaken with other primary care contractors.

Whilst bringing together all six Primary Care functions from PCTs into one has brought its challenges, there are some early signs of success – notably the creation of a joint Local Medical Committee meeting at a Cluster level.

COMMITTEE INVOLVEMENT:

- A first report on primary care performance has been reviewed at the Quality and Safely Sub-committee.

PUBLIC AND USER INVOLVEMENT:

- None to date but following this discussion document, public and user engagement will commence on the type and format of information to be provided to inform choice.

IMPACT ASSEESMENT:

- The proposal is to deliver a common core service and greater access to all patients across South East London should improve inequalities. An impact assessment will need to be undertaken once the actual detail has been agreed.

RECOMMENDATIONS:

The board (s) is asked to:-

- Confirm the areas to be addressed over the next 18 months
- Consider the suggested solutions
- Note the requirement for engagement with BSUs/LCCCs
- Note future papers with be submitted to the Board on procurement and premises against this improvement plan

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*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

ENCLOSURE 4

Developing a Primary Care Improvement plan for the next 18 months- a discussion document

AIM: To maximise the opportunity during the two year transition phase to make improvements both to access and quality of primary care services in South East London with the aim of leaving a robust and sustainable legacy as a result of the actions taken.

INTRODUCTION: This paper sets out key areas for development and improvement and the expected outcomes for this investment of resource during the transition period. The Quality, Innovation, Prevention and Productivity (QIPP) agenda will require both commissioners and providers to review how the improved outcomes are delivered.

The discussion paper has been developed by the cluster primary care team reflecting on initial findings in the first three months of operation. It is recognised that this document will be enhanced and developed further with input from Business Support Units (BSU), Local Clinical Commissioning Consortia (LCCC) and other cluster colleagues. It focuses in the first instance on the potential for improving General Practice but the approach will be extended to other Independent Contractor Groups (Dentists, Optometrists and Pharmacists) both as individual professional groups and where they interface with general practice colleagues.

Across the six PCTs there have historically been different approaches taken in commissioning primary care services. Whilst this paper proposes that a consistent approach is achieved in service delivery to patients, policies and procedures, it is recognised that the starting point and the 'how' will initially differ as cluster alignment is sought. Wherever possible existing good practice and shared learning operated within the cluster will be the starting point for improvements and assist the development of cluster policies and procedures.

It should be stated that poor performance and poor outcomes are not acceptable and that our aim is that patients should receive the highest quality care. This will require robust management and resource to address poor performance and outcomes when identified.

To achieve the aim set out above will require creativity, determination and commitment even when the 'going gets tough' if the maximum impact is to be achieved with the resulting direct positive impact on patient care.

ENCLOSURE 4

POTENTIAL CONSTRAINTS

There are some common themes under the heading 'potential constraints' which should be cited in each of the areas of development and improvement and therefore these are shown below as it will be essential that these are acknowledged and wherever possible solutions that will mitigate the potential risks are identified

- Resistance by contractors in bringing together six borough's historical ways of working e.g. premises policies, sickness and maternity leave policies, list validation policies – however this has been significantly mitigated by joint working with the LMC in the form of regular joint meetings at a Cluster level.

- The reduction in capacity within the primary care team (and other teams) means that priorities must be agreed upfront and some work will not be able to continue in the same way as before mitigated by smarter working facilitated by greater use of technology and better communication to contractors, public and patients.

- Differing approaches and expectations of BSUs/LCCCs in regard to primary care services and their interface with the Cluster primary care team. This will be addressed by a joint approach by those involved.

- Uncertainty in other areas of the reform agenda e.g. Public Health which interfaces with primary care.

- Systems that are not a streamlined e.g. approach to Complaints, Freedom of Information requests (FOI), communications to primary care staff, Complaints, Serious Incident Reporting (SI) will drain resources if not addressed.

- Clarity on resources particularly on upcoming premises developments

- Concurrently a need for the cluster primary care team to contribute to the development of performance management and of policies in advance of the creation of the National Commissioning Board which diverts management from the day to day management of existing contracts.

Many of the areas discussed in this paper will need to be negotiated with the six LMCs across the cluster. Encouragingly, the Londonwide LMC have recognised this need and the Chairs of the cluster's six LMC groups have agreed to meet regularly and focus on the agenda of bringing in a level of consistency however this is likely to be a time consuming process given the initial starting point.

AREAS OF IMPROVEMENT - key areas selected for discussion in this paper are:

- Access
- Communication
- Governance
- Information and Data analysis systems
- Issues of Concern
- Patient Engagement / Choice
- Performance Management
- Premises & Infection Control
- QIPP
- Workforce

ACCESS

Intended Outcomes: Patients in South East London (SEL) should be able to access a common core of primary care services from their GP practice as a minimum between the core opening hours of 8.00am – 6.30pm Monday to Friday (excluding bank holidays). Appointments or alternative consultation methods should be offered at time of patient calling for on day and advance bookings. In addition all patients should be able to access extended hours appointments at some time during the week (although this may not be from their own practice or by the clinician of their choice.) Patients should be able to see a GP or an experienced member of the practice team within 24 hours. Information about the surgery and access arrangements should be up to date and available on the NHS Choices website and in the Practice Leaflet.

Any patient - registered or unregistered - should be able to access walk in primary care services between the hours of 08:00-20:00 365 day a year, free at the point of delivery.

Patients should be able to access, and be clearly signposted to, out of hours primary care services when there is a level of clinical need, with a high quality provider. Patients should not have to dial more than one telephone number to reach their out of hour's provider. At no point in time should a patient pay any more than the standard cost for their call. 111 services will be developed with NHS SEL during 2112/13.

Promoting greater availability of primary care access should reduce use of secondary care services and increase patient satisfaction as measured through the National Patient Survey.

Opportunities	Suggested Solution
Through ongoing PMS Contract reviews and the development of local Key Performance Indicators it is possible to embed various points that will improve access for patients such as: - ending half day closing - setting a figure for the number of appointments that should be available as linked to registered population - booking opportunity at point of patient request for an appointment	Where a review of PMS Contracts is yet to be completed these indicators should be included wherever possible. If the opportunity arises in future negotiations in different settings these should be a priority for inclusion. An audit of utilisation of Unscheduled care services by patients registered with specific practices should be undertaken by the BSU. Primary care could then focus with the BSU on those practices with outlying numbers of patients attending alternative services where access could be improved.
Amongst many other things rolling out EMIS Web[1] or similar solution from other providers across the cluster would enable patient records to be viewed from more than one site. This would facilitate, amongst other things, the potential for joint working between smaller practices that cannot currently offer longer opening hours or benefit from peer support on a regular basis.	The introduction of EMIS Web or similar should be considered across the whole cluster. Currently a business case for the roll out of this capability across LSL and Greenwich is being developed. Bromley is also working to roll out EMIS web to its EMIS practices. To support a consistent approach Bromley and Bexley should also be encouraged to engage in this

[1] EMIS web is a web based software programme that is expected to work with both EMIS clinical systems and other systems to deliver a clinical system which; allows encrypted access to a patient's medical records from various sites with appropriate permissions, allows transfer of information between GP and Hospital, supports the delivery of the summary care record programme and the EPS 2 system (electronic transfer of prescriptions second phase, between GP and pharmacy

	programme jointly to avoid increased workload for the primary care team and create a robust, coordinated, equitable approach across the cluster
Increased opportunities for patient participation are likely to result in suggestions being made to practices about how to improve access and an improvement in the National Patient Survey responses.	The Patient Participation DES has been offered to all practices across the cluster. Monitoring by the primary care team of the actions and outcomes in a consistent way should result in more ideas being shared about access to services.
The development and implementation of the proposed 111 service will have the potential to change the out of hour's landscape dramatically.	The cluster primary care team's original establishment included an Out of Hours manager which has not yet been recruited to. It is proposed that this job description should be amended to include a key role in overseeing OOH providers/ DoS[2] interface and potentially acting as the interface for other primary care service providers (e.g. UCCs and GP Led Health Centres.)
Across the cluster we have two out of hours providers in the south of the cluster (where practices have opted out of OOH) and in the north of the cluster one further out of hours provider (where less than 10 practices have opted out of OOH.) This provides fertile learning through the ongoing benchmarking exercise on quality and outcomes within the OOH providers.	Ongoing monitoring of the quality of the OOH providers should continue to assure the Cluster that the quality of care complies with the National Quality Requirements. Wherever practices remain 'opted in' they should be expected as part of their Contractual requirements to take responsibility for the quality of their OOH provider.
The development of GP Led Health Centres and Urgent Care Centres provide a new opportunity to develop new and improved access routes to primary care services.	Whilst needing to recognise varying costs of different provider methods it is essential to consider the future of these centres as part of both the LCCC's Unscheduled care strategy and the core primary care strategy and not negate the potential for a local focus.
Access to services not provided by the practice to be reviewed and practice plans developed to address patient requirements	Linkage of non practice delivery of services to practice income

[2] DoS – Directory of Services – a director y that includes information about all services offered, opening hours etc.

COMMUNICATION

Intended Outcomes: There will be a clear communication strategy for dissemination / sharing of information on primary care services. This should be transparent, easy to access and meet with information governance and Caldecott guidance. Wherever possible information should be accessible electronically via the intranet or other suitable alternative. Patients should easily be able to access the Website which should be up to date and give clear guidance how to access relevant information including links to the NHS Choices website

Opportunities	Suggested Solution
The development of a cluster approach brings with it opportunities to streamline the approach to communications	Using the shared drive a cluster database by borough and by groups of professionals e.g. Lead GPs, Practice Nurses, Practice Managers should be set up on a shared drive. This should be updated by the primary care team as changes are received. No one else will be able to change this database.
	Clear guidelines should be set up as to the use of the database which will include the following areas - practices receive one main email a week which will include all of the non emergency communications for that week – generated from within primary care - when and if communications are sent out by the comms team - how requests for items for dissemination will be collated i.e. sent to one point rather than multiple points.
	Training and guidance should be available to support the development and ongoing maintenance of the cluster Internet and Intranet sites to ensure that they are accessible and fit for purpose.
Non-anonymised dissemination of data across the cluster should be agreed in all boroughs as a forerunner to the development of clinical commissioning.	It is recommended that this is the approach taken as experience has shown that understanding each practice's position across the borough or cluster plays a very influential role in the response shown by practices. Work with LCCC's and practices to understand information being produced and agreed where necessary corrective actions.
Publication, once verified by practice, of a minimum data set of information on a range of indicators of practice delivery and performance	Build on Londonwide Outcomes Framework to better inform patients of choices available to them in selecting their primary care provider
Development of 'PCT'/Practice Manager Fora in order to engage on a regular basis with local practice managers.	Establishment of quarterly meetings with small budget provided to practices prepared to support organisation/administration of fora.

GOVERNANCE

Intended Outcomes: A clear, easily understood, transparent approach to Governance throughout all aspects of our work must be adopted. In many cases in accordance with statutory requirements and in others because it ensures that good practice is followed.

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Opportunities	Suggested Solution
The opportunity to develop a cluster wide approach to audits, implementing NICE guidance, dissemination and responding to CAS[3] alerts, Information Governance, Caldecott requirements and CQC registration (as a few examples) wherever possible will encourage shared learning, shared experience, consistency and reduced duplication of activity	Wherever possible a cluster wide approach should be adopted and the use of technological advances (see information and data analysis systems) will need to be adopted in order to manage within the significantly reduced resources.
	In order to ensure best use of technological advances it will be essential that the level of compliance with the Information Governance (IG) requirements is raised. Compliance with IG across practices is not consistent and whilst there are some contractual levers available it would be extremely beneficial if additional experienced input could be identified on a short term basis in order to support the practices to create a streamlined approach that is sustainable.
CQC Registration brings with it both opportunities and challenges. It is likely that registration for GPs will be deferred by one year with implementation being with effect from 31.3.2013.	Wherever it is possible to incorporate ways of supporting practices in achievement of their CQC registration either through approaches to QOF (QIPP section) or approach to premises and infection control etc this should be maximised.

[3] The Central Alerting System (CAS) is the means by which alerts of various kinds e.g. medical, prescribing information are disseminated to the relevant groups of Practitioner. Part of the system involves checking whether a practitioner has responded to the information.

INFORMATION & DATA ANALYSIS

Intended Outcomes: As a cluster we should have a positive approach to the introduction of new technology with the intention of streamlining systems such as contract monitoring, payments, clinical service delivery, data analysis, service redesign modelling, validation and communication systems

Opportunities	Suggested Solutions
In the north of the cluster a system has been in operation for a number of years called Contract Focus. This provides a mechanism for collecting aggregated anonymised data which is then available to the PCT for use with reporting vital signs and performance management, payments to contractors and in some cases with add on modules for providing non-anonymised data to programmes such as the diabetic retinopathy screening service, the call and recall system for health checks and immunisation data to Rio. Lambeth have been working on creating a web based portal to this system which would enable practices to have web based access to the resulting performance data compiled by the PCT via the web reducing the need for dissemination of data	It is recommended that either Contract Focus (or in its newer version Population Focus) or another suitable alternative be procured. This would resolve the impact on the capacity of the primary care team due to the need to validate numerous claims for payment and raising of payments based on a paper based claiming system. Experience has shown that this system can be operational quite quickly and data could potentially be collected with effect from the beginning of this financial year. A business case is currently being prepared.
In the south of the cluster a system called Patient Care Information Systems (PCIS) is used so that information held on the national EXETER patient database system can be incorporated into report format and used for data analysis. This is not possible using the EXETER system itself (a compulsory system) which is very inflexible.	It is recommended that PCIS is introduced in the north of the cluster with the view that it will enable us to take a consistent approach and reduce time consuming transfer of data from one format into another manually. A business case is currently being prepared.
Introduction of the NHS Net, Outlook and suitable archiving arrangements will increase levels of assurance about information governance standards and confidentiality.	The use of the NHS net system does introduce both increased levels of assurance about confidentiality but its relatively low capacity for archiving of data and its somewhat cumbersome approach if used via the internet means that it is only a viable package if all components are introduced at the same time.
Introduction of a generic NHS Net mailbox for each practice with an agreement that it will be checked daily will create a mechanism by which urgent communications can be sent to practices using a specific route and it will not be dependent on an individual's ability to keep up with email traffic.	This should be undertaken at the same time as rolling out the NHS net system
Disseminating and obtaining a response to CAS[3] alerts is an essential requirement of the cluster. Several PCTs historically established an electronic system through which the alerts are disseminated and practices can respond.	Given the complexity of the current system and the difficulties in identifying the practices that have not responded without an electronic system with a reporting function it is recommended that the same system be introduced across the cluster. This is also one of the areas where agreement has to be reached about where the system will be initiated and managed.

