NHS
Kingston
Clinical Commissioning Group

Forty-second meeting in public of the
NHS KINGSTON CLINICAL COMMISSIONING GROUP (CCG)
GOVERNING BODY

Tuesday 5 March 2019
15:00 – 17:00

in the Fraser Chapel, at The King's Centre, Coppard Gardens, Chessington KT9 2GZ

PART 1 AGENDA

No	Time	Item	Executive Lead	Attachment
1	**STANDING ITEMS**			
1.1	15:00	• **WELCOME AND INTRODUCTIONS** • **APOLOGIES FOR ABSENCE AND CONFIRMATION OF MEETING QUORACY** (*see quorum at end of agenda*) • *Reminder to members to put mobile phones on silent or switch them off during the meeting*	Naz Jivani	
		DECLARATION OF INTERESTS: Members will be asked to declare any possible conflicts of interest at the start of the meeting that have not already been declared on the CCG Register. Members will also be asked to declare any awareness of fraud or bribery.		
1.2		**MINUTES OF THE FORTY FIRST MEETING** held on 8 January 2019 *Approval*	Chair	A
1.3	15:05	**ACTION LOG AND MATTERS ARISING** *Note*	Chair	A1
1.4	15:10	***QUESTION TIME**: an opportunity for questions to be asked on items included in the agenda*		
1.5		**ITEMS TAKEN IN PRIVATE ON 8 JANUARY 2019:** • Wesley Lodge closure • Mill Place update • 5% QIPP and PIDs • Request to convene a Collaborative Decision Making Committees In Common meeting In February 2019 • Review of Kingston & Richmond Local Delivery Unit Senior Management Structure • Remuneration Committees In Common *Approval*	Chair	Verbal
1.6		**CCG CHAIR'S REPORT** *Note*	Chair	Verbal

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No	Time	Item	Executive Lead	Attachment
1.7	15:20	**ACCOUNTABLE OFFICER'S REPORT** *Note*	SWL Accountable Officer	Verbal
1.8	15:25	**MANAGING DIRECTOR'S REPORT** *Note*	Managing Director	B
2	**COMMISSIONING**			
2.1	15:35	**SERVICE CHANGES:** 2.1.1 Closure of supported living provision at Mill Place 2.1.2 Closure of Wesley Lodge Nursing Home for People with Learning disabilities *Assurance*	Director of Commissioning	 C D
2.2	15:45	**CQC SEND INSPECTION: NEXT STEPS** *Information*	Director of Commissioning	E
2.3	15:55	**DEMENTIA DIAGNOSIS ACTION PLAN** *Information*	Director of Commissioning	F
2.4	16:05	**INTEGRATED QUALITY GOVERNANCE COMMITTEES IN COMMON REPORT** 2.4.1 SWL performance report 2.4.2 Integrated quality governance report *Discussion & information*	Director of Quality	 G1 G2
2.5	16:15	**FINANCE REPORT MONTH 10 2018** *Note*	Director of Finance	H
2.6	16:25	**INITIAL BUDGET 2019-20** *Approval*	Director of Finance	I
2.7	16:35	**COUNCIL OF MEMBERS REPORT** *Information*	Chair of Council of Members	J
3	**GOVERNANCE/BUSINESS**			
3.1	16:40	**THE NHS LONG TERM PLAN** *Information*	Managing Director	K
3.2	16:45	**BOARD ASSURANCE FRAMEWORK** *Discussion & approval*	Director of Corporate Affairs & Governance	L
4	**FOR INFORMATION**			
4.1		**MINUTES FOR INFORMATION AND UPDATES FROM SUB COMMITTEES:** ▪ Finance Committee ▪ Integrated Quality Governance Committee ▪ Primary Care Commissioning Committee ▪ Health & Wellbeing Board *Information*		 M1 M2 M3 M4

No	Time	Item	Executive Lead	Attachment
4.2		**RECENT POLICIES APPROVED BY EXECUTIVE MANAGEMENT TEAM**: 4.2.1 Primary care rebate scheme (PCRS) policy 4.2.2 Public Sector Equality Duty *Information*		 N1 N2
4.3		**REFERENCE DOCUMENT: GLOSSARY OF TERMS** *Information*		O
4.4	16:50	**DATE OF NEXT MEETING:** Tuesday, 7 May 2019 (3pm to 5pm) Venue: Fraser Chapel, The Kings Centre, Chessington		
5	**PUBLIC QUESTION TIME**			
5.1		***QUESTION TIME**: an opportunity for questions to be asked on items not included in the agenda*		

***Quorum**:*
The quorum of the meeting of the Kingston CCG Board shall be six (6) persons at least two (2) of whom shall be practising clinicians, at least one Lay Member and one voting Director (either the Accountable Officer, the Chief Finance Officer or the Managing Director). No business shall be transacted at a meeting unless the following are present:

- *Accountable Officer, the Chief Finance Officer or the Managing Director; and*
- *Chair or Vice Chair.*

CLOSE
To now resolve that the meeting is closed and the public be excluded from the Part 2 meeting because publicity would be prejudicial to the public interest by reason of the commercially sensitive or confidential nature of the business to be conducted in the second part of the agenda.

Kingston Clinical Commissioning Group Governing Body Meeting in Public	
Date	Tuesday, 05 March 2019

Document Title	Minutes of the 41st Meeting of Kingston Governing Body		
Lead Director (Name and Role)	Naz Jivani, Governing Body Chair		
Clinical Sponsor (Name and Role)	N/A		
Author (Name and Role)	Jo Dandridge, Governance & Business Lead		
Agenda item	1.2	**Attachment**	A

Purpose	Approval	√	Discussion		Noting	

MINUTES OF THE FORTY FIRST MEETING OF THE GOVERNING BODY OF KINGSTON CLINICAL COMMISSIONING GROUP HELD ON TUESDAY 8 JANUARY 2019 KING'S CENTRE, CHESSINGTON

PRESENT:	Dr Naz Jivani	CCG Chair
	David Knowles	Vice Chair & Lay Member
	Sarah Blow	Accountable Officer, SWL Alliance
	James Murray	Chief Finance Officer, SWL Alliance
	Jim Smyllie	Lay Member PPE
	Tonia Michaelides	Managing Director
	Dr Gareth Hull	GP Member
	Dr Annette Pautz	GP Member
	Dr Naeem Iqbal	GP Member
	Kathryn Yates	Nurse Member
	Iona Lidington	Public Health Representative
	Paul Gallagher	Lay Member & Audit Chair
MEMBERS IN ATTENDANCE:	Yarlini Roberts	Local Director of Finance
	Liz Meerabeau	Kingston's Healthwatch representative
	Dr Atin Goel	Council of Members Chair
	Fergus Keegan	Local Director of Quality
	Julia Travers	Local Director of Commissioning
	Jo Dandridge	Governance & Business Lead (note-taker)
APOLOGIES:	Dr Phil Moore	Deputy Chair – Clinical
	Dr Pete Smith	GP Member

Welcome and Introductions: Members of the public were welcomed to the forty first meeting of the governing body.

Declarations of interest relating to items on the agenda: Members were asked to declare any possible conflicts of interest that had not already been declared on the CCG Register. *(All declarations of interest for governing body members are listed in the register available at each meeting and also published on our website)*

19/01 MINUTES OF THE FORTIETH MEETING HELD ON 6 NOVEMBER 2018

The minutes of the fortieth meeting held on 6 November 2018 were agreed as an accurate record.

19/02 ACTION LOG & MATTERS ARISING

Members received a copy of the latest action log and noted that all actions were on track or completed.

19/03 ITEMS TAKEN IN PRIVATE ON 6 NOVEMBER 2018:

Members noted the following items had been taken in private:

- SWL system finance position
- Review of lay member remuneration in SWL Alliance CCGs
- CQC SEND inspection: outcomes and next steps
- Options appraisal – closure of supported living provision at Mill Place, Kingston

19/04 QUESTION TIME

There had been no questions submitted in advance of the meeting.

19/05 ACCOUNTABLE OFFICER'S REPORT

Sarah Blow, Accountable Officer advised the governing body on the publication of the NHS Long Term Plan and advised that there was a lot of work required to understand the detail within the plan. She added that to date there had not been any planning guidance received or detail of funding allocations.

However, the key priorities within the plan were as follows:

- Adult mental health services
- Children and young people
- Primary care & community health services
- Better care for major health conditions and earlier diagnosis of cancer
- Prevention and health inequalities

It was agreed that a breakdown of the detail within the Plan would be bought back to the governing body for further discussion at a future meeting.

The governing body NOTED the Accountable Officer's verbal report.

19/06 MANAGING DIRECTOR'S REPORT

This report highlighted items of interest for governing body members and the public on issues that were not contained within the substantive agenda.

- **Winter communications & engagement campaign**
  Members were informed of the work with local health and care partners to deliver a

targeted winter campaign using the national campaign messages. An internal communications campaign was also completed to recruit staff to become winter champions and help share the winter messages with the public.