The creation of a cluster based primary care team provided the opportunity to prepare for the creation of the National Commissioning Board and to bring together the records relating to practices across the cluster; using a simple and easily understood file naming convention and data management systems. Equally it was recognised that to operate across such a wide patch with responsibilities to undertake work in different boroughs it would be necessary to make arrangements for remote working with access to the necessary drives and mobile contact arrangements.	This has all been agreed in principle and needs prioritisation and resourcing.
Several boroughs had prior to 1 April 2011 begun a programme to introduce EMIS Web[2]. From a contractual perspective this brings the ability to see and treat patients from different sites, long term Summary Care Record compatibility for PCS which was not available from the old system, Electronic Transfer of Prescriptions (ETP2) with the pharmacists which is nearing completion, easier dissemination of service redesign templates, integral document management systems and reporting modules.	It is recommended that this programme continues because of the long term benefits in all areas. A business case is currently being prepared for the four boroughs that are supported by the cluster IT team.

This list does not incorporate other key systems such as those for risk management, developments relating to Rio, Choose & Book, service redesign / pathway modelling which bring together acute and primary care data

ISSUES OF CONCERN

Intended Outcomes: In conjunction with a systematic and consistent performance management approach the cluster primary care team will have systems and processes in place to identify and respond to issues of concern whether they relate to a clinical performance or contractual matter. Intelligence received from other teams such as PALS and complaints (within BSUs) will be incorporated into the process and a case management approach involving all key stakeholders will be in place. A clear governance and decision making structure will be in place to offer a consistent, transparent and fair approach.

Opportunities	Suggested Solutions
Taking a challenging, consistent and direct approach towards identifying and responding to issues of concern will improve patient safety, ensure that training and development needs can be addressed, improve health outcomes and ensure best use of NHS resources. This approach will also mean that LCCC will have a firm foundation on which to build	The cluster, BSUs and clinical commissioners should adopt the approach that issues of concern must be identified and appropriate responses initiated via the Issues of Concern team. There should be a requirement that information about such issues of concern should be provided to the Issues of Concern team in a timely way and the team should provide timely feedback on issues to the BSUs. In stating this it is recognised that responses may be developmental or remedial and not always punitive but the approach will depend on the circumstances.
	Agreement on resourcing actions brought about by pro-actively addressing Issues of Concern e.g. seek legal advice and commission an independent report regarding clinical & non-clinical matters, as and when necessary. Clinical capacity needs to be procured through a framework agreement to replace poor performers where patient safety is believed to be at risk. This will be short term while future services are procured.
	The active approach to identification of issues of concern has resulted in an increase in work for the counter fraud team. It is suggested that capacity within this team is increased and that one counter fraud service works across the whole cluster rather than the current fragmentation.

ENCLOSURE 4

PATIENT ENGAGEMENT / CHOICE

Intended Outcomes: Patients should be involved in decisions that need to be taken relating to the primary care services available and the methods of delivery. Patients should be able to exercise Choice about the care that they receive.

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Opportunities	Suggested Solution
The introduction of the Patient Participation DES sets out a programme by which more patients can be involved with decisions about the services that are delivered.	This should and has been offered to all practices. Careful and consistent monitoring of the DES should result in improved patient engagement.
Patient involvement with procurement exercises should be more defined with training for those involved	Learning should be shared between the boroughs about this process and how to get the most effective input to this and other processes.
The patient survey has been in place for several years now. We should maximise the way in which the information available can be utilised.	Information generated from the survey should be analysed in such a way as to show trends and practices with consistently poor satisfaction levels should be targeted to agree an improvement plan.
Contractors' performance information, once verified with contractors is published for public use	NHS SEL website/NHS Choices and other publications used to disseminate practice information to patients and the public to inform choice of provider

PERFORMANCE MANAGEMENT

Intended Outcomes: To implement a consistent approach to performance management across the cluster. To ensure that this complements the existing London wide Quality outcomes framework and that the SE London cluster is represented in the development of the London wide Performance Management Framework scheduled for implementation from April 2012. The framework should focus on improving quality and health outcomes and a number of key tools should be incorporated into the process including: clear and understandable data and interpretation, benchmarking across the cluster and wider comparable areas, taking a transparent and equitable approach to all contractors and offering development and support as well as contractual levers to help improve outcomes. A dashboard approach to the presentation of practice information will be created. The collation of information to populate the performance management framework should be generated and collected through technological solutions rather than a paper based system and ideally practices should be able to access the end product through a password protected web portal to avoid cumbersome dissemination of information.

Opportunities	Suggested Solution
The development of a London wide approach to Performance Management and Quality outcomes frameworks provides the opportunity to benchmark results across a wider area and the cluster approach in 2011/12 can feed in to the development of these frameworks	A sensible number of high priority indicators are agreed across the cluster along with a standardised approach and agreed thresholds so that a true, comparative picture is available for both practices and members of the Public. (This will need to take into account the learning from the comparative work on QOF, include caveats where relevant e.g. about list size and learning from Public Health about demographic issues). Work with LCCC's to determine how and in which way outcomes are taken forward within individual practices
The implementation and development of PMS Contract Reviews with the introduction of Key Performance Indicators and similarly APMS contracts which include KPIs, offer a further opportunity to manage very specific issues via the monitoring of locally agreed indicators.	Include both standard KPIs and some locally agreed indicators as part of Contract reviews and development needs to drive up and reward quality improvements.
	Wherever possible the same core template for GMS, PMS and APMS Contracts will be used across the Cluster for new Contracts issued.

PREMISES & INFECTION CONTROL

Intended Outcomes:

All primary care services should be delivered from fit for purpose premises which adhere to Health & Safety, Infection Control, DDA and other statutory requirements. This will be a clear requirement to ensure CQC Registration. Premises should be able to deliver sufficient capacity to meet the needs of the patients now and within at least the next five years taking into account the need to deliver service redesign which moves care closer to home. In making decisions about premises in use / required across the cluster (and therefore within each borough) accessibility for patients to a site from which they can receive primary care services must be taken into account.

A consistent approach to Infection Control visits, policies and protocols across the cluster should be developed recognising that this is an area where the lead should be coming from the BSU and Public Health departments. Ensuring that infection control requirements are adhered to is a key foundation stone for premises developments, service delivery and service redesign.

Business Cases that support the strategic priorities of the SE London Cluster & its constituent PCTs are more likely to be prioritised. Premises development proposals must be supported by a fully costed business case and deliver services to a minimum patient population of circa 6,000 patients with capacity for growth and provision for out of hospital services.

Opportunities	Suggested Solution
An experienced team leading on premises has been established at the cluster level. A cluster wide approach to premises – policies, funding, rent reviews etc can be established.	The governance structure including decision making groups must be established quickly
Learning can be shared across the cluster to maximise the opportunities from bidding for premises resources.	The estates team should be identifying opportunities for bidding across the whole cluster for 2012/13 and use the 2011/12 resources as flexibly and equitably as possible.
A BSU/LCCC/Primary Care Contracting 'joined up' plan to support infrastructure improvements should be drawn up.	Developments which should be prioritised should include those where practices are actively prepared to work with others to improve services and reduce potential professional isolation and/or should maximise the opportunity to enable provision of high quality primary care and out of hospital services to a given mass of population.
Determine that existing practices meet current statutory and CQC requirements	Appropriate surveys which both support practices in compliance with their CQC registration and meet the requirements to monitor the Contract

	consistency in terms of complying with regulation and assuring that correct rent and rates reimbursements are paid should be undertaken in relation to all GP Premises across the cluster and a business case should be developed by which this can be considered.
Some boroughs have begun to look at the capacity of their practices to take on additional patients and services. Consider the best model and implement it.	A capacity planning review, linked with the above, should be undertaken with every practice possibly as a self assessment with tight guidance – looking at both use of space for NHS purposes (links to maximum financial reimbursements) and capacity for additional patients / services.
The opportunity to streamline infection control audit arrangements across the Cluster will enable identification of improvement areas on a consistent basis.	In order to both support practices and assure NHS SEL that both premises and services meet infection control standards one audit tool should be adopted creating a consistent approach to monitoring, expectations and the levels of support offered to practices. Practices with inadequate infection control arrangements should have high risk services (e.g. minor surgery) either temporarily or permanently decommissioned and patients offered alternative access. In order to deliver this the interface with Public Health (where it is expected this function will remain) needs to be well established

ENCLOSURE 4

QIPP (Quality, Innovation, Productivity, Prevention)

Intended Outcomes: The primary care QIPP productivity targets set across the cluster for 2011/12 need to be actioned which will be challenging both in terms of the financial value and the timescales within which this has to be completed. In addition a focus on areas where improved quality, innovation and prevention provide opportunities for improvement need to be identified and developed. Throughout 2011/12 preparation needs to be undertaken in order to put in place the equally challenging productivity targets for 2012/13 and beyond.

Opportunities	Suggested Solution
In some of the boroughs a review of PMS (and in some cases GMS) Contracts have not been undertaken. As part of such a review key areas of focus can include addressing historic inequities of funding; introduction of a level of transparency between practices; developing KPIs that will generate improvement and focus on local needs whilst complying with the statutory requirement to undertake such reviews as well as the generation of productivity savings.	Wherever the PMS reviews have not been undertaken this will be actioned and the general approach to such reviews will follow, where possible, best practice from elsewhere ideally with a view to achieving consistency of approach and monitoring. A focus should be given about how best to deliver the intended outcomes set out throughout this paper and wherever possible complementary initiatives included within the PMS review format. In boroughs where reviews have previously taken place when and if there are opportunities to incorporate some of the specific areas of focus as part of future negotiations these should be taken.
Reviews of the Enhanced services currently provided provides the opportunity to both ensure that they deliver quality and value for money and that they still meet the local needs for which they were established.	The existing enhanced services should be actively reviewed as experience has shown that some are inequitable, out of date and in some cases payment is being made but work is not being undertaken. Service redesign associated with the Directed Enhanced Services (DES) should be undertaken e.g. Minor Surgery, IUD fitting. Local enhanced services (LES) provide a mechanism by which local needs can be addressed and therefore their potential should be utilised as part of the implementation plan for wider service redesign and quality improvements.
Agreement to robust list validation exercises both in terms of a one-off programme and an ongoing rolling programme will ensure that call and recall programmes can be effective; monitoring of cluster /borough achievements represent a true picture and resources are used most effectively.	A cluster wide approach to list validation will be developed in order to achieve consistency and fairness across all six boroughs. In some areas no funding has been allocated to this piece of work and whilst experience has shown that there will be savings generated an agreement to 'pump prime' this programme will need to be agreed. The majority of any savings realised will not be available until six months after letters are sent out to patients because of the time line for the process.
Agreement of a number of other policies across the cluster such as payments for locum reimbursement in cases of GP sickness, maternity and suspension or the approach to discretionary payments for GPs and their teams e.g. payments for attending meetings, undertaking work for/with the primary care team	In principle throughout the primary care arena one policy across all six areas should be agreed.

(excluding individual borough Clinical commissioning payments) should be agreed consistently to ensure fairness, transparency and one approach to be monitored rather than six.	
The approach to monitoring of QOF should be consistent, transparent and fair across all boroughs. The incorporation of Quality Indicators that support the clinical commissioning agenda provides an opportunity for interface working between the BSUs and the primary care team.	A consistent approach should be taken towards the monitoring of QOF and this will require the adoption of a consistent framework within which there will be local flexibilities determined by the BSU/LCCC as to the areas covered in service redesign and prescribing indicators. As outlined under the issues of concern section an active approach to poor performance or mismanagement of the QOF process should be identified and addressed formally using the full range of approaches through training, development, contractual and performance responses that are appropriate for the circumstances.
Ability to specify services and link to delivery of desired outcomes.	New services will be procured through Any Qualified Provider or through open tender. New contracts for the provision of primary medical services, except where existing contractual rights exist will be a standard APMS contract with KPIs representing 25% of income determined by delivery of appropriate KPIs.

ENCLOSURE 4

WORKFORCE – Non-clinical staff

Intended Outcomes:

Within a practice setting non-clinicians should all have contracts of employment, personal development plans, access to training and all other items that are required of a 'good employer'. This is a requirement of the GP Contracts. Patients can expect to be communicating with staff members who have been trained in their role as front line communicators and who have an ongoing development plan. Any suggestion that the receptionists are the 'wall' over which patients have to climb to reach their doctor / clinical advice is no longer acceptable. Staff will have a good understanding of the practice policies and confidentiality. Where new programmes are introduced for the first time across the cluster e.g. safeguarding, chaperone training, smear taking, experience has shown that commissioning a pan borough approach to achieve consistent baseline knowledge in the first instance has been the best approach. This requires both capacity and resources to commission training itself and unless the booking, monitoring and evaluation function is commissioned along with the course this needs to be held somewhere within the cluster/BSUs. Where on line mandatory training is available access should be arranged for all practice staff as well as cluster staff. Partner organisations should be encouraged to share access to courses with primary care staff

Opportunities	Suggested Solution
Development of consortia whilst focussing on the commissioning of services and engagement of service redesign may be able to attract resources that could support the training and development of all practice staff to play their part in the changes.	Consortia and BSUs should be encouraged to consider practice team development as part of their Organisational Development Plans. The governance structure including decision making groups must be established quickly
To maximise the benefits of any training that is still accessible for this group of staff. This may involve working with the Local Authority; acute and community Trusts and between some or all of the cluster PCTs.	A decision needs to be made about who will coordinate information about access to training; what is available and where the budgets are held; and then issue clear guidance to practices and the primary care team. An obvious suggestion would be the HR /OD leads for each of the BSU's who have in the main historically been responsible for training and had involvement in the various provider splits

WORKFORCE – Clinical staff

Intended Outcomes:

All clinical staff should initially be qualified to undertake the services that they are providing and that they continue to remain up to date through attendance at ongoing educational events. (This responsibility is one that the individual practitioner is responsible for ensuring as part of their professional accreditation.) In order to provide ongoing assurance the development of a consistent approach to appraisal and revalidation across the cluster with an expectation of 100% compliance with the system is expected in line with Contractual requirements is expected. In the current climate with development funding being available to consortia the maximum potential output from this resource across the whole workforce should be obtained if possible. Partner organisations should be encouraged to share access to courses with primary care staff

Opportunities	Suggested Solution
The appraisal and revalidation programme is ongoing and members of NHS SEL have been involved in the pilot phase of this project so we are well advanced and at the forefront of developments. Having a cluster wide team has the potential to embrace all the opportunities of this programme.	An expectation that there will be 100% compliance with the appraisal and revalidation programme should be the minimum standard across NHS SEL
Whenever new programmes of work are introduced for the first time consideration should be given to resourcing the commissioning of the first round of baseline training in order to ensure maximum consistency of approach across the cluster and better consistency for patients.	A decision needs to be made about who will coordinate information about access to training; what is available and where the budgets are held; and then issue clear guidance to practices. An obvious suggestion would be the HR /OD leads for each of the BSU's who have in the main historically been responsible for training and had involvement in the various provider splits

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21st July 2011

ENCLOSURE 5

PERFORMANCE REPORT

DIRECTOR RESPONSIBLE: Jane Schofield, Director of Operations

AUTHOR: Sean Morgan, Director of Performance

TO BE CONSIDERED BY: All

SUMMARY:
This is the first in-year performance report for 2011/12.