- **CCG Brexit Lead**
  Members were advised that in response to a request by NHS England, Jonathan Bates, Director of Commissioning Operations for the South West London Alliance had been identified as the board level lead and would undertake an assessment of risks associated with EU exit.

- **Commissioning team masterclass**
  Members heard of a masterclass that was held for various staff to refresh their knowledge in a number of areas including public health data and intelligence to build a case for commissioning change; using health and care data to build a business case; and using patient and public involvement and engagement to inform and develop service models and redesign projects.

- **Patient and Public Engagement (PPE)**
  Members were informed of the recent governing body development session held on patient and public engagement which focussed on the following areas:

  - CCG's duty to involve patients and the public
  - The benefits of engagement to ensure the high quality of our work
  - The risks of not engaging
  - The role of governing body members in challenging and seeking assurance that engagement has happened and demonstrating impact

- **Kingston Hospital award for staff retention & wellbeing**
  Members were advised that Kingston Hospital NHS Foundation Trust had been named Our Health Heroes winner in the 'National Skills Academy for Health' Staff Retention and Wellbeing Employer of the Year category for outstanding commitment to staff welfare.

- **Update on Connected Kingston**
  Members were informed of the soft launch of Connected Kingston which took place in September 2018 when the social prescribing digital tool went live. The full launch is on track to roll-out from the middle of January 2019 with a gradual build-up supported by a partnership communications campaign to the end of March. The evaluation approach, designed to be consistent with the Macmillan project, is currently being implemented with input from research members of the National Social Prescribing Network and a full report would be presented to a future meeting of the governing body.

The governing body NOTED the Managing Director's report.

19/07 DEMENTIA DIAGNOSIS RATE PERFORMANCE

Members received a report which informed them of the performance of the dementia standard against the targeted level and were also provided with a summary of the actions completed to date and those actions that were still to be undertaken.

Dr Nerida Burnie, who had recently taken up the role as the CCG's clinical lead for dementia advised members that the diagnosis rate in Kingston is 66.2% and this was 80 people short of the expected rate.

Members were informed of the following:

- Kingston CCG is in the minority of CCGs that are not achieving the standard
- The rate of nursing home beds and the proportion of people that are expected to have dementia are not outliers within Kingston, compared to South West London and the England average
- Kingston CCG meets with NHS England on a regular basis for support to increase the proportion of people diagnosed with dementia

Members noted that a memory nurse had been employed to undertake an audit of case finding at GP surgeries and to follow up on patients discharged from Kingston Hospital back into community care.

Members also discussed the potential source of low diagnosis rates being due to older people's nursing and residential home beds and it was noted that one of the actions needing prioritisation was to revisit the care home project to complete more assessments by those who did not participate the last time.

Members highlighted the experience of one GP whereby 80 patients had been identified within his practice and of these, 8 had been recommended for referral to the Memory Assessment Service but the individuals had all turned down the offer. It was agreed to link with the public health team regarding reducing the stigma of dementia to ensure that patients do not miss out on the invaluable support on offer.

The governing body expressed their appreciation to Dr Burnie for her continued contribution to improving the dementia diagnosis rate and also recognised that the target was particularly challenging. It was agreed to seek learning from other boroughs who had a similar resident population.

Discussion followed on potential other sources of patients and it was suggested to explore different ways to target vulnerable groups within the area, particularly those under represented with a lower prevalence such as BME groups, Koreans and the Tamil population. A request was made to review the data by practice code ethnicity that were lower than was expected. It was also suggested to connect with the voluntary sector within the borough and to review the linkages with their data.

A further suggestion was made to target those living on the periphery of the borough who are not registered with a Kingston CCG GP practice such as residents living near to West Barnes Surgery or Tudor Drive Surgery.

Members recognised that the staff working within care homes can often be quite transient and therefore certain areas of ongoing training and development would need to be considered.

The governing body NOTED the dementia diagnosis rate performance report and progress against the action plan.

19/08 CQC SEND INSPECTION NEXT STEPS

Members received a paper about the current progress on the requirement to produce a Written Statement of Action to address the areas of significant weakness identified in the Ofsted CQC inspection of Kingston's Special Educational and Disabilities Needs (SEND) provision.

Doreen Redwood, the CCG's Children's Lead Commissioner informed members of the key actions that had been achieved since the inspection letter was received and of the next steps to effect service improvement.

Members were also asked to discuss the role of the SEND governing body champion.

Increased staffing capacity through a Designated Medical Officer support and a Designated Clinical Officer to ensure delivery of the SEND statutory responsibilities.

Members also discussed the proposed inclusion of a statement of commitment in relation to SEND within Kingston CCG's constitution but after discussion it was felt that this was not the appropriate route to take.

Members considered the seriousness of the outcome of the inspection report for the CCG and were committed to working in partnership with the local authority's Achieving for Children team to take forward the recommendations. The CCG's Managing Director and the new permanent Managing Director of Achieving for Children have recently met together and agreed that going forward they will meet on a regular basis and will raise awareness with members on the Kingston Partnership Board.

In response to a query about the progress on occupational therapy and physiotherapy members noted that a gap analysis had been undertaken across Kingston & Richmond and the integrated disabled children's service was also being reviewed with regards to the educational or health needs of these children.

Members agreed that going forward progress on SEND provision would be a standing agenda item for the governing body.

The governing body NOTED the current progress and next steps and AGREED that the discussion on the SEND governing body champion would be taken outside of the meeting and the outcome would be reported to the next meeting.

19/09 COMMISSIONING

09.1 SWL Performance Assurance Report

Members received the report and noted the following:

- The Referral to Treatment (RTT) performance standard was achieved in September 2018 with outcomes of 93% and 99.7% respectively.

- Despite achieving the RTT performance standard, in terms of reducing the waiting list against the March 2018 reported position of 7,963 incomplete pathways, September's outcome was 9,162. This was a variance of 1,501 patients against a target of 7,661 for September. There was one patient waiting over 52 weeks for treatment.

- All the cancer performance standards were achieved with the exception of the 31 day chemotherapy.

- Kingston's Improving Access to Psychological Therapies (IAPT) service is working well, achieving all four access, recovery and waiting times standards up to November 2018.

- A&E performance at Kingston Hospital in September 2018 was 91.9%, in October which was below the 92.6% operating plan trajectory for the month.

09.2 Integrated Governance Committee Report

A report detailing issues discussed at the most recent Integrated Governance Committee meetings held on 20 November 2018 and 18 December 2018 was circulated for information.

Members were informed of the following key points to be aware of :

- Accident & Emergency performance at Kingston Hospital has improved throughout 2018-19 compared to 2017-18 but has yet to reach the 95% standard
- Mental health / Improving Access to Psychological Therapies (IAPT) performance for access and recovery remain above target for April-November 2018, continuing the good performance seen in Qtr 4 2017-18
- Dementia diagnosis rates remain challenging for Kingston CCG, with diagnosis rates of 62.2% compared to a target of 66.7% year to date
- All Referral to Treatment (RTT) 18 weeks and diagnostic targets are being met
- All activity performance is within the 2018-19 Operating Plan expectations, except for GP referrals which are above plan

Members noted there had been one mixed sex accommodation (MSA) breach in October 2018, at Brighton and Sussex University Hospitals NHS Trust, bringing the total number of breaches for 2018/19 to two. The other breach was at Imperial Hospital.

Members noted that as part of the reporting from the Clinical Quality Review Groups to the Integrated Governance Committee, South West London & St George's Mental Health NHS trust had undertook a table top review of all current serious incident investigations with senior trust/NHS England and CCG staff to understand current trends and themes and to seek assurance that terms of reference for each serious incident are appropriate.

Members attention was drawn to the Improvement and Assessment Framework (IAF) Dashboard for 2018-19 which displayed the areas where Kingston CCG is in the best, worst and interquartile ranges benchmarked with all CCGs in England.

Members highlighted the relatively lower than expected numbers of people on a GP learning disability register and questioned the timescale for completing the register as it was noted that the LD partnership Board which is supported by Healthwatch record annual health check data. It was also reported that the CCG was looking to appoint to the position of CCG clinical lead for LD to support the work in this area.

The governing body NOTED the SWL Performance Assurance Report and the local Kingston performance report.

09.3 Elective Activity update

The governing body received a paper highlighting the increase in the total size of the Referral to Treatment (RTT) Patient Tracking List (PTL,)

Members were informed that as part of the 2018-19 Operating Plan, there is an expectation that the total size of the RTT PTL, the total waiting list should be sustained at the March 2018 levels by March 2019.

Members were made aware that since March 2018, the RTT PTL has increased, with distinct rises London. Kingston Hospital and Kingston CCG have maintained the RTT standard, but there has been a growth in the PTL which is linked to additional demand at Kingston Hospital. There are a range of actions in place and the referral rate in Kingston CCG has reduced to 2.5% with total referrals on plan.

The governing body NOTED the increase in the total size of the RTT PTL.

19/10 FINANCE REPORT - Month 8

Members received the finance report for Month 8 (November 2018) and noted the following:

- As at Month 6, the CCG expects to meet all financial targets, including the planned surplus of £1.06m
- Non recurrent benefits and some reserves have been utilised to enable the delivery of the planned in year surplus
- The CCG plans to meet the Mental Health Investment Standard, increasing mental health services by 3.5% in 2018/19
- The cash target and Better Payment Practice Target were achieved.
- Kingston CCG is marginally ahead of target for QIPP in November and expects to fully achieve planned annual savings of £9.8m

Members noted that at month 8, the CCG holds mitigations of £2.63m against risk of £2.64m and if all identified potential risks materialise a surplus £12k below plan would only be achieved.

Members were also advised that details of the 2019-20 CCG financial allocations were still awaited.

The governing body NOTED the Finance Report.

19/11 COUNCIL OF MEMBERS REPORT

Members received a report detailing items discussed at the most recent Council of Member meetings held on 13th November and 11th December 2018.

This included updates on the following:

- Refresh of the CAMHS Local Transformation Plan for 2018-19
- National Diabetes Prevention Programme
- Kingston Medical Services 2018-19 service specification
- Obstetrics and foetal medicine at Kingston Hospital
- Connecting Your Care project
- Demonstration of EMIS software

The governing body NOTED the Council of Members Report.

19/12 INTEGRATED QUALITY GOVERNANCE COMMITTEES IN COMMON ACROSS THE KINGSTON & RICHMOND CCG'S LOCAL DELIVERY UNIT

Members received a paper seeking support and approval for establishing the Kingston & Richmond CCG's Integrated Quality Governance (IQG) Committees in Common (CiC).

Discussion was held and it was highlighted that the establishment of the IQG committees in common will reduce duplication, be more effective and will be streamlined in line with the same approach as the recently established Kingston & Richmond CCG's LDU Audit CiC and Finance CiC.

Members also received the proposed terms of reference for the IQG CiC which had been previously discussed and approved by the respective chair and members of the Integrated Governance Committee in Kingston and the Quality, Safety & Performance Committee in Richmond.

Members highlighted that public health were not referenced in the non voting membership section.

Discussion followed on the voting members and quoracy section within the terms of reference and the following was agreed:

- there only needed to be one governing body GP member from each CCG rather than the two that were currently listed
- a public health representative to be added to the list of non-voting attendees
- the quorum should be reduced to three members, that of a clinician, a lay member and a local director

The governing body considered the joining of the two committees a very sensible approach and subject to the above amendments, unanimously APPROVED the Terms of Reference for the IQG Committee in Common across the Kingston & Richmond CCG's Local Delivery Unit

19/13 SWL FINANCE COMMITTEES IN COMMON – TERMS OF REFERENCE

The governing body received a copy of the terms of reference setting out the membership, remit, responsibilities and reporting arrangements of the SWL Finance Committees in Common (SWL FCiC).

Members noted that legal advice had been sought and had not identified any issues with the iterations that had been made to the terms of reference. The main amendment was for a minimum of three GPs from across the 6 CCGs therefore allowing greater flexibility to maintain quoracy and GP engagement.

The governing body NOTED & unanimously APPROVED the finalised version of the SWL Finance CiC Terms of Reference in accordance with each CCG's constitution.

19/14 SAFEGUARDING CHILDREN 2017-18 ANNUAL REPORT

Members received a copy of the annual safeguarding children report which was presented by the Director of Quality. The report provides assurance to the governing body that the CCG is meeting its statutory obligations with regard to safeguarding children's arrangements.

Members noted that the CCG has a statutory duty to work in partnership with Local Safeguarding Children Boards (LSCB) in conducting Serious Case Reviews (SCR) in

accordance with Working Together to Safeguard Children (2015). However, during 2017-18, there had been no open serious case reviews.

Members were also advised that the report included a set of priorities for 2018-19 and this included the continued awareness raising of PREVENT anti-radicalisation through training for CCG employees and within member practices.

Members commented that it would be beneficial for the Safeguarding Children annual report to be linked to the SEND review.

Members were advised that the Children Looked After annual report was also available on request as it had not been included within the report as it was not an area of concern highlighted by Ofsted.

19/15 KINGSTON HEALTH AND CARE PLAN

Members received attachment E, a copy of the latest iteration of the health and care plan for 2019–21.

The report provided feedback from the borough engagement event and updated the governing body on the next steps and revised timeline for producing the local health and care plan now scheduled for July 2019.

Members noted that a discussion document would be presented to the governing body in March 2019 developed from the draft priorities from the Joint Strategic Needs Assessment and incorporating details for navigating around the health & care system and a new focus on self-help.

Members then viewed a short film that had been taken of the recent borough engagement event and were pleased to be able to experience a sample of feedback on the health and care system from participants. However, it was noted that the film was not able to capture the energy and enthusiasm within the room and the positive commitment gained.

Members noted that the next steps were to take the insight gathered from other local groups and develop a communications and engagement plan and a discussion document

The governing body NOTED the progress in development of the Kingston Health and Care Plan and thanked the communications and engagement team for their valued support with the borough event.

19/16 EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE NHS ENGLAND ASSURANCE OUTCOME

Members received a report which summarised the outcome of the 2018-19 EPRR Assurance process and updates on work carried out against the annual work plan.

Members noted that Kingston CCG was rated as ‘substantial’ in compliance with 5 Amber ‘partially compliant’ scores against their relevant core standard. An action plan has been discussed with the senior management team and submitted to NHS England.

***Action**: Nominations would be sought for a lay member to be part of the EPRR assurance process.*

The governing body NOTED the outcome of the NHS assurance process and APPROVED the inclusion of the outcome in the CCG’s Annual Report

19/17 BOARD ASSURANCE FRAMEWORK SUMMARY

Members received a report providing an overview of the risks, controls, assurances and action currently identified on the corporate risk register and Board Assurance Framework (BAF).

Members noted that there were currently 27 risks identified on the risk register and of these 2 were very high risks and 16 were high.

Members were advised that the full risk register is reviewed by the Executive Management Team on a monthly basis.

Members were also informed that the internal auditors had produced a benchmarking report of all SWL CCG risks registers.

Members noted that the recent internal audit review of risk management within the CCG had not highlighted any significant areas of concern. There were some recommendations made and these were currently being implemented.

Members were also advised that the Governance, Risk & Office Manager had now commenced in post, whose main role will be to ensure the Board Assurance Framework is continuously kept up to date.

Members noted that risk K16 relating to the '*potential over performance in acute services which could jeopardise the CCG's ability to meet statutory financial obligations'* could be downgraded now that the year end deal had been completed.

The governing body NOTED the Board Assurance Framework summary report.

19/18 MINUTES FOR INFORMATION AND UPDATES FROM SUB COMMITTEES

18.1 Kingston & Richmond CCGs' Finance Committee
Minutes of the Finance Committee meetings held on 24 July, 25 September, 30 October and 27 November 2018 were received for information.

18.2 Kingston & Richmond CCGs' Audit Committee
Minutes of the Audit Committee meeting held on 24 July 2018 were received for information.

18.3 Primary Care Commissioning Committee
Minutes of the Primary Care Commissioning Committee meeting held on 2 October 2018 were received for information.

Members were advised that at the subsequent meeting of the PCCC held in December 2018 there had been substantial discussion on the following:

- Key performance indicator (KPI) specifications for Kingston Medical Services (KMS) contract
- Care Quality Commission (CQC) breach notice for Chessington Park surgery
- Primary Care at Scale (PCAS) pilot act
- Integrated urgent care procurement

18.4 Health and Wellbeing Board
Minutes of the Health and Wellbeing Board meeting held on 13th September 2018 were received for information

19/19 RECENT POLICIES APPROVED

The governing body received a copy of the recently approved policies for information.

19.1 Learning & development policy
19.2 Alcohol & substance misuse policy
19.3 Stress management policy
19.4 Confidentiality policy
19.5 Information Governance framework
19.6 Information Management policy
19.7 Information Security policy
19.8 Information Governance policy
19.9 Information Quality policy

The governing body NOTED the recent policies approved.

19/20 DATE OF NEXT MEETING TO BE HELD IN PUBLIC

Tuesday 5th March 2019 (3-5pm)
Venue: King's Centre, Chessington

19/21 QUESTION TIME

None.

ACTION LOG for Kingston CCG GOVERNING BODY in public meeting - LIVE ACTIONS

Commenced: March 2018

Date of next meeting: 05.03.19. Last updated 26.02.19

Action No.	Action	Owner	Date raised	Date due	On track Overdue More than 4 weeks late	Comments (i.e. why action is not resolved / completed)
KGB09	Nominations would be sought for a lay member to be part of the EPRR assurance process.	Fergus Keegan	08/01/2019	05/03/2019	On track	
KGB10	Discussion on the SEND governing body champion to be progressed and the outcome reported to the next meeting	Julia Travers	08/01/2019	05/03/2019	On track	

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Kingston CCG Clinical Commissioning Group Governing Body meeting in public	
Date	Tuesday, 05 March 2019

Document Title	Managing Director's Report		
Lead Director (Name and Role)	Tonia Michaelides, Managing Director		
Clinical Sponsor (Name and Role)	N/A		
Author(s) (Name and Role)	Tonia Michaelides, Managing Director		
Agenda Item No.	1.8	**Attachment No.**	B

Managing Director's Report

The following report highlights items of interest to governing body members and the public which are not discussed in detail in the rest of the agenda.