The Performance Report and performance dashboards (the appendices to the main Report) will cover the Headline and Supporting Measures (as set out in the national 2011/12 Operating Framework), as well as the previous set of public health indicators which are retained for 2011/12. This suite of metrics replaces and builds on the Vital Signs indicators in use for the previous three years.

The intention is that this set of Measures will only apply for one year and will be replaced by the NHS Outcomes Framework and the Public Health Outcomes Framework respectively from 2012/13.

The Report consists of a narrative on those indicators for which in-year data is already available. At the time of writing we have in-year performance data for:

- A&E 4-hour wait standard - data to w/e 3 July
- Referral to Treatment (RTT) waits - data for April and May
- Diagnostic waits - data for April and May
- Healthcare associated infections (MRSA and C. *diff*.) - data for April and May
- Cancer waits - data for April
- Mixed sex accommodation - data for April and May

The data on the public health indicators and the measures covering mental health and community services are available quarterly and will not therefore be included until Q1 data starts to be available from the end of July. For some of the public health indicators, such as mortality rates and childhood obesity, the data is published annually. This data will be incorporated in the performance dashboards as soon as it is available and in depth analysis will be undertaken for the next version of the Performance Report.

A&E 4-hour standard

During 2011/12 five new headline performance measures will be introduced, with data taken from patient level (SUS) data. In Q1 data quality will be tracked, given that these are new measures with a new data flow. Until these measures are formally introduced from Q2 the previous A&E 4-hour wait standard will be monitored and performance managed. However, performance is being tracked for type 1 (main A&E) services only, whereas activity in Urgent Care Centres (UCCs) and Walk-In Centres (WICs) was previously 'mapped' into an aggregate measure.

Performance in April was reasonably strong with all Trusts consistently above 95% for type 1 performance within 4 hours. However, in May and June performance has been extremely poor, other than at Lewisham. This is partly due to very high levels of A&E attendances, which have been running at Winter peak levels, as illustrated in the Report. The reasons for this are not yet understood. When SUS (i.e. patient-level) data for May is received further in depth analysis will be undertaken. The Report describes the latest position at each provider and the action being taken to improve performance.

Healthcare Associated Infections

The DH has set challenging targets for both MRSA and C. *diff*. reduction for 2011/12. The position at M2 (i.e. for April and May) is disappointing. There is a high risk that the annual trajectories will not be met. The details are set out in the report.

Referral to Treatment (RTT) Waits

SLHT and GST continue to fail to meet most of the RTT standards in the year to date. The primary metrics (i.e. the Headline Measures) for 2011/12 are the 95th percentile waits (for admitted and non-admitted pathways and also for incomplete pathways, i.e. patients not yet treated). The median waits are in the set of Supporting Measures. Both Trusts have long-standing backlogs of patients already waiting over 18 weeks, which in both cases have not been adequately addressed in 2010/11 despite commissioners paying for additional activity specifically to address this issue. Both Trusts have particular long waits in Orthopaedics, but are also failing to meet the standards in other specialties such as Ophthalmology at SLHT and ENT at GSTT. The Report sets out the position in more depth and describes the actions being taken.

Cancer Waits

Performance across South East London has consistently been high with almost all the standards being met. The exception is the 62-day standard for treatment following urgent GP referral at Guy's & St Thomas' where performance has been below the 85% standard. This is partly due to a persistent issue of late referrals being received by GSTT from other hospitals, including those outside London which use GSTT as a cancer centre. The Trust is

focused on eliminating all delays that are internal and within its control, with a specific focus on the urological pathway which has the highest number of breaches.

Eliminating Mixed Sex Accommodation

SLHT had 100 mixed sex accommodation breaches in April (59 at PRUH and 41 at QEH) and 117 in May (25 at PRUH and 92 at QEH). These breaches were in endoscopy and day surgery. SLHT has reported that the endoscopy issues at the PRUH site were resolved in mid-April and the PRUH is now fully compliant, other than when emergency cases have to be added to planned single gender lists. The issues at QEH have not been fully resolved in day surgery, the Report gives an update from site visits held on 14 June. There were no breaches elsewhere in the sector in May, with just a very small number of isolated breaches in April.

KEY ISSUES:

The Report describes where performance has been below the expected standard and highlights risks to future delivery. The actions being taken are summarised to give the Board assurance that performance issues are being appropriately addressed.

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 for the acute measures mostly relate to organisational issues rather than demographic issues.

Appendices - the performance dashboards are appended, covering separate commissioner and provider views of performance on the Headline and Supporting Measures respectively. The commissioner data is for the responsible population of South East London, irrespective of the providers at which patients are treated. The provider dashboards are for the NHS Trusts and Foundation Trusts located within South East London. Performance issues at any other providers that have a significant impact on South East London residents (such as St George's for Lambeth residents and Dartford & Gravesham for Bexley residents will be highlighted when they occur). Future performance reports will contain a Public Health dashboard with the previous suite of public health measures which have been retained as specified in the Operating Framework.

COMMITTEE INVOLVEMENT:

- An earlier version of this report went to the Performance, Finance & QIPP Committee on 30 June.

PUBLIC AND USER INVOLVEMENT: N/A

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:
The board (s) is asked to:-

- Note the Report
- Note that a fuller report including the public health indicators will be brought to future meetings, with the September Board report being based on a complete set of Q1 data

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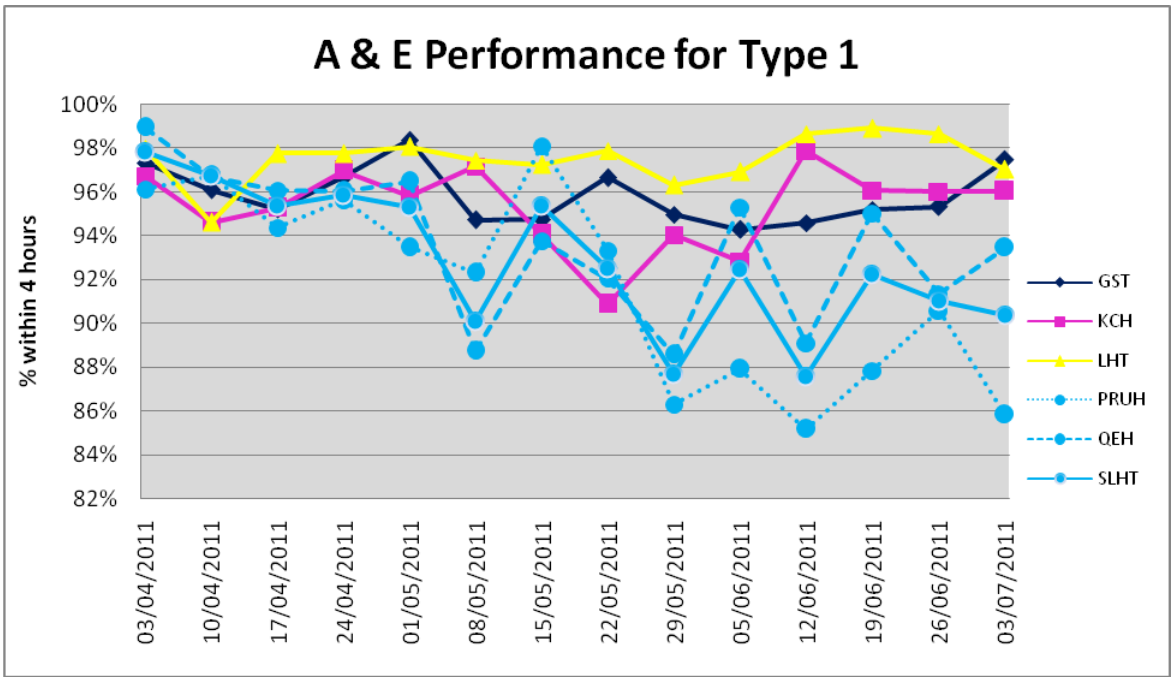
*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

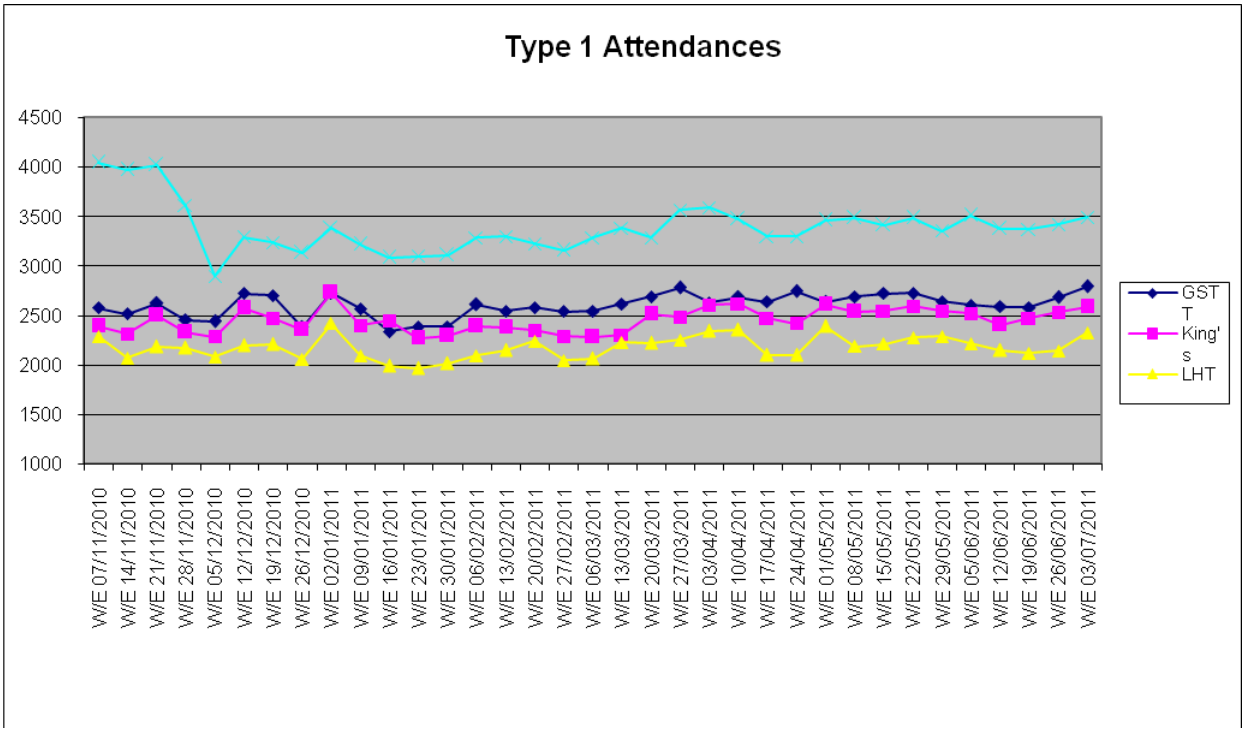
1. A & E

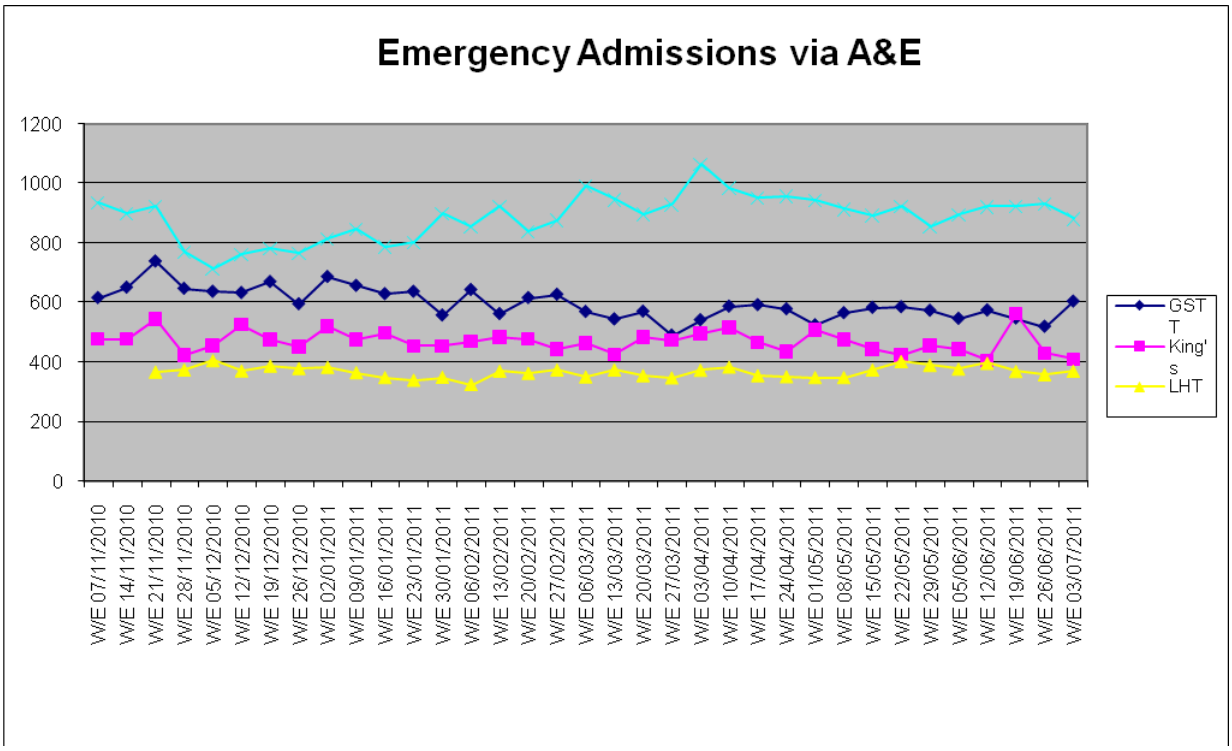
- New clinical indicators to be implemented from Q2
- Q1 focus was on data quality
- Quality performance to be assessed on both new clinical indicators and pre-existing 4 hour standard



	Issues	Action
SLHT	• Performance deteriorated since April, particularly at PRUH • High number of attendance, higher than winter peak • High admission ratio	• Formal escalation to wider health community. • Ongoing improvement work to deliver the headline indicators, including pathway workshops with key stakeholders • Work continues with the IST, recommendations being implemented . Whole systems diagnostic event (IST led) held on 30th June • The Trust continues to make the reduction in the number of medically fit patients in acute beds a priority
KCHFT	• Performance deteriorated since April but has improved in recent weeks • Attendances slightly higher than expected • Admission ratio static, and recently declining • ED physical redevelopment has resulted in reduction in CDU capacity	• Speciality teams to ensure 60 mins response from referral to review. • CDU was temporarily relocated and expanded to increase capacity while speciality teams ensure robust plans for rapid ED responsiveness and improved bed management • ED to change current model for minors management to ensure patients are seen by decision making clinicians, within 60 mins