Moving Forward Together – CCGs in south west London, merger discussions

There are a number of new developments, both nationally and locally, that mean it's a good time for CCGs in south west London to review the way we work:

- We have been working together as six CCGs for over a year and we think we can do things better together, for the benefit of our patients
- The national NHS Long Term Plan and its emphasis on the new primary care networks, and the indication that NHS England expects to see CCGs coming together in each STP area. For SW London this means that we are exploring what functions we could hold across SWL as a single CCG
- Strengthening of local health and care partnerships, and the development of the six local health and care plans.

CCG governing bodies across south west London have met to talk about how we approach this change. A key part of the discussions were that we should delegate to borough level, to ensure local accountability and delivery. We also need to keep a clear focus on how we all deliver better health and care for the people in each of our boroughs, and move more resource to frontline health and care services.

CCG chairs and the south west London management team have proposed and agreed a series of principles, and these can be grouped into the following headings:

- We will continue to be a clinically-led organisation
- We will maintain our focus on today
- We will streamline how we operate
- We will design an organisation with the future in mind
- We will move forward together, and engage people in how we do this

It was also agreed:

- We needed to begin conversations with each GP membership with an initial case for change
- That the GP membership, and CCG staff would be involved in designing the way we work going forward
- We would create a governance oversight committee which will include lay members
- A leadership forum would be created for senior CCG staff

CCG Time to Change pledge

Sarah Blow, Accountable Officer, signed a Time to Change pledge on behalf of Kingston and Richmond CCGs, on 26 February at Thames House.

The campaign is run by Mind and Rethink Mental Illness, and by signing up, we are demonstrating our commitment to change how we think and act about mental health and ensure that colleagues who are facing these problems feel supported in our workplace. We have recruited 13 staff volunteers as mental health champions who will receive dedicated training in the next few months. We are also planning a range of activities which include, mental health workshops, mindfulness sessions, training for line managers and healthy workplace initiatives. We have also published a range of resources and information on our staff intranet site.

Kingston borough – Time to Change Hub

Kingston has been selected as one of eight areas to tackle mental health stigma locally after winning a bid to become one of 2019's Time to Change Hubs.

Time to Change Kingston will be joining 13 funded Hubs across England to help change the way we all think and act about mental health problems.

The Hub will combine the insights of the national Time to Change campaign with local knowledge. They will support communities, workplaces and schools to take action to end negative attitudes and behaviours towards people experiencing mental health problems in their communities.

In Kingston, the hub will be led by local champions working jointly with Kingston Council as Time to Change Hub host, Healthwatch Kingston as the Time to Change Hub coordinator, Mind in Kingston and over 20 other local organisations from the voluntary sector, the health service and businesses.

For more information about the Time to Change hub in Kingston or to get involved please visit www.healthwatchkingston.org.uk/TTCkingston

Staff survey

The NHS national staff survey results were published on 26 February. We are pleased to report that 83.7% of CCG staff filled in this year's survey.

We are currently reviewing the results through our Ways of Working Group, and will be drafting an action plan to respond to any areas for improvement which have been identified. We will bring a full report about this to the May governing body meeting.

CCG Improvement and Assessment Framework ratings for mental health, dementia, learning disabilities and diabetes.

The CCG Improvement and Assessment Framework provides information to healthcare organisations, professionals and patients about how their local NHS services are performing and is used by national teams to drive organisational improvement through focused support.

	Kingston
Cancer	Outstanding
Maternity	Outstanding
Mental Health	Good
Dementia	Good
Learning Disabilities	Requires Improvement
Diabetes	Requires Improvement

Learning disabilities: this rating looks at reliance on specialist inpatient care for people with a learning disability and/or autism, the proportion of people with a learning disability on the GP register receiving an annual health check and the proportion of the population on a GP learning disability register. We will be appointing a GP clinical lead who will develop and support delivery of a programme of work to drive improvement in this area.

Diabetes: this rating measures treatment targets and also the availability of structured education programmes for people with diabetes. We are developing a plan to improve recording of diabetes education programmes in primary care.

Further information can be found here:
https://www.england.nhs.uk/commissioning/regulation/ccg-assess/clinical-priority-areas/

Cancer outcomes – annual assessment outcome for CCG commissioned cancer services

The annual assessment outcomes for CCG commissioned cancer services 2018/19 for Kingston Hospital NHS Foundation Trust, Royal Marsden NHS Foundation Trust and St George's Healthcare NHS Foundation Trust have been shared.

I am pleased to report that 'routine surveillance' has been the outcome for all three trusts. This confirms that the services are either 100% compliant with no risks identified, or for services that have not reached 100% compliance, the regional teams have identified that this is not a material issue.

Macmillan GP for Kingston and Richmond

Dr Shanaz Meeran, GP partner at Sheen Lane Medical Centre, has been appointed as Macmillan GP for Kingston and Richmond. She will promote the priorities of our cancer strategy to ensure that cancer is detected in its early stages and that support is available for patients who are living with and beyond cancer.

Dr Meeran is an established GP trainer with an interest in cancer, education and dermatological disorders. Dr Meeran hopes to make a real difference to patient care by

supporting GPs in timely diagnosis and appropriate referral. She will also seek to improve communication with secondary care teams.

Public sector equality duties annual report

At its January meeting, the Executive Management Team approved the CCG's annual equalities duty report, which highlights the progress made by the CCG in delivering its statutory equality duties during 2018.

The Equality Act 2010 requires the CCG, annually, to publish information, demonstrating its compliance with section 149(1) of the Equality Act 2010.

The report content builds on last year's and includes narrative on workforce data in relation to equalities, evidence of engagement activities reaching groups with protected characteristics and equalities information in relation to key work areas e.g. commissioning, safeguarding and primary care.

Equality work planned for 2019 includes:

1. Review effectiveness of our shared process for equality analysis.
2. Identify opportunities to run an equality delivery audit across both CCGs and where appropriate with a local provider(s).
3. Explore sharing staff equality training and development resources with local NHS partners.
4. Consider incorporating training on equality duty in the GP education half days, one for clinicians and one for practice managers on equality duty.
5. Review our community outreach programme to ensure the focus is on patients and local people who face barriers to who face specific barriers to being involved in our work and whose specific needs must be considered.
6. Implement the workforce disability equality standard.

Commitment to improving end of life care

GP practices in the borough will now be able to display a 'daffodil mark' as a sign of commitment to improving end of life care, as part of a new partnership between the Royal College of GPs and the terminal illness charity Marie Curie.

Dr Catherine Millington-Sanders, South West London Lead for End of Life Care, has been part of the team working on this.

The mark, synonymous with the charity, is based on a new set of criteria called the Daffodil Standards – a set of eight quality improvement statements designed to support primary care teams in delivering care to patients living with an advanced, serious illness or at the end of their lives, and their loved ones. By adopting the Standards, GP practices commit to making improvements in at least three of eight core aspects of care each year, with the aim of having reviewed all of them after three years.

Connecting your Care

Health and social care providers are working to improve the way they connect care for patients across south west London.

For people registered with a GP in Kingston, Connecting your Care will be joining up GP and hospital records for four south west London hospitals, so that GPs, along with doctors and nurses, will be able to immediately see important information about their patients through a secure system, to help them make more informed decisions about their care. The four hospitals that are linked into the system are:

- Kingston Hospital NHS Foundation Trust
- Croydon Health Services NHS Trust
- St George's Healthcare NHS Trust
- Epsom & St Helier University Hospitals

In the future, we will also be working with other health and social care providers to share a more detailed care record for patients across south west London. This will include the treatment they receive from community NHS services, mental health services and some social care services.

Materials to support the launch are available in GP practices and a programme of media and social media activity is planned. Patients can opt out of Connecting your Care by visiting www.swlondon.nhs.uk/connectingyourcare and downloading the opt-out form. Paper copies of the forms have also been sent to GP practices and the PALS teams within the participating hospitals.

Connected Kingston

Connected Kingston, the social prescribing programme for Kingston, continues to grow with over 90 'champions' trained to have strengths based conversations with members of the public, signposting or referring them to local services and activities in the borough via www.connectedkingston.uk. Training sessions have been held with GP practice staff across Kingston, and this base continues to grow.

The recently published NHS Long Term Plan, confirms a funding commitment from 1 July 2019 for social prescribers, as an embedded workforce in primary care networks, once these are set up. Discussions are underway in Kingston to make sure this builds on the work done to date within the Connected Kingston programme. This will help support the social prescribing capability in Kingston, effectively moving it from the 'small development' phase to a 'substantial and sustainable' business as usual delivery model for the future. These developments will involve the support of health and care partners in Kingston including the CCG, Kingston GP Chambers, local practices and locality teams.