		• Detailed action plan developed with IST is managed through the Emergency Care Board which is in place to ensure whole system support of emergency pathways
GSTFT	• Performance fluctuating, but improvement on previous financial year, recent weeks has also shown a improving trend • Higher number of attendances, similar to those experienced during winter peak • Admission ratio declining	• Medical staffing levels increased with additional locum staff • PCT level analysis of higher attendances discussed at Urgent Care Network • Emergency pathway redesign programmed underway




Emergency Admissions via A&E
1200
1000
800
600
400
200
0
W/E 07/11/2010
W/E 14/11/2010
W/E 21/11/2010
W/E 28/11/2010
W/E 05/12/2010
W/E 12/12/2010
W/E 19/12/2010
W/E 26/12/2010
W/E 02/01/2011
W/E 09/01/2011
W/E 16/01/2011
W/E 23/01/2011
W/E 30/01/2011
W/E 06/02/2011
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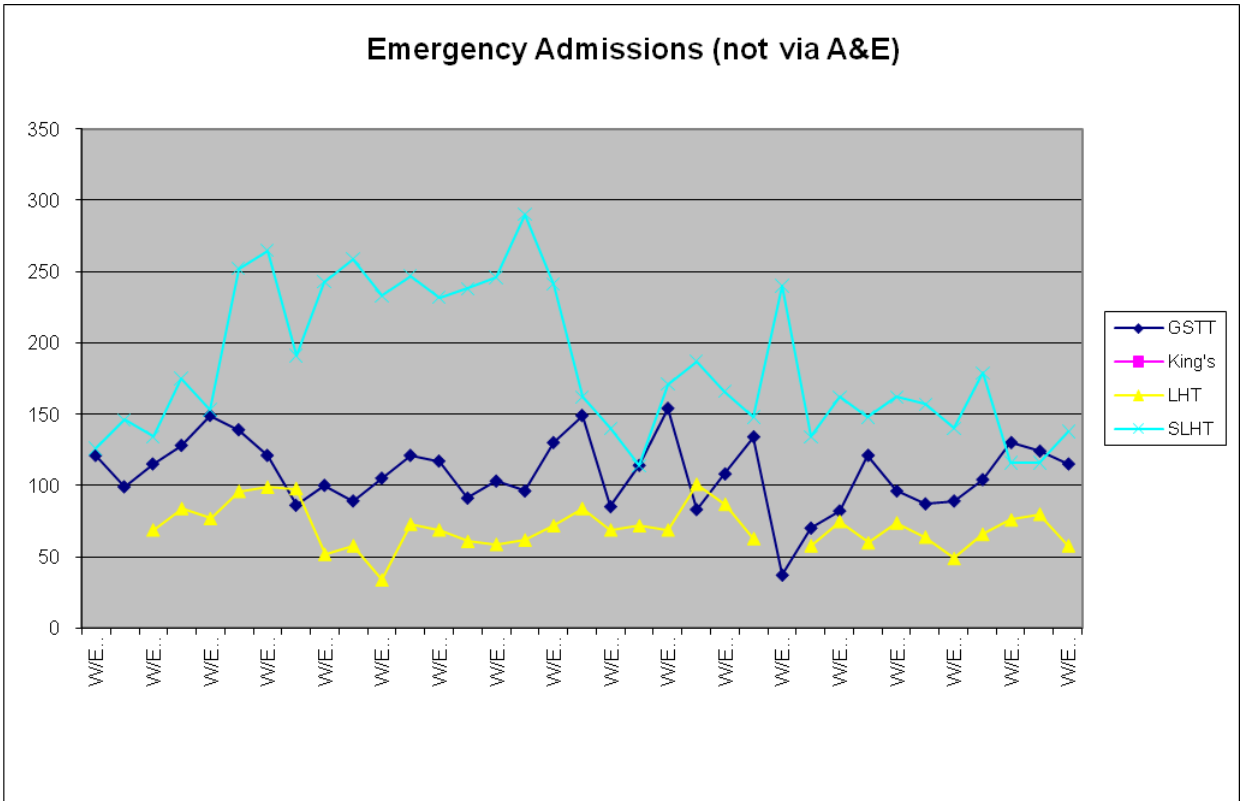
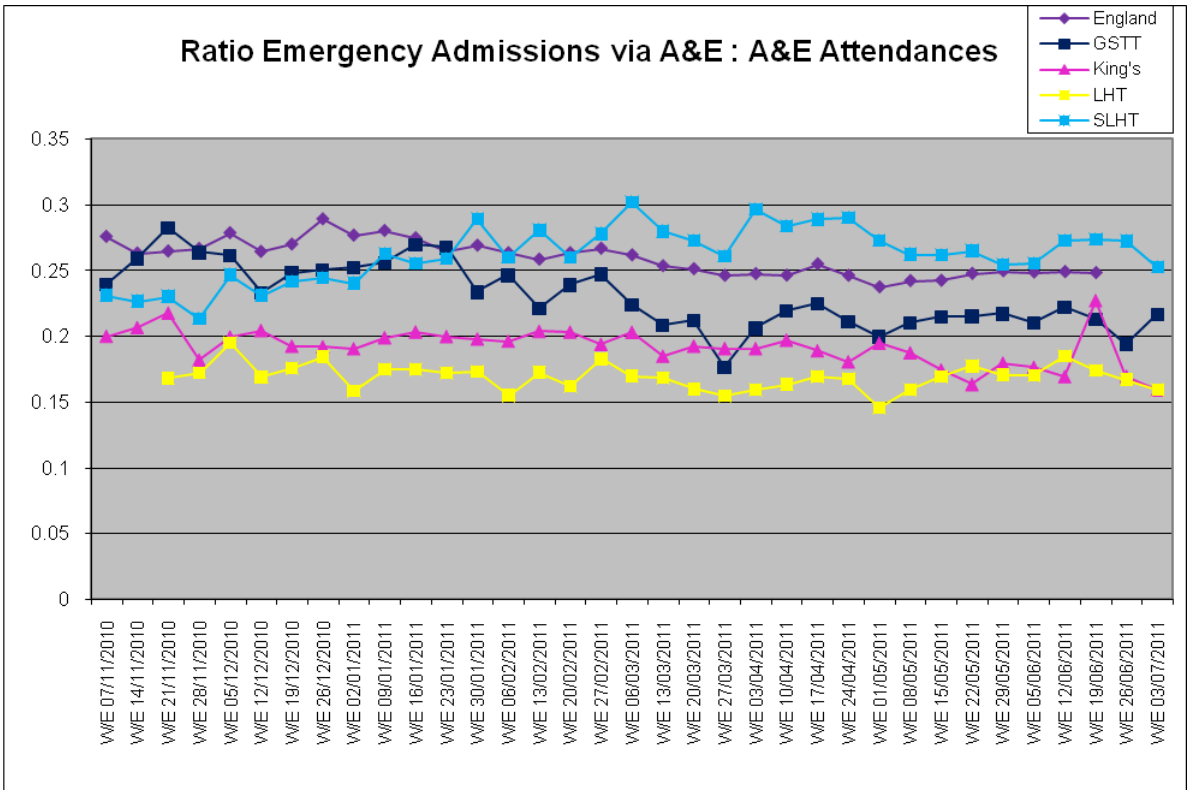
W/E 26/06/2011
W/E 03/07/2011
GST T
King's
LHT


Emergency Admissions (not via A&E)
350
300
250
200
150
100
50
0
GSTT
King's
LHT
SLHT

ENCLOSURE 5



2. Healthcare Associated Infections – MRSA and CDI

	Issues	Action
SLHT	• Trust only had 1 MRSA attributable case in 2010/11, however have already had 2 attributable cases in April 2011/12 – 1 at QEH, 1 at PRUH; no cases in May. • Both patients risk fed and suffered from aspiration pneumonia • Both patients colonised nose and throat • Variability in microbiologist opinion • Audit compliance variable in both areas • Lack of knowledge of competence of medical staff taking blood cultures	• Root cause analysis (RCA) investigation completed for both cases • Strategy developed which sets out specific response to any reportable infection control incident. • 6 weekly action learning meetings to be implemented to ensures shared learning • Notifications sent to all staff outlining the audit requirements for the month • Rapid Walk round programme to be implemented to ensure environmental issues are identified and resolved • Governance meetings for all wards with MDT membership including infection control practice
GSTFT	• 4 cases of MRSA cases, 2 in April and in May. Higher than would be expected • CDI cases are consistent with the local agreed target but higher than the nationally set objective	• All MRSA bacteraemias where RCA indicates issues of practice will be reviewed by the CEO with the CD and lead consultant for the patient • Introduction of IV insertion packs, IV e-learning training programme • reviewed and re-issued cannulation guidance

	• Re-enforced MRSA de-colonisation policy requirements • Review of all MRSA +ve patients with IV devices by microbiologist to determine clinical need; replace with lines inserted under strict aseptic control by IV line team is needed, • CDI Action Group has been established • Additional focus on anti-microbial stewardship • RCA investigation of every CDI case • Environmental hygiene- a three month sampling programme is active in high risk areas • Introduction of a sporicidal decontaminant agent • Investigation has shown a low incidence of cross infection in CDI • targeted clinical campaigns to increase awareness and action on both MRSA and CDI

3. Referral to Treatment Times (RTT)

	Issues	Action
SLHT	• Trust is not delivering on any of the RTT standards • Backlog exists in a number of specialties with Orthopaedics for admitted and Ophthalmology for outpatients being of significant concern.	• Trust has developed specialty level trajectories to clear backlog, based on demand and capacity analysis. Clearance expected by Q3, but some specialties may be earlier. • Additional information requested from trust to ensure trajectory on track • 18 wks likely to stay below target until this point, 95th percentile to improve over coming months. • Additional sessions and improved theatre productivity in place • Comprehensive validation exercise to clean incomplete pathway list underway • QMS site as an Elective Care Centre in the medium term
GSTFT	• Trust did not deliver on any of the RTT standards in April • Delivered on non admitted RTT standards only in May • Backlog exists in a number of specialties, with Orthopaedics for admitted being of significant concern.	• IST supporting 6 specialties with capacity and demand modelling. • All specialties not hitting targets have action plans, and expect to be back on target and to maintain from July, except orthopaedics • PCTs have commissioned sufficient activity to achieve waiting time targets and significant extra activity already in place.

		• For Orthopaedics , the trust consider capacity and demand to be in balance, however the issue of the backlog remains.
LHT	• Since community services became part of trust in October, trust has not meet the RTT for incomplete pathways, predominately as a result of waits for autistic spectrum disorder	• Additional locums have been recruited to cover consultant absence and backlog clearance. • Discussions underway between the trust and the commissioners (LB Lewisham) for further additional resource to clear the backlog. • Modelling underway in the trusts to confirm capacity required to maintain target.

4. Diagnostics

	Issues	Action
SLHT	• Previously low numbers of patients breaching 6 wk wait threshold, however increasing number in April and significant step increase in May.	• Additional routine Endoscopy lists scheduled • Validation of current waiting lists underway • Pathway reviews underway • Capacity and Demand analyses completed for Endoscopy • Lead Clinicians reviewing service across sites • Targeting of diagnostic waiting times 2-4 weeks including reporting
King's	• Previously low numbers of patients breaching 6 wk wait threshold, increase in previous months, appeared to be addressed through action plan, however further unexpected increases in April • Breaches in both scoping and echocardiology.	• For scoping a number of the actions from the plan have been put in place, including, locum consultant in post to cover consultant sickness, improvements to administration processes and switching between colonoscopies and flexi sigmoidoscopies where appropriate • However the action plan included increased capacity through weekend working and using facilities at LHT. The latter is now no longer possible due to capacity constraints and therefore only weekend working is being used to increase capacity. Resulting in a longer time to clear backlog. Likely that the number of breaches for May will be higher than April. Expect backlog to be cleared in November. • Medium term plan for a new build which will increase capacity and accommodate single sex requirements, due to be up and running in March 2012. • Echocardiology breaches – additional capacity has been put in place to address this backlog. Expect backlog to be cleared in October.
GSTFT	• Sleep studies and paediatric urodynamics, areas of particular concern	• For paediatric urodynamics additional capacity has been put in place, however there is a mismatch between capacity and demand, and is therefore likely that there will continue to be some breaches in the coming months. • Additional physical capacity and clinics have been put in place for sleep studies. The trust are ahead of their original trajectory to clear the backlog by October.

5. Cancer Waits

	Issues	Action
GSTT	• The Trust has consistently performed below the 85% standard for the 62-day target for time from urgent GP referral to treatment, however a significant proportion of the breaches are due to late referrals from cancer units, including from outside London. • All the breast symptom 2-week target breaches (18 in April) were due to patient choice, i.e. the patient did not accept an appointment offered within the 2 week period.	• The Trust is focusing on those elements of the Pathways where it can ensure that any internal reasons for breaches are eliminated, including through improved access to endoscopy and eliminating delays in the urological pathway
King's	• The 50% performance shown in the dashboard for the 62-day target for treatment from referral from screening services was due to just 1 breach out of two patients treated in the month	

6. Mixed Sex Accommodation

	Issues	Action
SLHT	• 100 breaches reported in April, only slightly lower than the level reported in March, however the trust continues to declare itself compliant. • Problem areas are endoscopy and day surgery, partly due to urgent and emergency work for patients of one gender compromising single sex lists of the other. To a lesser extent, also issues with step down from critical care.	• Follow-up visit from Cluster and NHS London lead held on 14 June, to assess compliance. • Trust provided an updated action plan. • Patients awaiting day procedures now in separate sex waiting areas. • Day surgery unit now ring-fenced for surgery only, no longer have medical outliers. • Critical care action plan to be updated to include escalation to divisional manager/executive is issues irresolvable by site manager