The public launch of Connected Kingston will be on National Social Prescribing Day on 14 March 2019. A variety of public promotional activities are planned.

It was proposed at the last governing body meeting to bring a full report on the evaluation of Connected Kingston to the March meeting. However, given the number of people who have accessed or been referred to services via the platform to-date has been small, we will bring a fuller report on this to the November meeting of the governing body when it has been in the public domain for six months, when patient numbers will be higher and so our data will be more informative.

Winter champions

I would like to thank CCG staff who have volunteered as winter champions this year engaging with people in their local communities and voluntary groups to share information to help members of the public stay well over the winter.

Tonia Michaelides
Managing Director of Kingston and Richmond CCGs

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	Closure of Supported Living Provision at Mill Place		
Lead Director **(Name and Role)**	Julia Travers, Director of Commissioning		
Clinical Sponsor **(Name and Role)**	Dr Phil Moore, Chair (Clinical)		
Author(s) **(Name and Role)**	Rachel Rowan, Mental Health Commissioner Julia Travers, Director of Commissioning		
Agenda Item No.	2.1.1	**Attachment No.**	C

Purpose **(Tick as Required)**	Approve ✓	Discuss	Note

Executive Summary

In November 2018, the governing body was informed in the part 2 meeting that the CCG had been notified by Hestia (voluntary sector provider of supported living provision) that Mill Place (an eight-bedded supported living provision based in Kingston for people with mental health (MH) and substance misuse problems) will be closing because of a decision by their landlord to sell the property when the lease ends in July 2019.

Hestia had decided not to buy the property and because of this decision, the governing body was advised that the CCG would therefore need to work with the clients to find suitable alternative accommodation.

Before work commenced with the clients living in Mill Place, the CCG sought advice from the chair of Kingston Council's Health Overview Panel who confirmed that formal engagement and consultation was not required for this service change because the closure is outwith the CCG's and provider's control.

In November 2018, of the eight clients resident in Mill Place, five had been or were in the process of being stepped down from the service, leaving three clients who required rehousing in the same level of supported living.

As of February 2019, there are six clients in Mill Place. Three clients are due to be stepped down, leaving three clients to be re-accommodated over the coming months.

The CCG is working with the remaining clients, their families where consented, the Mill Place team and RBK Care Managers to assess their needs and identify suitable alternative accommodation.

Background:

The service at Mill Place has been commissioned by the CCG for over two years and provides low to medium supported living to clients who are generally independent with proficient living skills and can take their own medication. Clients will stay for between 6 months to 2 years before stepping down to lower support or possible independent living depending on the client.

Reason for Governing Body Review:

To update the governing body on this service change and give assurance of the process and progress in managing the timely transfer of the clients to suitable alternative accommodation.

Key Issues:

1. Currently there are six clients and two vacancies at Mill Place. Three clients are due to be stepped down leaving three clients to be re-accommodated over the coming months.
2. There is currently sufficient capacity within the system to absorb people using Mill Place which provides medium to low level support.

Conflicts of Interest:
None

Mitigations:
N/A

Recommendation:
The governing body is asked to:
1. Note the content of this report

Corporate Objectives This document will impact on the following CCG Objectives:	1. Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do 2. Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities 3. Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation

Risks This document links to the following CCG risks:	1. Potential public/service user resistance to closure of a supported living service 2. Accruing void costs due to vacancies as clients are stepped down
Mitigations Actions taken to reduce any risks identified:	1. Hestia to make sure that the three remaining clients and, where relevant, their families are fully involved in finding suitable alternative accommodation. There will also be an engagement exercise undertaken as part of the placement review work to ensure that the views of relevant stakeholders are fully considered in any proposed change in accommodation re-provision for clients 2. CCG will check whether there is the possibility of reducing void costs by Hestia terminating the lease earlier with the private housing company

Financial/Resource/ QIPP Implications	The funding associated with the clients in Mill Place will be utilised to fund their alternative care placement

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A

Patient and Public Engagement and Communication	The CCG is working with the service provider, Hestia to ensure that the three remaining clients and, where relevant, their families are fully involved in finding suitable alternative accommodation.

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
		Click here to enter a date.	
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	N/A

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	Closure of Wesley Lodge Nursing Home for People with Learning disabilities		
Lead Director (Name and Role)	Julia Travers Director of Commissioning		
Clinical Sponsor (Name and Role)			
Author(s) (Name and Role)	Arlene Thomas-Dickson (Mental Health Commissioner)		
Agenda Item No.	2.1.2	**Attachment No.**	D

Purpose (Tick as Required)	Approve ✓	Discuss ✓	Note ✓

Executive Summary

In November 2018, the governing body in part 2 received a paper that informed the CCG of Your Healthcare's intention to end the contracted agreement for residential nursing care at Wesley Lodge for people with learning disabilities (LD) by the end of the financial year March 2019.

Wesley Lodge is an eight-bedded nursing care home, situated in the Borough of Elmbridge which provides residential nursing care to residents of Kingston, Richmond and Surrey with severe learning disabilities and complex physical health needs. The current service is provided by Your Healthcare CIC (YH) and Kingston CCG is the host commissioner.

There are presently 4 residents in Wesley Lodge commissioned by:

- Kingston CCG – 1 resident
- Richmond CCG - 2 residents
- Surrey Local Authority - 1 resident.

The chair of Kingston's Health Overview Panel (HOP) was contacted and provided with relevant information about Wesley Lodge and the proposed closure. The closure of Wesley Lodge is not seen as a significant change for the HOP and therefore the CCG is not required to consult on this service closure.

The CCG's learning disabilities commissioning case manager is working with the Wesley Lodge residents, their families and the staff to identifying suitable alternative placement.

At the time of YHC advising commissioners of their decision, there were 5 residents living in Wesley Lodge.

Background:

Your Healthcare has provided a high level of LD residential and nursing care for residents at Wesley Lodge over the years. Wesley Lodge was purpose built and opened in 1995 by Kingston & Richmond Health Authority (K&RHA) to support the resettlement of 8 adults with learning disabilities from long-stay hospital provision back to local community setting accommodation.

In 2007, Wesley Lodge was registered as a care home. It is now registered with the CQC as a care home with nursing and was rated "good" in 2016 following their last unannounced inspection.

The intention and purpose of Wesley Lodge was to integrate people back into the community and to move away from an institutional setting; however, over the years the complex and changing needs of the residents and the location of the lodge away from public access, shops and leisure activities has made integration a challenge for the staff and residents.

The building also does not meet the vision for highly individualised care tailored to each resident's need.

All the residents at Wesley Lodge have complex LD and physical health needs as well as mental health comorbidity. However, they are different from one another in their disabilities, age, needs, interests, likes and dislikes. The understanding through 'Valuing People' and 'Transforming Care' highlights the importance in recognising individual's quality of life and in doing this it is felt that living in non-institutionalised settings will enable them all to participate more fully in their favoured activities.

Purpose of Committee Review

To update the governing body on this service change and give assurance of the process and progress in managing the timely transfer of the clients to suitable alternative accommodation.

Key Issues:

1)Wesley Lodge is an 8 bedded LD Nursing Home; there are presently 4 residents at the Lodge with high level of care needs.

- 2 residents for Richmond CCG
- 1 resident for Kingston CCG, and
- 1 for Surrey Local Authority

2) The chair of Kingston's Health Overview Panel was contacted and provided with relevant information about the Lodge and the proposed closure. The closure of the lodge is not seen as a significant change for the HOP and therefore the CCG is not required to consult on this service closure.

3) Your Healthcare with support from commissioners is leading the engagement with families of the remaining 4 residents who, along with the residents, will all be involved in decision-making around alternative accommodation.

4) The CCG's learning disabilities commissioning case manager for Kingston and Richmond CCGs is working with the Wesley Lodge residents, their families and the staff to identifying suitable accommodation.

5) Accommodation has been identified for the 3 residents of Kingston and Richmond. residents, however this depends on the providers being able to meet their needs. Two suitable spaces have been identified within a local authority block purchase. Awaiting decision on local authority to authorise the placement.

Conflicts of Interest: None
Mitigations: N/A

Recommendation: The Governing Body are asked to note the contents of this report	
Corporate Objectives This document will impact on the following CCG Objectives:	1. Enable local people, patients, carers and stakeholders to have a greater influence on the services we commission and keep the patient voice at the centre of what we do. 2. Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities 3. Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation
Risks This document links to the following CCG risks:	1. Potential families' resistance to the closure of Wesley Lodge. There has been no resistance from family members. 2. Accruing void costs due to vacancies as residents move out. 3. One of the resident has a court protection order; a solicitor has been advising around this.
Mitigations Actions taken to reduce any risks identified:	1. Your Healthcare is leading the engagement with the families of the remaining 4 residents. They will be

	involved in decision-making around alternative accommodation. 2. Your Healthcare would like to avoid the increase to the void costs as much as possible and is therefore working towards the end of March 2019.

Financial/Resource/ QIPP Implications	Within the financial envelope for 2018/2019 Any slippage post March 2019 will require discussion with regards to void costs.
Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A
Patient and Public Engagement and Communication	Currently there are 4 residents and 4 vacancies at Wesley Lodge. This leaves 4 residents from Kingston and Richmond CCGs and Surrey Local Authority (LA) for whom suitable alternative accommodation is being sought. Kingston LD Commissioning Case Manager is working with residents, their families and the staff at Wesley Lodge to identify suitable accommodation; using the knowledge of the staff and family will be key. YH is undertaking family engagement to ensure all questions and concerns from families are answered and dealt with effectively.

	Committee/Group Name:	Date Discussed:	Outcome:
Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Finance Deliver Group	Tuesday, 27 November 2018	To consult with the chair of the Kingston Health Overview Panel for a steer on what action is required. To present paper to the Kingston Governing Body.
	To the Chair of the Kingston HOP.	Friday, 07 December 2018	On the **4/1/19** received a response from Cllr Ravalia “no further input needed from HOP on this

			matter". This is not considered a significant change.
	Kingston Governing Body	Tuesday, 08 January 2019	To work with finance to understand void cost. YH to document any concerns raised by family members and their responses/action.
	Surrey local Authority Closure meeting Elmbridge Locality	5th February	Surrey was satisfied that due process has been followed. It has one resident there and is making arrangements for them to be rehoused.

Supporting Documentation	N/A

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	CQC SEND Inspection: Next Steps		
Lead Director (Name and Role)	Julia Travers, Director of Commissioning		
Clinical Sponsor (Name and Role)	Dr Naz Jivani, Chair		
Author(s) (Name and Role)	Doreen Redwood, Children's Lead Commissioner		
Agenda Item No.	2.2	**Attachment No.**	E

Purpose (Tick as Required)	Approve	Discuss	Note
			✓

Executive Summary

- In September 2018, the Care Quality Commission (CQC) and Ofsted inspected Kingston's Special Educational and Disabilities Needs (SEND) provision.
- The CQC assessed Kingston's SEND provision as requiring improvement and a Written Statement of Action (WSoA) is required to be produced in conjunction with Achieving for Children (local authority children services provider).
- The Written Statement of Action (WSoA) outlines the actions that are required to address the areas of weakness identified in the inspection report. The WSoA was finalised on 11 February for submission to Ofsted and CQC. The WSoA is attached as appendix 1.
- An update is provided on key action taken since the previous report was considered by the governing body in January 2019.

1. Background

The SEND joint inspection programme with Ofsted and CQC evaluates implementation of the reforms introduced by the Children and Families Act 2014.

The Ofsted and CQC inspection report was received on 23 October 2018 and raised significant concerns about the effectiveness of the local area resulting in the requirement to produce a WSoA to address the following areas of significant weakness:

- The overall poor quality and monitoring of education, health and care (EHC) plans, including contributions from health professionals.
- The timeliness of leaders ensuring that the annual review process and any subsequent amendments to EHC plans are consistently made in line with the SEN code of practice.
- The strategic leadership and monitoring of the CCG's work in implementing the 2014 reforms.
- To ensure that there is a productive and positive relationship between parents and parent representatives, including a parent carer forum.

The January 2019 report informed members of the governing body:

- That approval to fund an additional programmed activity to ensure that the designated medical officer (DMO) supports the CCG to meet its SEND statutory responsibilities was agreed by finance committee in December 2018.
- The approval to fund a designated clinical officer post was granted by the December finance committee.
- That a SEND partnership board chaired by Kingston Council's chief executive that includes CCG membership had been established and was due to have its first meeting
- The following high level commitment SEND statement was agreed:

  "The CCG is committed to ensuring the commissioning and delivery of high quality health services for parents/carers and children and young people with special education needs and disability that results in improved outcomes and life chances through exceeding where necessary our statutory duties and responsibilities outlined in the Children & Families Act 2014"

- That the WSoA was work in progress in collaboration with local area partners.

2. Current Position

Since the January 2019 report to the governing body, the following actions have been undertaken:

- **The Designated Medical Officer** – Following the approval by the December 2018 Finance Committee, the DMO commenced the additional increase in sessions in January 2019

- **The Designated Clinical Officer** – The recruitment process of the DCO has commenced and went live on NHS jobs during February 2019. It has been agreed that the DCO post should be covered via a short secondment to mitigate the recruitment delay. This will enable key pieces of work to be started and for the CCG to evidence that it is addressing some of the key areas of concern outlined in the WSoA.

- **Quality Assurance** – A meeting is planned between all partners for late March to develop the quality assurance framework and process for the quality assurance of all EHCPs. The Council for Disabled Children will be providing assistance to Kingston as part of its free package of support to those local areas that require improvement.

- **Joint Commissioning** – The first meeting of the Kingston SEND Partnership Board chaired by the new chief executive of the Kingston Council took place on 13 February 2019. The CCG was represented by the managing director and the director of commissioning.

- **SEND Transformation –** A draft three-year SEND transformation plan has been developed led by Achieving for Children that sets out the context, challenges and the actions that need to be taken to improve quality, manage demand and control costs of SEND services. Formal consultation will commence in March 2019.

- **Written Statement of Action** - The WSoA was completed in collaboration with all partners that outlines the joint actions to be taken to address the concerns arising from the SEND inspection.

  The WSoA addresses the following key areas:

  (a) The overall poor quality and monitoring of EHC plans, including contributions from health professionals

  The key outcomes identified in this section are:

  - All education, health and care plans will be produced in partnership with health, education and social care and will be of high quality and impact positively on outcomes for children and young people with SEND.
  - Quality assurance is embedded and used to drive service improvement.

  (b) The timeliness of leaders ensuring that the annual review process and any subsequent amendments to EHC plans are consistently made in line with the SEN code of practice

  The key outcomes identified in this section are:

  - Annual reviews and subsequent amendments are completed within statutory timescale.

  (c) The strategic leadership and monitoring of the CCG's work in implementing the 2014 reforms

  The key outcomes identified in this section are:

  - There will be effective strategic leadership and oversight of the health implementation and ongoing delivery of the SEND reforms by the CCG governing body.
  - Improved quality, effectiveness and performance of SEND health services that ensure local and national performance targets are met.
  - Health commissioned services demonstrate improved outcomes for children and young people with SEND and compliance with the reforms.
  - Commissioning budgets are used more effectively to improve service access and reduce waiting times thereby improving user experience.
  - Primary care is responsive to the needs of children and young people with SEND.

  (d) **To ensure that there is a productive and positive relationship between parents and parent representatives, including a parent carer forum**.

  The key outcomes identified in this section are:

  - There will be a productive and positive relationship between the local authority and CCG and parents/carers and parent representatives, including a parent forum.

- The local offer will provide an accurate and up to date description of the available health services that includes clear referral and access information.
- Increased opportunities for parents and carers to participate and give feedback on provision to inform future activity and development of services.

The WSoA was due to be submitted to Ofsted and CQC on 11 February 2019. However, due to a Council scrutiny call-in, the WSoA will now need to be submitted by no later than 25 February 2019. The final WSoA will be presented to the governing body at its May 2019 meeting.

- **Governing Body SEND Executive -** The CCG managing director will undertake the role of the governing body executive and is expected to have a strong working relationship with the DMO and DCO. Regular meetings have also been planned between the governing body chair, the executive and other key officers within the CCG to ensure that a strong focus and momentum is maintained to achieve the required improvement.

- **Section 75 Agreement –** Work has commenced on reviewing the Section 75 agreement that outlines our joint commissioning arrangements with the Royal Borough of Kingston upon Thames.

(e) Next Steps

The Written Statement of Action
Following submission of the WSoA to Ofsted and CQC, the local area will receive feedback about the areas that require further work. The local area will then be required to address these concerns and re-submit the WSoA to Ofsted and CQC for final approval.

Service Improvement Activity
The service improvement work will be underpinned by a strong co-design approach with parents/carers and children and young people. Some examples of service improvement activity are listed below:

a) 0-5 Neuro Development Pathway
Work is planned to commence during March to deliver a co-designed and co-delivered re-design of the 0-5 neuro development pathway. This will identify the service gaps, address pre-and post-diagnostic support and ensure the pathway is NICE compliant to address the issue of the long waiting times for assessments.

b) Therapy Services Review
The review report of therapy provision is planned to be released by Achieving for Children for consultation with stakeholders by end of March with the aim for finalisation of the proposals in May 2019. The CCG will work with stakeholders to define and agree the service model and offer for therapies which will inform the future commissioning and procurement of therapy services.

c) Engagement with parents and carers

SEND Family Voices ended as the parent carer forum (PCF) for Kingston and Richmond on 1 October 2018. Contact, the national charity for families with disabled children, has been given the responsibility for appointing a replacement PCF. Currently individual consultation and engagement activities continue to be undertaken with parents and carers.