Performance Measures for 2011/12

		Measure	Definition	How Performance will be Judged	Threshold (if appropriate)	2010/11 Outturn							2011/12 Latest Period							2011/12 YTD							2011/12 Forecast Outturn						
						Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total
		Headline Measures																														
Quality (Safety, Effectiveness & Patient Experience)	HQU01	HCAI measure (MRSA & CDI)	MRSA bacteraemia	Against plan	More than 1 SD away from Trust plan	6	4	4	8	7	8	37	0	0	0	2	1	1	4	1	2	0	3	2	5	13							
	HQU02		CDI	Against plan		60	86	48	110	80	108	492	9	8	8	16	7	13	61	12	16	15	27	17	24	111							
	HQU03_01	Ambulance quality - Cat A response times	Cat A response within 8 mins	Against minimum threshold	75%																											
	HQU03_02		Cat A response within 19 mins	Against minimum threshold	95%																											
	HQU04	Patient experience survey	Outliers identified using NHS PF approach + narrative & results of local surveys																													
	HQU05	RTT waits (95th percentile measures)	RTT - admitted 95th centile	Against max threshold	23 weeks	25.2	30.6	25.7	26.3	24.9	26.4		28.7	29.4	26.8	27.1	22.7	26.2															
	HQU06		RTT - non-admitted 95th centile		18.3 weeks	18.8	18.8	15.9	16.9	16.0	17.4		19.3	17.4	15.2	16.0	14.8	16.5															
	HQU07		RTT - incomplete 95th centile		28 weeks	32.5	26.6	42.7	25.0	30.8	25.2		31.1	28.5	43.6	24.4	28.1	23.3															
	HQU08	MSA breaches	Numbers of unjustified breaches	minimal breaches		43	23	59	0	4	1	130	33	25	64	0	0	5	127	60	77	89	0	0	8	234							
	HQU09	A&E Quality Indicators (5 measures)	Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	Against minimum threshold	>5%																											
	HQU10		Total time spent in A&E department - 95th centile		>4 hours																											
	HQU11		Left department without being seen rate		>5%																											
	HQU12		Time to initial assessment - 95th centile		>15 mins																											
	HQU13		Time to treatment in department - median		>60 mins																											
	HQU14	Cancer 2 week, 62 days (aggregate measures)	2 week wait - % seen in 2 weeks of all urgent referrals & referrals for breast symptoms	Against minimum threshold	93%	97.7%	94.5%	97.5%	96.0%	96.5%	96.7%	96.4%																					
	HQU15		62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme		>=86%	88.0%	92.1%	83.5%	87.9%	89.9%	88.4%	88.6%																					
	HQU16	Emergency Readmissions	Emergency readmissions within 30 days	System indicator																												
Resources (Finance, Capacity & Activity)	HRS01	Financial forecast outturn & performance against plan	Financial forecast outturn performance against plan at organisational and regional level. In addition, no PCT forecast deficits are expected and no provider should plan for a forecast deficit unless part of an agreed recovery plan	Perf against plan and absolute performance by exception																												
	HRS02	Financial performance score for NHS Trusts	Quarterly provider performance ratings to be given based on financial performance and position	System indicator																												
	HRS03	Delivery of running cost targets	Actual running costs to be compared to target running costs at regional level. Definition of running costs to form part of planning guidance.	System indicator																												
	HRS04	Progress on delivery of QIPP savings	QIPP delivery (savings and re-investment) in 2011/12 and QIPP for 2012/13 to 2014/15	Perf against plan																												
	HRS05	Acute Bed Capacity	G&A available beds	System indicator																												
	HRS06	Non elective FFCEs	Non-elective FFCEs	System indicator		21,400	26,333	22,487	34,665	25,044	33,447	163,376	1774	2248	1961	2781	2040	2646	13450	1774	2248	1961	2781	2040	2646	13450							
	HRS07	Numbers waiting on an incomplete Referral to Treatment pathway	Total numbers waiting at the end of the month on an incomplete RTT pathway	System indicator		10,838	18,771	16,641	16,106	14,211	15,088	91,655	13451	19476	16347	16818	14505	15786	96383	24739	38412	33126	31486	30535	29289	187587							
	HRS08	Health visitor numbers	Numbers of HVs	Perf against plan																												
	HRS09	*Workforce productivity*	*for workforce - IC defn*																													

ENCLOSURE 5

Performance Measures for 2011/12

		Measure	Definition	How Performance will be Judged	Threshold (if appropriate)	2010/11 Outturn								2011/12 Latest Month								2011/12 YTD							
						Guy's & St. Thomas'	King's	Lewisham Healthcare	South London Healthcare	LAS	Oxleas	South London & the Maudsley	SEL Provider Total	Guy's & St. Thomas'	King's	Lewisham Healthcare	South London Healthcare	LAS	Oxleas	South London & the Maudsley	SEL Provider Total	Guy's & St. Thomas'	King's	Lewisham Healthcare	South London Healthcare	LAS	Oxleas	South London & the Maudsley	SEL Provider Total
		Headline Measures																											
Quality (Safety, Effectiveness & Patient Experience)	HQU01	HCAI measure (MRSA & CDI)	MRSA bacteraemia	Against plan	More than 1 SD away from Trust plan	4	16	2	1				23	2	1	1	0				4	4	1	1	2				8
	HQU02		CDI	Against plan		120	106	24	65				315	20	8	1	7				36	33	18	4	10				65
	HQU03_01	Ambulance quality - Cat A response times	Cat A response within 8 mins	Against minimum threshold	75%					75.1%								77.9%								77.0%			
	HQU03_02		Cat A response within 19 mins	Against minimum threshold	95%					99.0%								99.3%											
	HQU04	Patient experience survey	Outliers identified using NHS PF approach + narrative & results of local surveys					Performance under review	Under-performing																				
	HQU05	RTT waits (95th percentile measures)	RTT - admitted 95th centile	Against max threshold	23 weeks	27.8	24.3	24.9	29.7					29.0	19.6	21.1	31.3												
	HQU06		RTT - non-admitted 95th centile		18.3 weeks	19.0	16.6	12.5	19.0					17.6	16.8	12.1	18.6		7.2								7.2		
	HQU07		RTT - incomplete 95th centile		28 weeks	28.5	17.6	35.6	34.6					30.0	17.1	30.9	36.3		35.7								35.7		
	HQU08	MSA breaches	Numbers of unjustified breaches	minimal breaches		DNR	0	4	114		0	0	118	0	0	0	117		0	0	117	1	6	0	217		0	0	224
	HQU09	A&E Quality Indicators (5 measures)	Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	Against minimum threshold	>5%																								
	HQU10		Total time spent in A&E department - 95th centile		>4 hours																								
	HQU11		Left department without being seen rate		>5%																								
	HQU12		Time to initial assessment - 95th centile		>15 mins																								
	HQU13		Time to treatment in department - median		>60 mins																								
	HQU14	Cancer 2 week, 62 days (aggregate measures)	2 week wait - % seen in 2 weeks of all urgent referrals & referrals for breast symptoms	Against minimum threshold	93%	96.6%	96.4%	96.1%	96.4%				96.4%	95.8%	98.6%	97.1%	96.7%				96.8%								
	HQU15		62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme		>~86%	84.5%	92.0%	89.9%	90.9%				92.8%	86.1%	90.0%	94.4%	91.4%				89.4%								
	HQU16	Emergency Readmissions	Emergency readmissions within 30 days	System indicator																									
Resources (Finance, Capacity & Activity)	HRS01	Financial forecast outturn & performance against plan	Financial forecast outturn performance against plan at organisational and regional level. In addition, no PCT forecast deficits are expected and no provider should plan for a forecast deficit unless part of an agreed recovery plan	Perf against plan and absolute performance by exception																									
	HRS02	Financial performance score for NHS Trusts	Quarterly provider performance ratings to be given based on financial performance and position	System indicator																									
	HRS03	Delivery of running cost targets	Actual running costs to be compared to target running costs at regional level. Definition of running costs to form part of planning guidance.	System indicator																									
	HRS04	Progress on delivery of QIPP savings	QIPP delivery (savings and re-investment) in 2011/12 and QIPP for 2012/13 to 2014/15	Perf against plan																									
	HRS05	Acute Bed Capacity	G&A available beds	System indicator																									
	HRS06	Non elective FFCEs	Non-elective FFCEs	System indicator		41,232	51,799	19,509	58,297				170,837																
	HRS07	Numbers waiting on an incomplete Referral to Treatment pathway	Total numbers waiting at the end of the month on an incomplete RTT pathway	System indicator		34,132	21,793	8,555	36,992				101,472	34,251	25,766	8,307	38,393				106,717	67,961	48,802	16,867	75,819				209,449
	HRS08	Health visitor numbers	Numbers of HVs	Perf against plan																									
	HRS09	*Workforce productivity*	*for workforce - IC defn*																										

Performance Measures for 2011/12

		Measure	Definition	How Performance will be Judged	Threshold (if appropriate)	Sign-off criteria	2010/11 Outturn							2011/12 Latest Period							2011/12 YTD							2011/12 Forecast Outturn						
							Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL Cluster Total
	Supporting Measures																																		
	SQU01	VTE Risk assessment	% of all adult inpatients who have had a VTE risk assessment	Improvement		90% of adult inpatients risk assesed for VTE on admission																													
	SQU02	% deaths at home (inc care homes)	No reg deaths at home/no. registered deaths	Perf against plan		An increasing proportion of deaths occurring in usual home																													
	SQU03_01	Ambulance quality indicators (all othermeasures)1	Call Abandonment Rate	Improvement																															
	SQU03_02		Re-contact rate following discharge of care	Improvement																															
	SQU03_03		Outcome from Cardiac Arrest	Improvement																															
	SQU03_04		Service Experience	Improvement																															
	SQU03_05		Outcome from acute STEMI	Improvement		Thrombolysis within 60 mins. Primary angioplasty within 10 mins of call																															
	SQU03_06		Outcome from stroke for ambulance patients	Improvement		Patients arriving at hyperacute stroke unit within 60 mins																															
	SQU03_07		Outcome from Cardiac Arrest- survival to discharge	Improvement																															
	SQU03_08		time to answer call	Improvement																															
	SQU03_09		time to treatment	Improvement																															
	SQU03_10		Ambulance calls closed with telephone advice or managed without transport to A&E	Improvement																															
	SQU04_01	A&E quality indicators (all other measures)	Ambulatory care	Improvement		Ambulatory care for cellulitis cases (60-90% of admissions). For DVT >90% of admissions																															
	SQU04_02		consultant sign-off	Improvement																															
	SQU04_03		Service Experience	Improvement																															
	SQU05_01	Cancer waits (all 9 measures)	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	Against minimum thresholds	93%		97.7%	94.8%	97.5%	95.7%	96.5%	96.5%	96.4%	96.8%	93.4%	99.3%	96.6%	97.2%	98.1%	96.8%															
	SQU05_02		Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Against minimum thresholds	93%		97.7%	93.3%	97.4%	97.4%	96.9%	97.4%	96.6%	100.0%	95.4%	100.0%	90.4%	100.0%	96.5%	96.7%															
	SQU05_03		Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer	Against minimum thresholds	85%		86.2%	90.6%	81.1%	85.6%	88.5%	85.6%	86.6%	88.9%	89.2%	85.7%	90.6%	86.7%	92.3%	89.0%															
	SQU05_04		Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from and NHS Cancer Screening Service	Against minimum thresholds	90%		96.9%	98.5%	95.2%	97.2%	94.1%	100%	97%	-	100.0%	100.0%	75.0%	100.0%	-	91.7%															
	SQU05_05		Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	Against minimum thresholds	85%		96.8%	96.2%	90.5%	95.0%	92.0%	98.1%	94.5%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	95.7%															
	SQU05_06		Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	Against minimum thresholds	96%		97.6%	98.8%	98.3%	98.9%	97.0%	98.0%	98.2%	95.8%	100.0%	100.0%	100.0%	95.0%	100.0%	98.5%															
	SQU05_07		Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is Surgery	Against minimum thresholds	94%		98.3%	96.8%	97.3%	97.1%	96.4%	95.7%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%															
	SQU05_08		Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime	Against minimum thresholds	98%		99.6%	99.5%	99.4%	99.6%	100%	99.3%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%															
	SQU05_09		Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	Against minimum thresholds	94%																														
	SQU06_01	Stroke indicator	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	Against minimum thresholds	80%		85%	93%	79.8%	82%	92%	92%	87%																							
	SQU06_02		Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	Against minimum thresholds	60%		44%	63%	No outpatient service	100%	82%	100%	70%																							
Quality (Safety, Effectiveness & Patient Experience)	SQU07	Community services	Place holder																																
	SQU08	Carers breaks	Agree and make available to local people policies, plans and budgets to support carers	Through planning checklist																															
	SQU09	Access to NHS dentistry	Current 24 month measure	Perf against plan			102,540	133,105	149,768	156,972	160,154	143,760	846,299																							
	SQU10	Staff engagement[2]	Overall Staff Engagement score is calculated from responses to multiple questions in the annual NHS staff survey	Improvement		Year-on-year increase, or be sustained for top 10%, with bigger increases for those scoring lowest																															
	SQU11	PROMS scores		Improvement																															
	SQU12	Maternity 12 weeks	% women who have seen a midwife by 12 days and 6 days of pregnancy	Against minimum thresholds	90%																														
	SQU13	Mental health measures - EI	The number of new cases of psychosis served by early intervention teams year to date	Perf against envelopes for commissioners																															
	SQU14	Mental health measures - CR/HT	Commissioner measure is number of episodes	Perf against envelopes for commissioners.		Progressive increase each quarter																															
	SQU15	Mental health measures - CPA	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the quarter (QA).	against threshold	95%																														
	SQU16	Mental health measures - IAPT	Proportion of people with depression referred for psychological therapy and proportion referred for therapy receiving it.	Perf against plan		Ongoing improvement																															
	SQU17	Low value procedures	Number of identified low value procedures carried out (indicator under development)																																
	SQU18	Smoking Quitters	Smoking quitters per 100,000 population	Perf against plan		Continue to increase over time																															