Purpose:

To inform governing body members of:

- Current progress on the requirement to produce a WSoA to address the areas of significant weakness identified in the Ofsted CQC SEND Inspection letter
- Key actions that have been undertaken since the January 2019 report to the governing body and;
- Some example of service development activities to effect service improvement

Reason for Governing Body Review:

- To discuss and note progress in respect of responding to the recommendations arising from the Ofsted CQC SEND Inspection

Key Issues:

1. The WSoA has been jointly developed between local partners with a submission date of 11 February 2019 to Ofsted and CQC.
2. The increased staffing capacity through the DMO and the DCO that has been agreed to ensure delivery of SEND statutory responsibilities.
3. The first meeting of the Kingston SEND Partnership Board chaired by the new chief executive of Kingston Council took place on 13 February 2019.
4. The completion of a SEND Transformation Plan has been led by Achieving for Children.

Conflicts of Interest:
N/A

Mitigations:
N/A

Recommendation:

The governing body is asked to:

- Note current progress and next steps

Corporate Objectives This document will impact on the following CCG Objectives:	1. Better Health 2. Better Care 3. Sustainability 4. Leadership

	5. Engagement

Risks This document links to the following CCG risks:	There is a risk of failing to meet some of the national performance targets based on previous performance
Mitigations Actions taken to reduce any risks identified:	The development of the written statement of action is required by Ofsted and CQC as evidence that the inspection recommendations are being adequately addressed.

Financial/Resource/ QIPP Implications	At this stage the full cost of delivering the actions in the WSoA has not been fully quantified. However, it is likely that additional funding will need to be identified to address the shortfall in therapy provision and addressing improving the waiting time for a 0-5 neuro development assessment

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	Access to special education provision needs to be provided to those children and young people defined as having a SEN under the Children and Families Act 2014 and a disability under the Equality Act 2010. The mitigations include: • Provision of an education health and care plan (EHCP) to make special educational provision to meet their needs, to secure the best possible outcomes for them across education, health and social care and, as they get older, prepare them for adulthood • Provision of SEN support to those children and young people who have specialist needs that should be met in a mainstream setting but do not meet the threshold for having an EHCP.

Patient and Public Engagement and Communication	The Ofsted /CQC inspection findings have been published by the local Authority on the Local Offer website.

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	N/A	Click here to enter a date.	
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	Appendix 1 - WSoA

achieving for children

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Appendix 1

SEND LOCAL AREA

Written Statement of Action

February 2019

Introduction

This document outlines the commitment of Kingston Council, Kingston's Clinical Commissioning Group (CCG) and Achieving for Children (AfC) to address the areas of concern which were identified in Kingston's local area SEND inspection, which took place between 17-21 September 2018.

The document addresses four key areas:

- **Significant concern 1:** The overall poor quality and monitoring of Education, Health and Care plans, including contributions from health professionals
- **Significant concern 2:** The timeliness of leaders in ensuring that the annual review process and any subsequent amendments to EHC plans are consistently made in line with the SEN code of practice
- **Significant concern 3:** The strategic leadership and monitoring of the CCG's work in implementing the 2014 reforms
- **Significant concern 4:** To ensure that there is a productive and positive relationship between parents and parent representatives, including a parent carer forum.

Our written statement of action has been produced in close partnership with the CCG, AfC and Kingston Public Health so that all key partners are working together with urgency and determination to address these weaknesses. In addition, we have shared the document with our young people, and a focus group of parents and carers because we recognise the importance of co-production, shared ownership and commitment across all elements of the system.

The monitoring of the progress towards addressing the agreed significant concerns will take place in a quarterly meeting with the Department for Education (DfE) and NHS England, and feeding into this our progress will be considered through the Kingston SEND Partnership Board which will be held on the same day. Other SEN team plans, CCG work plans and internal performance systems will all measure progress and ensure strong accountability.

In addition, Kingston Public Health will be working with the CCG and AfC partners to ensure that the SEND Joint Strategic Needs Assessment recommendations are utilised and inform the commissioning intentions of all partners so that resources, provision and activity is based on an accurate assessment of the SEND population in Kingston.

Kingston's Written Statement of Action is integral to both the Local Area SEND Transformation Plan which has been written and shared with all key partners and the local health and care plan that is currently in the process of finalization. These plans will energise all partners in the SEND system to deliver real transformation for our local children, young people and their parents and carers. It also embeds the principles of the 2014 Children and Families Act.

The Local Area SEND Transformation plan vision for 2020 has five key components

- Children, young people, parents and carers are listened to and **engaged.**
- **Local provision** is expanded so that children's education, health and care needs can be met locally.
- The **whole system**, with education, social care and health services at the core, works together and with families.
- Provision is high quality and delivered by well trained and supported **professionals**.
- The community is supported to meet the needs of all children and young people by embracing diversity and **inclusion**, so that all children and young people with SEND have the opportunity to play, learn and grow-up together locally.

Transformation addresses five key issues over the next 3 years

1. Developing new approaches to early intervention so that children with SEND are supported to remain in mainstream schools.
2. Increasing the range & quality of local education, health and care provision for children and young with SEND.
3. Improving business insight and implementing more commercial approaches to the commissioning of SEND placements and support.
4. Engaging all stakeholders, including all parents and carers, in reforming the SEND system and changing attitudes and behaviours.
5. Promoting independence and strengthening transition for children and young people with SEND through school phases and into their adulthoods.

In terms of governance, the SEND Transformation Plan will be overseen by a Strategic SEND Partnership Board which will be chaired by the Chief Executive of Kingston Council, Ian Thomas. The governance structure below outlines both Education and CCG structures which will oversee the Written Statement of Action progress and link directly to the SEND Partnership Board and its strategic oversight so that progress is monitored frequently and effectively.

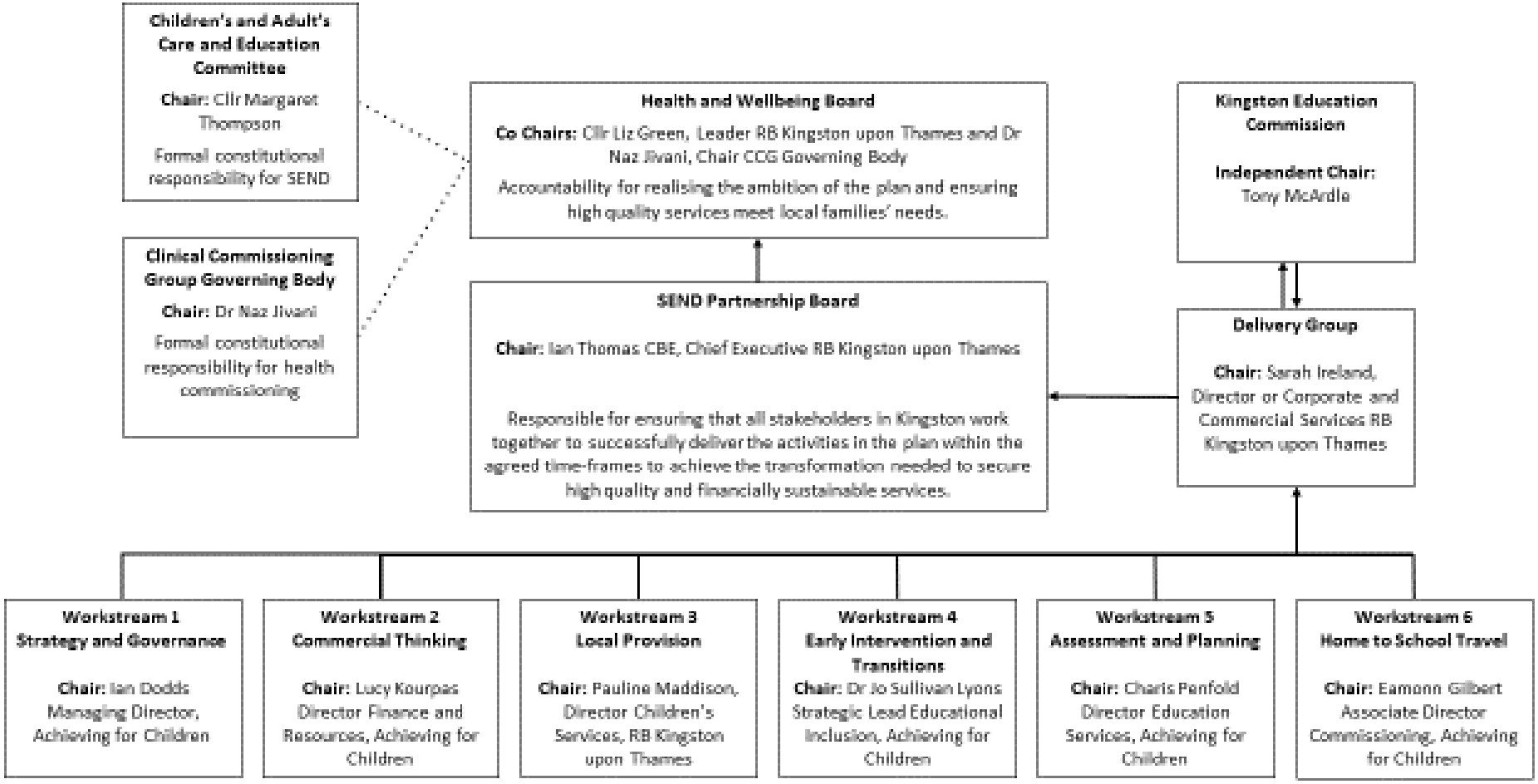
The six workstreams will deliver some of the activities which are directly linked to the action points from the SEND Local Area inspection.
In particular, Workstream 1 focuses on systemic change and accountability of all partners which links directly to significant concern 3 – CCG Leadership.