ENCLOSURE 5

	SQU19	Breastfeeding at 6-8 weeks	Prevalence of breastfeeding at 6-8 wks after birth (also coverage?)	Perf against plan		Increase in prevalence each quarter. Data coverage of at least 95%	45.4%	52.9%	61.7%	45.4%	73.8%	71.9%	59.9%														
	SQU20	Breast screening	Extension of breast screening program to women aged 47-49 and 71-73	Improvement																							
	SQU21	Bowel screening	Extension of bowel screening program to men and women aged 70 up to 75 birthday	Perf against plan		Commence rollout for 70-75s on completion of first two-year screening round for 60-69s																					
	SQU22	Cervical screening test results	All women to receive results of cervical screening tests within 2 weeks	Against minimum thresholds	98%		20.5%	27.6%	20.4%	98.2%	97.3%	98.2%	63.4%														
	SQU23	Diabetic retinopathy screening	Percentage of eligible people offered screening for the early detection (and treatment if needed) of diabetic retinopathy in the previous twelve months	Against minimum thresholds			107%	102%	96%	98%	99%	101%	100.3%														
	SQU24	Referral to Treatment waits (median wait measures)	RTT - admitted median	Against minimum thresholds	11.1 weeks		8.8	10.7	8.7	8.1	8.4	8.1		9.7	10.9	9.1	8.0	8.6	8.4								
	SQU25		RTT - non-admitted median	Against minimum thresholds	6.6 weeks		3.9	4.0	2.2	2.2	1.5	2.3		4.8	5.2	2.4	1.9	1.0	2.5								
	SQU26		RTT - incomplete median	Against minimum thresholds	7.2 weeks		6.4	4.5	6.5	6.5	6.3	6.6		7.2	5.2	7.4	6.7	6.5	6.3								
	Additional	Diagnostic Waits	Number of diagnostic waits > 6 weeks	Against minimum thresholds	minimal breaches		10	17	13	39	20	36	135	11	74	10	64	17	63	239	11	74	10	64	17	63	239
	SQU27	Coverage of NHS Health Checks	% people ages 40-74 who have been offered a health check	Perf against plan		Increase no. offered and undertaken until 2012 on phased basis. Thereafter, stable number of checks p.a.	0	5.7%	5.7%	31.8%	4.3%	0.4%															
	SQU28	People with Long Term Conditions feeling independent and in control of their condition	% of people with LTCs who said they had had enough support from local services/orgs	system indicator			72.2%	75.6%	70.7%	70.6%	69.3%	69.7%	71.3%														
	SQU29	Emergency admissions for Long Term Conditions	Number of emergency admissions to hospital for people who have a Long-Term Condition each month	system indicator																							
	SQU30	Safeguarding	Place holder																								
Resources (Finance, Capacity & Activity)	SRS01	Total pay costs	Total costs of staff (to include cost of staff within provider contracts)	Perf against plan and in comparison to workforce																							
	SRS02	Total workforce (WTEs)	*Workforce*																								
	SRS03	Year to date financial position	In year cumulative surplus/(deficit) position and how it relates to the forecast	Perf against plan																							
	SRS04	NHS Trusts Breakeven duty	NHS Trusts three year break even duty	System Indicator																							
	SRS05	Delivery of 2% recurrent headroom	All PCTs required to ensure that 2% of their recurrent funding is only ever committed non-recurrently. The 2% to be held by SHAs with PCTs accessing the funding through business cases	System Indicator																							
	SRS06	PCT legacy debt position	PCTs with legacy debt issues (that arose prior to 2011/12) to be dealt with by the end of 2012/13. PCTs to work with developing GP consortia to ensure no new deficits in 2011/12 to 2012/13	System Indicator																							
	SRS07	Underlying financial position of PCTs and NHS Trusts	Recurrent position of PCTs and Trusts as reported in FIMs	Perf against plan/system indicator																							
	SRS08_01	Length of stay (Acute and MH)	Average spell duration for non-same day acute discharges	System indicator																							
	SRS08_02		Average spell duration for non-same day MH discharges	System indicator																							
	SRS09	Daycase rate	Proportion of elective FFCEs which are for daycases.	System indicator		Increase in rate over the planning period	80.0%	81.5%	80.0%	77.6%	81.3%	78.6%	80.0%	76.8%	81.0%	78.1%	76.8%	80.4%	76.9%	78.6%							
	SRS10_01	Delayed Transfers of Care (Acute & MH)	Delayed Transfers of Care (Acute) - Comm measure is no of delays per 100,000 population.	System indicator/use thresholds from PF		Low and/or decreasing rate								19	10	11	6	1	3	50	32	17	23	18	6	6	102
	SRS10_02		Delayed Transfers of Care (MH) - Comm measure is no of delays per 100,000 population.	System indicator/use thresholds from PF		Low and/or decreasing rate								0	2	4	4	0	3	13	1	4	4	8	0	6	23
	SRS11	GP written referrals to hospital	No of GP written referrals	Perf against plan & system indicator		Realitic plans, consistent with sustaining RTT waiting times	30,644	78,105	43,139	63,390	59,526	51,381	326,185	2745	6057	3292	5358	4833	4699	26984							
	SRS12	Other referrals for a first outpatient appointment	No of other referrals	Perf against plan & system indicator		Realitic plans, consistent with sustaining RTT waiting times	25,992	47,517	35,137	46,337	48,745	44,906	248,634	2254	3820	2872	3829	4676	3705	21156							
	SRS13	First outpatient attendances following GP referral	No 1st outpatient attendances after GP referral	Perf against plan & system indicator		Show activity to sustain RTT waiting times	29,878	63,332	42,604	52,574	48,608	43,881	280,877	2700	4512	3105	4570	3778	4056	22721							
	SRS14	All first outpatient attendances	No of first outpatient attendances	Perf against plan & system indicator		Show activity to sustain RTT waiting times	60,142	105,064	82,801	115,143	101,343	104,945	569,438	4971	7416	6148	8702	8049	7728	43014							
	SRS15	Elective FFCEs	No of elective FFCEs (ordinary adms & separately daycases)	Perf against plan & system indicator		Realitic plans, consistent with sustaining RTT waiting times	29,446	47,363	30,238	30,505	33,724	27,106	198,382	2182	3614	2351	2294	2504	2038	14983							
	SRS16	A&E attendances	Number of attendances at A&E departments in a month (total and type 1)	System indicator		There should be a reduction in growth																					
	SRS17	Ambulance Urgent & Emergency Journeys	Number of urgent and emergency journeys via ambulance, monthly	System indicator		Reduction in growth																					
	SRS18	Community activity	Place holder																								
	SRS19	*Staff absences*	Workforce: Number of days sick as a proportion of number of days available?			Reduction in the sickness absence rate																					
	SRS20	*Temporary staffing costs*	Workforce																								
	SRS21	*Clinical staff numbers*	Workforce																								
	SRS22	*Management numbers*	Workforce			Reduced numbers of administrative posts																					
	SRS23	*Redundancy numbers*	Workforce			Compulsory redundancies are minimised wherever possible																					

Performance Measures for 2011/12

		Measure	Definition	How Performance will be Judged	Threshold (if appropriate)	Sign-off criteria	2010/11 Outturn							2011/12 Latest Month							2011/12 YTD						
							Guy's & St. Thomas'	King's	Lewisham Healthcare	South London Healthcare	LAS	Oxleas	South London & the Maudsley	SEL Provider Total	Guy's & St. Thomas'	King's	Lewisham Healthcare	South London Healthcare	LAS	Oxleas	South London & the Maudsley	SEL Provider Total	Guy's & St. Thomas'	King's	Lewisham Healthcare	South London Healthcare	LAS	Oxleas	South London & the Maudsley	SEL Provider Total
	Supporting Measures																												
	SQU01	VTE Risk assessment	% of all adult inpatients who have had a VTE risk assessment	Improvement		90% of adult inpatients risk assesed for VTE on admission	91.6%	91.5%	92.3%	29.1%				75.7%															
	SQU02	% deaths at home (inc care homes)	No reg deaths at home/no. registered deaths	Perf against plan		An increasing proportion of deaths occurring in usual home																							
	SQU03_01	Ambulance quality indicators (all othermeasures)1	Call Abandonment Rate	Improvement															0.1%										
	SQU03_02		Re-contact rate following discharge of care, by phone within 24 hours	Improvement															1.9%										
	SQU03_02		Re-contact rate following treatment at the scene, within 24 hours	Improvement															1.8%										
	SQU03_03		Outcome from Cardiac Arrest	Improvement																									
	SQU03_04		Service Experience	Improvement																									
	SQU03_05		Outcome from acute STEMI	Improvement		Thrombolysis within 60 mins. Primary angioplasty within 10 mins of call																								
	SQU03_06		Outcome from stroke for ambulance patients	Improvement		Patients arriving at hyperacute stroke unit within 60 mins																								
	SQU03_07		Outcome from Cardiac Arrest- survival to discharge	Improvement																									
	SQU03_08		time to answer call, 95th percentile (seconds)	Improvement															11										
	SQU03_09		time to treatment, 95th percentile (mins)	Improvement															12										
	SQU03_10		Ambulance calls closed with telephone advice	Improvement							3.35%								5.6%										
	SQU03_10		Ambulance calls managed without transport to A&E	Improvement															26.4%										
	SQU04_01	A&E quality indicators (all other measures)	Ambulatory care	Improvement		Ambulatory care for cellulitis cases (60-90% of admissions). For DVT >90% of admissions																								
	SQU04_02		consultant sign-off	Improvement																									
	SQU04_03		Service Experience	Improvement																									
	SQU05_01	Cancer waits (all 9 measures)	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	Against minimum thresholds	93%		96.6%	95.7%	96.1%	96.6%				96.6%	96.8%	98.5%	96.7%	96.4%												
	SQU05_02		Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Against minimum thresholds	93%		96.1%	98.5%	96.3%	95.7%				96.6%	91.3%	100.0%	100.0%	97.9%												
	SQU05_03		Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer	Against minimum thresholds	85%		78.2%	90.5%	89.8%	89.7%				85.6%	82.4%	92.4%	93.1%	91.0%												
	SQU05_04		Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from and NHS Cancer Screening Service	Against minimum thresholds	90%		96.5%	100.0%	78.9%	97.9%				96.7%	100.0%	50.0%	100.0%	100.0%												
	SQU05_05		Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	Against minimum thresholds	85%		95.3%	96.7%	96.0%	93.3%				95.2%	95.2%	-	100.0%	92.9%												
	SQU05_06		Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	Against minimum thresholds	96%		96.22%	99.4%	99.2%	99.4%				97.9%	97.4%	100.0%	100.0%	98.6%												
	SQU05_07		Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is Surgery	Against minimum thresholds	94%		93.2%	99.2%	100.0%	98.7%				96.3%	96.2%	100.0%	100.0%	100.0%												
	SQU05_08		Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime	Against minimum thresholds	98%		99.3%	100.0%	100.0%	100.0%				99.6%	99.0%	100.0%	-	100.0%												
	SQU05_09		Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	Against minimum thresholds	94%		94.2%							94.2%	96.4%															
Quality (Safety, Effectiveness & Patient Experience)	SQU06_01	Stroke indicator	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	Against minimum thresholds	80%																								
	SQU06_02		Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	Against minimum thresholds	60%																								
	SQU07	Community services	Place holder																										
	SQU08	Carers breaks	Agree and make available to local people policies, plans and budgets to support carers	Through planning checklist																									
	SQU09	Access to NHS dentistry	Current 24 month measure	Perf against plan																									
	SQU10	Staff engagement[2]	Overall Staff Engagement score is calculated from responses to multiple questions in the annual NHS staff survey	Improvement		Year-on-year increase, or be sustained for top 10%, with bigger increases for those scoring lowest																								
	SQU11	PROMS scores		Improvement																									
	SQU12	Maternity 12 weeks	% women who have seen a midwife by 12 days and 6 days of pregnancy	Against minimum thresholds	90%																								
	SQU13	Mental health measures - EI	The number of new cases of psychosis served by early intervention teams year to date	Perf against plan for providers.																									
	SQU14	Mental health measures - CR/HT	Provider measure is % of inpatient admissions that have been gatekept by CR/HT	Perf against threshold for providers	Provider threshold = 95%	Progressive increase each quarter																							
	SQU15	Mental health measures - CPA	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the quarter (QA).	against threshold	95%																								
	SQU16	Mental health measures - IAPT	Proportion of people with depression referred for psychological therapy and proportion referred for therapy receiving it.	Perf against plan		Ongoing improvement																							
	SQU17	Low value procedures	Number of identified low value procedures carried out (*indicator under development*)																										
	SQU18	Smoking Quitters	Smoking quitters per 100,000 population	Perf against plan		Continue to increase over time																							

ENCLOSURE 5

	SQU19	Breastfeeding at 6-8 weeks	Prevalence of breastfeeding at 6-8 wks after birth (also coverage?)	Perf against plan		Increase in prevalence each quarter. Data coverage of at least 95%																								
	SQU20	Breast screening	Extension of breast screening program to women aged 47-49 and 71-73	Improvement																										
	SQU21	Bowel screening	Extension of bowel screening program to men and women aged 70 up to 75 birthday	Perf against plan		Commence rollout for 70-75s on completion of first two-year screening round for 60-69s																								
	SQU22	Cervical screening test results	All women to receive results of cervical screening tests within 2 weeks	Against minimum thresholds	98%																									
	SQU23	Diabetic retinopathy screening	Percentage of eligible people offered screening for the early detection (and treatment if needed) of diabetic retinopathy in the previous twelve months	Against minimum thresholds																										
	SQU24	Referral to Treatment waits (median wait measures)	RTT - admitted median	Against minimum thresholds	11.1 weeks		6.6	8.1	11.0	12.7					8.1	6.9	10.8	12.6												
	SQU25		RTT - non-admitted median	Against minimum thresholds	6.6 weeks		2.7	3.7	1.0	4.0					2.9	4.3	0.9	5.2		0.7								0.7		
	SQU26		RTT - incomplete median	Against minimum thresholds	7.2 weeks		6.7	6.6	5.8	5.6					7.5	5.7	6.4	6.6		6.3								6.3		
	Additional	Diagnostic Waits	Number of diagnostic waits > 6 weeks	Against minimum thresholds	minimal breaches		59	75	0	22				156	68	144	0	77		0		289	68	144	0	77		0		289
	SQU27	Coverage of NHS Health Checks	% people ages 40-74 who have received a health check	Perf against plan		Increase no. offered and undertaken until 2012 on phased basis.																								
	SQU28	People with Long Term Conditions feeling independent and in control of their condition	% of people with LTCs who said they had had enough support from local services/orgs	system indicator																										
	SQU29	Emergency admissions for Long Term Conditions	Number of emergency admissions to hospital for people who have a Long-Term Condition each month	system indicator																										
	SQU30	Safeguarding	Place holder																											
	SRS01	Total pay costs	Total costs of staff (to include cost of staff within provider contracts)	Perf against plan and in comparison to workforce																										
	SRS02	Total workforce (WTEs)	*Workforce*																											
	SRS03	Year to date financial position	In year cumulative surplus/(deficit) position and how it relates to the forecast	Perf against plan																										
	SRS04	NHS Trusts Breakeven duty	NHS Trusts three year break even duty	System Indicator																										
	SRS05	Delivery of 2% recurrent headroom	All PCTs required to ensure that 2% of their recurrent funding is only ever committed non-recurrently. The 2% to be held by SHAs with PCTs accessing the funding through business cases	System Indicator																										
	SRS06	PCT legacy debt position	PCTs with legacy debt issues (that arose prior to 2011/12) to be dealt with by the end of 2012/13. PCTs to work with developing GP consortia to ensure no new deficits in 2011/12 to 2012/13	System Indicator																										
	SRS07	Underlying financial position of PCTs and NHS Trusts	Recurrent position of PCTs and Trusts as reported in FIMs	Perf against plan/system indicator																										
	SRS08_01	Length of stay (Acute and MH)	Average spell duration for non-same day acute discharges	System indicator																										
	SRS08_02		Average spell duration for non-same day MH discharges	System indicator																										
	SRS09	Daycase rate	Proportion of elective FFCEs which are for daycases.	System indicator		Increase in rate over the planning period	66.1%	77.1%	86.1%	85.7%				77.9%																
	SRS10_01	Delayed Transfers of Care (Acute & MH)	Delayed Transfers of Care (Acute) - Prov measure is no delays as a proportion of a count of activity or beds.	System indicator/use thresholds from PF		Low and/or decreasing rate									13	2	2	25				42	22	8	9	49				88
Resources (Finance, Capacity & Activity)	SRS10_02		Delayed Transfers of Care (MH) - Prov measure is no delays as a proportion of a count of activity or beds.	System indicator/use thresholds from PF		Low and/or decreasing rate														6	7	13						9	13	22
	SRS11	GP written referrals to hospital	No of GP written referrals	Perf against plan & system indicator		Realitic plans, consistent with sustaining RTT waiting times	95,500	77,771	41,847	131,217				346,335																
	SRS12	Other referrals for a first outpatient appointment	No of other referrals	Perf against plan & system indicator		Realitic plans, consistent with sustaining RTT waiting times	121,458	70,650	29,159	81,834				303,101																
	SRS13	First outpatient attendances following GP referral	No 1st outpatient attendances after GP referral	Perf against plan & system indicator		Show activity to sustain RTT waiting times	83,209	65,117	33,232	120,262				301,820																
	SRS14	All first outpatient attendances	No of first outpatient attendances	Perf against plan & system indicator		Show activity to sustain RTT waiting times	197,509	172,147	61,953	201,584				633,193																
	SRS15	Elective FFCEs	No of elective FFCEs (ordinary adms & separately daycases)	Perf against plan & system indicator		Realitic plans, consistent with sustaining RTT waiting times	68,050	56,186	21,149	84,420				229,805																
	SRS16_01	A&E attendances	Number of attendances at A&E departments in a month (total)	System indicator		There should be a reduction in growth	159,933	149,216	112,958	222,424				644,531																
	SRS16_02	A&E attendances	Number of attendances at A&E departments in a month (type 1)	System indicator		There should be a reduction in growth	133,045	125,173	112,958	200,477				571,653																
	SRS17	Ambulance Urgent & Emergency Journeys	Number of urgent and emergency journeys via ambulance, monthly	System indicator		Reduction in growth																								
	SRS18	Community activity	Place holder																											
	SRS19	*Staff absences*	Workforce: Number of days sick as a proportion of number of days available?			Reduction in the sickness absence rate																								
	SRS20	*Temporary staffing costs*	Workforce																											
	SRS21	*Clinical staff numbers*	Workforce																											
	SRS22	*Management numbers*	Workforce			Reduced numbers of administrative posts																								
	SRS23	*Redundancy numbers*	Workforce			Compulsory redundancies are minimised wherever possible																								

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 6

FINANCE REPORT

DIRECTOR RESPONSIBLE: Marie Farrell, Director of Finance, Procurement, ICT & Estates

AUTHOR: Ben Sturgess, Nick Brown, Dave Harris & Mark Cheung

TO BE CONSIDERED BY: All

SUMMARY:
This report sets out the year to date and forecast year end position of each of the South East London PCTs and Bexley Care Trust, expenditure risks and delivery against cash management targets in 2011/12.

KEY ISSUES:
The cluster is facing significant financial risks in 2011/12 which will require close management, as set out in the report. Of particular concerns are current indications of potential acute over performance.

COMMITTEE INVOLVEMENT:

- Organisational priorities and expenditure proposals as set out in this report have been included in Strategy Plans and Operating Plans, following public engagement and consultation.

PUBLIC AND USER INVOLVEMENT: N/A

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:
The board (s) is asked to:-
1. Note that the position reported is Month 2 based on adjusted Month 1 acute data.

2. Note that limitations of forecasting year end positions at this early stage of the financial year and that the robustness of forecasts will improve as the year progresses.

3. Note that the current position is forecast breakeven against plan, however there are indication that acute over performance is increasing based on latest (month 2) SUS data, which has not yet been validated.

3. Note the expenditure risks set out in the report, particularly in relation to QIPP delivery and activity growth.

4. Note progress in delivering cash management targets for 2011/12.

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*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

1. Introduction

1.1. This report summarises the year to date and forecast outturn position for each of the PCT's in the NHS South East London Cluster as at Month 2. The report also sets out the position relating to updates on contracts with Trusts, QIPP savings initiatives and PCT financial management targets and duties. At this stage of the year, it is difficult to forecast year end positions with certainty, particularly given timescales for data validation processes. The detail of individual PCT positions has previously been reviewed at the Cluster's Performance, Finance and QIPP Committee on 30th June.

2. Headline Financial Performance

2.1. Year to date and forecast financial performance assessments across the cluster are highlighted below:

Table 1: Headline Financial Performance

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Total SEL cluster
Year to Date Expenditure Position	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Total Budget	57,298	80,489	79,552	110,511	90,624	87,489	505,963
Total Expenditure	57,298	80,239	78,794	108,062	89,728	86,476	500,597
Total (Over)/ Underspend	0	250	758	2,449	896	1,013	5,366
	0.0%	0.3%	1.0%	2.2%	1.0%	1.2%	1.1%
Forecast Year End Expenditure Position							
Total Budget	353,498	509,948	487,018	663,176	543,759	531,259	3,088,659
Total Expenditure	351,253	503,955	482,406	656,392	538,384	525,402	3,057,792
Total (Over)/ Underspend	2,245	5,993	4,612	6,784	5,375	5,857	30,866
	0.6%	1.2%	0.9%	1.0%	1.0%	1.1%	1.0%
Forecast Full Year Performance Against planned surplus							
Planned Full Year Surplus	2,245	5,993	4,612	6,784	5,375	5,857	30,866
Forecast variance against planned Surplus	0	0	0	0	0	0	0
Year to Date QIPP savings initiatives							
Planned QIPP Savings	938	1,383	1,654	1,548	1,537	1,645	8,706
Actual/ Forecast Savings	938	1,383	1,654	1,548	1,537	1,645	8,706
QIPP Savings (Over)/ Underspend	0	0	0	0	0	0	0

2.2. As at month 2 budgets are under spent by £5.366m across South East London. It should be noted that all PCTs have profiled the delivery of their planned surpluses through the year and that this differs by PCT. As at month 2 all PCTs are in line with profiled plans and on target to deliver the planed control total of £30.866m surplus for the year which overall represents the 1% required by the 2011/12 Operating Framework. However, for 2011/12 it has been agreed with NHS London that for Bexley Care Trust,

the 1% target surplus is reduced by £1.8m, to reflect repayment of the deferred historic debt repayment.

2.3. The month 2 year to date position is based on the latest available financial monitoring information but for some areas of expenditure this information is not yet reliable enough for firm conclusions to be drawn. For example:

- Acute services year to date positions are based on Month 1 information. The provision of acute performance information is driven by national 'SUS' systems and timetables and month 2 information has only recently been received. Whilst it has not been possible to validate data for this report, there are indications of potential acute over performance.
- Primary care prescribing expenditure information is provided by the national Prescriptions Pricing Authority (PPA) for which there is a 2 month delay in the provision information.
- We are currently finalising Central team and PCT/Bexley Care Trust Corporate budgets and month 3 expenditure information will reflect the outcome of this work.

2.4. While we have provided high-level year end forecasts in this report, due to the limitations of forecasting due to the above factors, forecasts are based on risk assessments of QIPP and activity risks and as such the robustness of forecasts will improve as the year progresses.

2.5. The Cluster Finance team liaising with Shared Business Services to transfer the financial services hosting arrangements for Bexley and Greenwich PCTs from Oxleas NHS Trust to Shared Business Services from 1st October 2011. Updates will be provided to the Board and its Committees during the year.

3. The Financial Context – Risks and Financial Risk Management

3.1. The 2010/11 Operating Framework required PCT's to deliver surpluses of 1%. However two South East London PCT's, namely Bexley and Southwark were allowed to set a control total lower than this in acknowledgement of their particular financial pressures.

3.2. Overall the SEL cluster delivered its control total in 2010/11, and these surpluses will be carried forward under the RAB regime to 2011/12 which gives some flexibility for what will be a challenging financial year. However, Southwark and Bexley have reduced flexibility in light of the reduced control total delivery in 2010/11. Similarly, although Lewisham PCT delivered its planned control total surplus in 2010/11 this was achieved by non recurrent proceeds from a capital disposal. Overall therefore there is slightly higher risk for these PCTs, particularly as Southwark delivered a challenging QIPP programme to secure financial balance in 2010/11. Whilst this evidences the capability to deliver, securing further challenging QIPP in 2011/12 may be more difficult as the "low hanging fruit" has been secured.

3.3. PCT Operating Plans for 2011/12 reflect the continuing significant tightening of public sector finances after a prolonged period of high growth and also to reflect emerging health and budget management priorities, including the requirement to reduce corporate running costs and the requirement for PCTs to set aside 2% of funds for non-recurrent investments. This has required PCTs to plan for and implement a series of QIPP savings initiatives and cost improvement programmes in order to achieve required financial surpluses and to secure improvements in quality.

3.4. In 2011/12, QIPP savings initiative plans total £73.9 million across the sector. Planned QIPP schemes have reduced from £76.5m following the mediation of the Lewisham Healthcare contract, which reduced Lewisham PCT's planned QIPP savings by £2.6m. An initial RAG rating of schemes showed an assessed QIPP shortfall across the cluster

and this assessment is being updated to reflect the final agreement of contracts with providers. It is currently assumed in forecasts that any shortfalls in delivery are mitigated by the delivery of further cost improvement programmes and further contingency measures.

4. Update on PCT Resource Allocations and Budgets

4.1. PCT budgets are based on both confirmed and anticipated Resource Limit allocations, as set out in PCT Operating and FIMS plans for 2011 and updated to reflect additional information received since the submission of plans. A number of resource assumptions for 2011/12 are to be confirmed, particularly relating to access 2% Non-Recurrent Funds, the treatment of running cost reductions and "Pass through" payments to provider trusts, e.g. consultants' distinction awards. Further clarification is being sought from NHS London.

5. Year to Date Expenditure Position

5.1. The year to date expenditure position for each PCT in the Cluster as at 31st May 2011 (Month 2) is summarised below: As at month 2 budgets are under spent by £5.366m across South East London. It should be noted that all PCTs have profiled the delivery of their planned surpluses through the year and that this differs by PCT and as at month 2 all PCTs are meeting their planned surpluses.

Table 2: Year to Date Expenditure Position

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Total SEL cluster
Year to Date (Over)/ Underspend	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Acute	67	0	(5)	0	0	0	62
Client Groups	(295)	0	0	0	0	0	(295)
Primary Care	65	0	6	0	0	0	71
Corporate Budgets	197	0	253	0	0	0	450
Other Budgets and Reserves	(33)	250	504	2,449	896	1,013	5,078
Total	**0**	**250**	**758**	**2,449**	**896**	**1,013**	**5,366**

6. Forecast Year end expenditure Position

6.1. Forecasts of the year-end financial position are challenging at the early stages of the financial year, in particular within the acute sector, where validated 'frozen' monitoring information for month 2 is not available until August and due to the fact that demand and activity trends are inherently variable. In addition, QIPP savings initiative plans are in some cases phased and some are not due to impact until later in the year. Forecasts based on extrapolation of Month 2 are therefore unlikely to be robust, and will be subject to change.

6.2. The likely case forecast year end position based on risk assessments across all expenditure areas has been assessed based on historic underlying performance, an assessment of the delivery of QIPP and also known financial pressures such as on Non-Contracted Activity (NCAs) and continuing care. Within the risk assessment these

pressures can currently be met from within 0.5% contingencies held by each PCT, although the Bexley position is considered particularly vulnerable as all available contingencies have been released. However, some of the contingencies are being held in respect of planning assumptions which may not crystallise, and there are also further opportunities arising from potential reductions in running costs which may mitigate the position.

6.3. The likely forecast year end position, based on the risk assessment, by service area is summarised below:

Table 3: Year-end Expenditure Forecast – Likely Case

LIKELY CASE FORECAST	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Total SEL cluster
Forecast Full Year (over)/ Underspend	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Acute	(1,703)	(2,303)	(2,011)	(2,291)	(2,224)	(2,317)	(12,849)
Client Groups	(500)	(100)	0	(400)	0	0	(1,000)
Primary Care	0	(100)	0	(450)	(500)	0	(1,050)
Corporate Budgets	500	0	0	0	0	0	500
Other Budgets and Reserves	3,948	8,496	6,623	9,925	8,100	8,174	45,265
Total	**2,245**	**5,993**	**4,612**	**6,784**	**5,375**	**5,857**	**30,866**
Forecast Full Year Performance Against planned surplus							
Planned Full Year Surplus	2,245	5,993	4,612	6,784	5,375	5,857	30,866
Forecast variance against planned Surplus	0	0	0	0	0	0	0

6.4. The planned full year surplus across the sector is £30.866m and this has been updated to reflect changes to final PCT surpluses, which have been carried forward to 2011/12 and added to planned 2011/12 surpluses in line with guidance from NHS London. While it is currently forecast that all PCTs will meet planned full year surpluses, any forecast at this stage should be treated with a degree of caution given financial and service risks in 2011/12, including risks on QIPP savings initiatives.

7. Service Financial Positions

7.1. A summary of PCT financial positions by service area are provided below. Further details are contained in the Finance Report to the Performance, Finance and QIPP Committee.

7.2. Acute Services

- **Expenditure Position**

  Across the cluster, acute services are broadly breaking even at month 2, but at this stage of the year it is difficult to forecast year end positions with any certainty.

Month 2 activity data has very recently been received and appears to indicate potential over performance, although the data has yet to be validated. At this point, it is anticipated that pressures may be contained within available contingencies; however there are particular concerns in respect of the Bexley and Lewisham positions as a result of the financial risk previously identified. Year-end forecasts are based on assumptions of a level of activity growth and delivery of QIPP savings initiatives and shows a forecast overspend of £12.8m across the Cluster. While assumptions differ by Trust, depending on contractual agreements reached and also the level of activity commissioned by each PCT.

- **Contract Updates**

  The SEL Cluster is co-coordinating commissioner for four key provider acute contracts and contracts envelopes and terms have been agreed for all four, with formal signing of contracts expected by the end of June. A small number of local contracts are being finalised and the anticipated outcome of negotiated are included in PCT budgets.

- **Acute Claims Management**

  A robust contract monitoring and claims management system is in place across the cluster in 2011/12. Challenge letters were issued to the four main acute providers in SE London, and to acute providers outside SE London, within the national deadline of Wed 8th June. These challenges totalled almost £3 million across the Cluster in month 1 and updated on the outcome of these challenges will be presented in future reports.

- **Acute Services – Financial Risks in 2011/12**

  Given underlying population and incidence activity trends and also acute sector QIPP savings initiatives, the acute sector expenditure position is considered to be high risk and the risks are significantly higher than indicated in the year end forecasts set out above. This will require close monitoring and management during 2011/12. Further details are provided below:

  - **Delivery of QIPP Savings Initiatives** – Acute sector QIPP initiatives account for over half of all assumed savings in 2011/12. While a proportion of acute sector savings are guaranteed to commissioners, the risk for a degree of savings initiatives, particularly in relation to GP initiated new outpatient referrals and A&E attendances, rests in full with PCTs. This will require close monitoring and regular updates to RAG ratings as the year progresses.

  - **Emergency Readmissions –** Operating Framework and PbR guidance for 2011/12 sets out new payment rules for Emergency Readmissions within 30 days of an original admission. The resulting savings are to be reinvested in reablement schemes. While this is neutral to commissioners, we will need to ensure close monitoring of actual savings to commissioners and also reinvestment plans to ensure neutrality.

  - **Activity growth** – Activity volumes in contracts are predominantly based on an assessment of 2010/11 forecast outturn plus additional volumes required to meet 18 weeks waiting times targets and also reductions in activity in line with PCT QIPP savings initiatives. Additional volumes have not been commissioned to meet underlying population and activity increases and remaining reserves to meet demand pressures within PCT budgets are limited.

- **Price Impacts –**The impact of new PbR tariffs in 2011/12 has been included in Trust contracts in 2011/12, however the introduction of new A&E tariffs in 2011/12, based on HRG 4 for the first time, is considered to be potentially material to PCTs and this will be require close monitoring.

- **NCAs and exclusions** – Expenditure against non-contracted activity budgets have been increasing across the cluster and growth rates are in excess of underlying activity growth rates in contracts. The SEL Cluster will be undertaking a review of 2010/11 expenditure across all PCTs to audit activity trends to explain the increases and required management.

7.3. **Client Groups**

- **Expenditure Position**

  A month 2, client group budgets across the cluster are breakeven, with the exception of Bexley which is overspent by £295K. While pressures are being faced by all PCTs, these are mitigated by available reserves. At year end, client group budgets are forecast to overspend by £1.0m mainly as a result of pressures relating to continuing care budgets and at Southwark there is currently an unusually high incidence of referrals for children and adolescent mental health services in the first two months of the year. Similarly, there has been an unpredicted increase in activity in adult mental health. These overspends are being actively investigated.

- **Client Group Services – Financial Risks in 2011/12**

  - **Continuing Care** - The key area of risk in 2011/12 relates to continuing care clients where numbers are relatively small and volatile and the cost of a continuing care package can vary significantly by client this is an area of performance that will need to be kept under close review. Some boroughs are reporting an increase in client numbers in recent months.

  - **South London & The Maudsley Contract** - All elements of the SLaM contract with the exception of specialised services and the complex and forensic placements are managed on a block contract basis. Agreed risk share arrangements are in place specifically for complex and forensic placements whereby risk is equally shared for both over and under-performance on a 50/50 basis and contractual ceilings are in place. It is anticipated that there will be ongoing demand pressures across mental health specialist services. QIPP savings have been secured via the contract and delivery of savings will therefore not present a risk and we are working closely with SLAM to ensure the effective delivery of the savings through its programme management approach. It is anticipated that there may be ongoing demand pressures across mental health specialist services which is reflected in the forecast below.

  - **Oxleas Contract**– The contract is managed on a block contract basis with the exception of placements which represents a risk depending on client numbers.

7.4. **Primary Care**

- **Expenditure Position**

  As at month 2, primary care expenditure is largely in line with plan, however a complete review of Primary care budgets is being undertaken and monthly positions and forecasts will be further refined. In addition, prescribing activity data is reported to PCTs by the Prescription Pricing Authority (PPA), an external body. There is

usually a two-month lag in the reporting of prescribing data and as such April activity data has not yet been received for month 2 reporting. The year end forecast expenditure position for primary care services is a forecast overspend of £1.050m and this is based on discussions with each borough in respect of an early assessment of QIPP and other financial risks during 2011/12.

- **Primary Care – Financial Risks in 2011/12**

  - **QIPP Initiatives**

    Primary Care, including primary care prescribing, represents nearly 20% of total QIPP plans for 2011/12. Whilst some areas where savings can be delivered have been identified in Primary Care, a number of areas pose a high risk of non-delivery. Most Primary Care budgets were set net of QIPP savings i.e. non-delivery will have to be managed with under spends in other areas or by identifying new QIPP opportunities elsewhere as early as possible to mitigate this risk.

  - **APMS/PMS/GMS**

    All contracts are currently performing to expenditure plan to Month 2 based on the assumption that QIPP savings will be delivered from PMS reviews. PMS contract reviews have been undertaken and applied in four of six Boroughs. Work is underway to extend this to the remaining two Boroughs with a view to enacting new prices in the first half of the financial year.

  - **Dentistry**

    All contracts are currently performing to expenditure plan to Month 2 based on activity report from Dental Payment Division (DPD) of the Business Services Authority (BSA). The Dental allocation is now within PCTs' baseline from 2011/12 onwards. It is envisaged that Patient Charge Revenue (PCR) which is high financial risk area for PCTs will continue to be recovered fully due to effective performance management which is already in place in some Boroughs. Work is underway to roll this out to others.

  - **Community Pharmacy**

    The Global sum was devolved to PCTs in 2010/11. There has been a change in the methodology applied to data/activity capture. Spend is now driven by patient GP registration as opposed to dispensing Pharmacy which is not within the control of PCTs and this has resulted in financial pressures which are being monitored.

7.5. **Corporate Budgets and Running Costs**

Discussions are ongoing between the central team and local Business Support Units in respect of the agreement of costs across all organisations to ensure that target savings are met. It is clear that the opportunities of centralizing arrangements will need to be maximized in terms of delivering the anticipated reductions. However, until this work can be completed, at this stage it is assumed that the year to date position is breakeven. Year end forecasts are based on anticipated positions but this will require further updates as the year progresses.

PCT running cost targets are yet to be set for 2011/12 and are a key risk for the year ahead.

7.6. **Other Budgets & Reserves**

PCT budgets include reserves set aside to deliver planned underspends in 2011/12 and also the required 0.5% contingency reserves. Both reserves have been phased and this is reflected in both M2 and forecast year end positions.

8. QIPP Savings Initiatives

8.1. The achievement of financial targets in 2011/12 is predicated on the delivery of QIPP schemes. The target savings for 2011/12 are £73.9 million across the Cluster. Planned QIPP schemes have reduced from £76.5m following the mediation of the Lewisham Healthcare contract, which reduced Lewisham PCT's planned QIPP savings by £2.6m.These savings are included within PCT budgets for 2011/12, meaning that non-delivery of savings will need to be managed by underspends and the development of further Cost Improvement Programmes.

8.2. Work is ongoing to identify alternatives in case of slippage, and opportunities to accelerate QIPP delivery including :

- investment of the 2% non recurrent funding to accelerate and pump prime QIPP schemes, subject to meeting NHS London criteria.
- Meeting the expectation of a significant reduction in running costs by maximizing the opportunities of cluster arrangements
- rationalise estates and contracts

8.3. While the draft updated risk assessment shows an anticipated shortfall, we have shown a balanced position at month 2, in advance of detailed monitoring information and forecasts.

9. Cost Improvement Programmes, Contingency Measures and 2% Non-Recurrent Funds

9.1. The Cluster faces significant financial and service pressures in 2011/12. Effective and robust monitoring systems which detect adverse variances at an early stage are therefore a priority for the Cluster. A robust claims management and contract monitoring system is in place and it is proposed that the cluster moves to an integrated ledger system to ensure consistency and accuracy of reporting together with a rigorous approach to the development and acceleration of QIPP schemes. 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.

- **Use of 2% Non-Recurrent Funds**

As part of the national Operating Framework, the 2% Non-Recurrent funds are being held by the SHA and the release of this money will be based on business cases signed off by the cluster Finance Director and Chief Executive and authorised by the SHA. It is clear that any proposals put forward by the Cluster will be scrutinised very carefully by NHS London and the Cluster and there is a process and timetable to revise existing schemes to more clearly demonstrate adherence to the criteria.

10. **Financial Management – Cash Management Strategy**

10.1. The objectives of PCT cash management strategies are to:

- Ensure the production and regular updating of cash plans, ensuring they are based on robust and accurate information on the value and timing of receipts and payments.
- Ensure that the PCT Cash Limits are met and to minimise remaining year-end cash balances to within Department of Health targets (under £50K).
- Ensure monthly cash drawings are managed to minimize month end balances (under £250K).
- Ensure income due to the PCTs is collected efficiently and outstanding debtors are minimised, avoiding the need for bad debts to be written off.
- Ensure creditors are paid efficiently and on time so that the Better Payment Practice Code (BPPC) can be met and outstanding creditor balances are, wherever possible, minimised.
- Support cash management across the broader NHS by ensuring payments to NHS Trusts and PCTs are managed effectively.

10.2. Cash Management Performance can be measured using the targets set out below.

Better Payment Practice Code (BPPC) Target Under the Better Payment Practice Code (BPPC), PCTs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. This is measured both in terms of the total value of invoices, and the number of invoices by count.	**Manage Within Cash Limit** The plan is updated as cash limit allocations are made by the Department of Health during 2011/12. Actual cash drawings are monitored on an ongoing basis against this cash plan.
Aged Debtors An analysis of the age of outstanding debtors.	**Income Collection** Planned and actual cumulative income in 2011/12 across the Cluster.

10.3. PCT performance against these targets will be presented to the Joint Board on an exception basis and the position rating to aged debtors is set out at Appendix A. Full details of performance are set out in the Finance Report to the Cluster's Performance, Finance and QIPP Committee.

11. Conclusion

11.1. This report sets out the year to date and forecast year-end financial position for the South East London Cluster including details of anticipated financial risks.

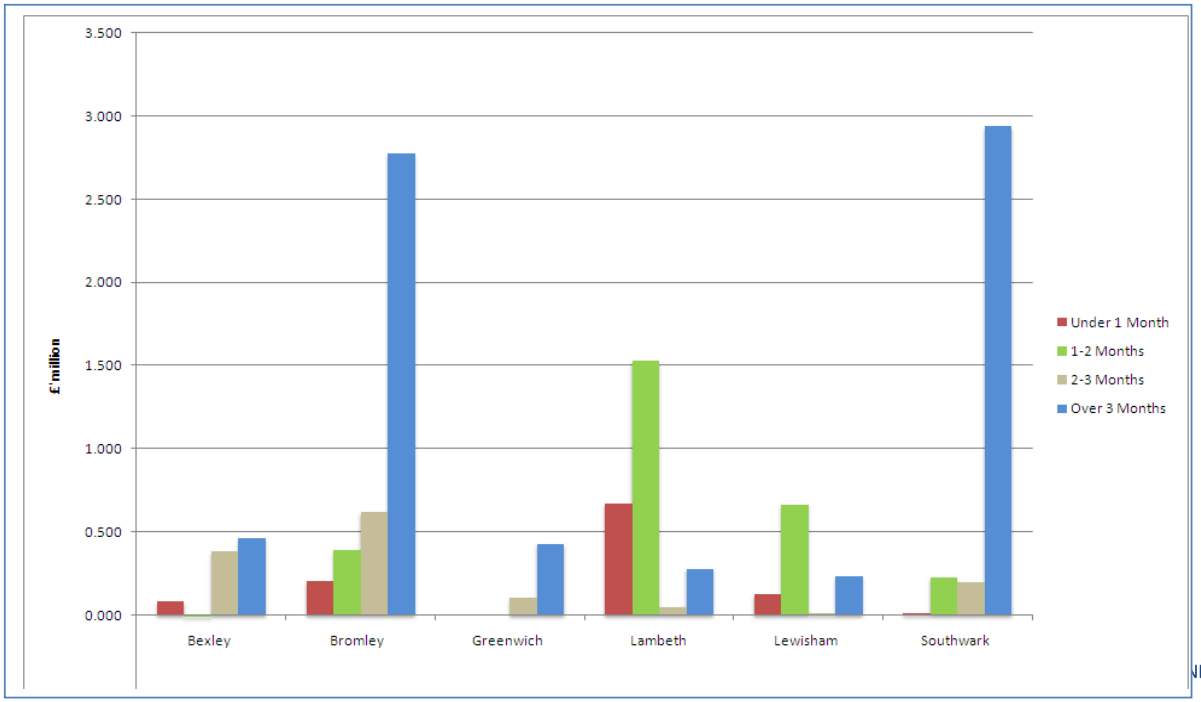
11.2. Further details are contained in the Finance Report to the Cluster's Performance, Finance and QIPP Committee.

Cash Management Strategy - Aged Debtors

The chart below shows the current analysis of outstanding debtors as at 31st May 2011. Outliers across the Cluster are explained below.

- Southwark PCT has a bad debt provision of £1.2m, In addition, £1.3m is outstanding with Kings College Hospital FT which relates to rent recharges for Dulwich Hospital. We are attempting to get these invoices paid.
- For Bromley PCT, of the total £2.8m over 3 months, £2.2m relates to South London Healthcare Trust. These debtors were agreed by SLHT as part of the agreement of balances exercise so therefore do not pose a risk. However, payment has not been received due to cash issues at SLHT. The Cluster is now in the process of liaising with SLHT to agree a repayment plan.

Chart 1: Aged Debtors as ay 31st May 2011



	Bexley	Greenwich
	£'million	£'million
Under 1 Month	0.081	0.000
1-2 Months	0.000	0.000
2-3 Months	0.384	0.102
Over 3 Months	0.460	0.430

	Bromley	Lewisham
	£'million	£'million
Under 1 Month	0.205	0.124
1-2 Months	0.393	0.665
2-3 Months	0.618	0.015
Over 3 Months	2.774	0.232

	Lambeth	Southwark
	£'million	£'million
Under 1 Month	0.670	0.015
1-2 Months	1.529	0.226
2-3 Months	0.050	0.200
Over 3 Months	0.279	2.938

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 7

ENCLOSURE 7

NHS SOUTH EAST LONDON CLUSTER BUSINESS PLAN

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Kathryn MacDermott, AD Strategy and QIPP

TO BE CONSIDERED BY: All

SUMMARY:
The 19th May Board meeting considered the draft SEL Business Plan and objectives. Since that meeting the objectives for each BSU and central team directorates have been reviewed and updated.

The updated workplans can be found on the website.

KEY ISSUES:
The BSU work plans have been agreed by each BSU MD and are consistent with the BSU Business Plans. The central team directorate work plans have been agreed by the Director of Development.

The SEL Business Plan has set the framework for the individual objectives and Personal Development Plans and these have been cross checked with the SEL Business Plan for consistency and coherence. By undertaking this process we can be assured that the delivery of the corporate objectives is embedded throughout the organization. All PDPs will be used to develop a cluster training and development plan.

Each objective has a timescale and progress on the individual PDPs and the overall plan will be reviewed on a quarterly basis by the Cluster Management Board (CMB).

COMMITTEE INVOLVEMENT:
- Development Board
- Cluster Management Board
- BSU Management Boards

RECOMMENDATIONS:
The board (s) is asked to:-

- Note the updated work plans and process for review

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*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.