Workstream 3 which builds local provision which meets the identified needs of our children and young people with SEND must incorporate the therapeutic provision and strategies for increasing confidence for parents and carers in the Kingston Local Offer.

Workstreams 4 and 5 are inextricably linked to Significant Concerns 1 and 2 and develop SEN systems, processes and engagement with providers so that our statutory duty for the EHCP process is robust, effective and high quality.

All six Workstreams will emphasise the importance of engagement and opportunities for parents, cares and children and people to actively contribute to SEND improvement across the Local Area. Whilst much of the SEND Transformation and Written Statement of Action focuses on children with EHCPs, the focus on supporting children receiving appropriate intervention, services and provision at SEN Support level will be addressed in detail through Workstream 5.

SEND Transformation Governance Structure



In addition to the SEND Partnership Board, governance of the WSOA is also overseen through AfC and CCG internal governance mechanisms:

Achieving for Children

Governance Mechanism	Activity	Significant Concern
Performance, Quality and Improvement Board	Monthly oversight of the written statement of action through SEN dataset and qualitative discussion across social care and health partners	1,2,3,4
AfC Senior Leadership Team	Monthly senior leadership team to focus on progress in SEN team action plan	1,2,3
AfC Workforce Board	Focus on professional development for SEN, social care and health teams	1,2
AfC Director's Board	Accountable for AfC overall performance	1,2,3,4
Parent Panel	Termly Update	1,2,3,4

Clinical Commissioning Group

Governance Mechanism	Activity	Significant Concern
Kingston Clinical Commissioning Group Governing Body	Accountable for the overall performance of KCCG and bi-monthly oversight of the written statement of action through SEN dataset and qualitative discussion across Social Care and Education partners	1,2,3,4
Kingston and Richmond Integrated Quality Governance Committees in Common	Monthly focus on the performance, quality and delivery of the written statement of action	1,2,3,4
Kingston and Richmond Finance Committees in common	Responsible for approving financial resources to support the delivery of the written statement of action.	1,2,3,4
Parent Panel	Termly update	1,2,3,4

RAG RATING KEY	
RED	The action has not yet started or there is significant delay in implementation. The action must be prioritised to bring it back on track to deliver improvement.
AMBER	The action has started but there is some delay in implementation. The action must be monitored to ensure the required improvement is delivered.
LIGHT GREEN	The action is on track to be completed by the agreed date. Evidence is required to show that the improvement has been embedded and sustained.
GREEN	The action has been completed and there is evidence that the improvement has been embedded and sustained.

Initial RAG rating		Current Month October		Direction of travel since the previous quarter
RED		RED		
AMBER		AMBER		
LIGHT GREEN		LIGHT GREEN		
DARK GREEN		DARK GREEN		
COMPLETED		COMPLETED		
TOTAL		TOTAL		

Written Statement of Action

Significant Concern 1: The overall poor quality and monitoring of Education, Health and Care plans, including contributions from health professionals

Aim of this programme of work:

Every EHC plan will be fit for purpose and fulfil statutory requirements under the 2014 Children and Families Act

KPIs / Targets for assessing overall success of the programme:

- 95% of new EHC plans completed by August 2019 in 20 week timescale, and all partners complete assessments in a timely manner
- All partners and teams are confident and competent in fulfilling statutory duties for EHC assessment and understand their responsibilities under the 2014 Children and Families Act
- Quality assurance processes for existing EHC plans includes education, health and social care and indicates plans are fit for purpose and accurately reflect a child / young person's needs and appropriate education, health and care provision
- Feedback from Parents and carers indicates confidence in the assessment process and the quality of final EHC plans
- Feedback from Education settings indicates confidence in the assessment process and the quality of final EHC plans

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/Lead	Timescale	RAG Initial	Progress update January 2019
All EHC Plans will be produced in partnership with Health, Education and Social Care and will be of high quality and impact positively on outcomes for children and young people with SEND.	<u>Training and Induction of staff</u> Revisit principles of 2014 reforms across AfC, Providers and health teams - training presentation to be shared with all teams. Cascade learning about SEND 2014 reforms. Training meeting slides revisit 2014 principles.	1. Performance for completing EHC plans within 20 week timescale improves from 69% in November 2018 to 95% by August 2019 and is maintained at that level or higher. 2. Health and social care advice for EHCPs is	Director for Education Services/Designated Clinical Officer	Workstream – Assessment and Planning Workstream - Engagement	Training completed to wider teams by 30/4/19 Designated Clinical Officer, SEN and Social care		Module 1 is being written. Dates of delivery for Module 1 have been agreed. Plan for invitations to be sent w/c 29/10/18. Each module will be delivered 3 times in 3 different

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/Lead	Timescale	RAG Initial	Progress update January 2019
	Evaluate increased knowledge, confidence and competence in post- briefing evaluation survey. Write and lead training on process, specificity, and writing high quality EHCPs for schools, health partners and social care - led by Educational Psychology Service, Designated Clinical Officer, Social Care and SEN Leaders. SEN team to work in partnership with health and social care colleagues to support confidence of all staff in understanding how to complete their EHCP contributions. EHCP Training programme written for all new case officers and health professionals based on skills audit and self-evaluation. EHCP training programme delivered to ● School SENCOs ● Therapists ● SEN team ● Social care professionals ● Health professionals	provided within the 6 week timescale – 95% by September 2019 and maintained at that higher level. 3. Increased parental confidence in EHCPs measured through feedback gained after final plan agreed: • % who felt that they were fully engaged in the assessment and writing of the plan • % who felt that the plan accurately reflected their child's education, health and social care need • % who felt that the plan would help their child make progress towards the outcomes. 4. Feedback from education setting is gained after final plan agreed by: • % who felt that the plan accurately reflected the child/young person's needs. • % who felt that the plan would make significant improvement to the children/young person's	SEN Leaders, the Principal Educational Psychologist& Director for Education Services Designated Clinical Officer		to complete more detailed training by 30/6/19		venues. These will then be evaluated and inform modules 2, 3 & 4. Date agreed for training input to Disabled Children's Team. Director for Education Services has drafted first of series of briefings for all AfC staff, first to be sent following publication of SEND Inspection Report This will be shared with public Health and CCG for broader circulation.

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/Lead	Timescale	RAG Initial	Progress update January 2019
	Education Psychology Service to write and complete 'specificity' training and deliver to all SENCOs, SEN, Educational Psychology Service and Therapists. Social care to agree content and roll out to all teams.	access to teaching, learning and progress. • % who felt that the provisions in the plan would succeed in ensuring that the child / young person reached the outcome set out in the plan. • % of young people who report that the EHC assessment process has been positive and they are happy with the final plan 5. % of AfC, and Health colleagues identify increased confidence and competence in their role and contribution to the EHC process.	AfC Intelligence team & AfC Workforce development – impact of training Designated Clinical Officer				
	Create strong induction programme for all new EHC coordinators. Embed induction skills audit and link to fortnightly training Lead fortnightly mandatory SEN team training. Social Care to include SEN training in all staff induction SEN training for 'care' assessment contributions for all	Induction skills audit in place Induction programme in place. Feedback from new appointments collected and used to inform future training 90% attendance at on-going fortnightly training. Competence and confidence scales in SEN team increase by 30%. Health Induction programme in place. Health providers	Director for Education Services & AD SEND AD Workforce Development		January 2019 – Self -evaluation finalised and shared		Initial planning meeting with Workforce Development. Meetings planned with Health providers from January 2019.

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/Lead	Timescale	RAG Initial	Progress update January 2019
	Child Protection, Referral and Assessment, CP, Independent Reviews, Leaving Care and Permanency teams. Develop an induction module for all health commissioned providers of SEND services.	training records show all new staff in relevant posts have received induction training Social care managers initial training for 'care' assessment completed.	KCCG Designated Medical Officer/ Designated Clinical Officer		April 2019		Social care managers training discussed and agreed at leadership team meeting – 14/1/19.
	Add capacity to SEN team to fulfil quality assurance activity through senior leaders, and to implement effective data system through Business Support team.	SEN structure revised and agreed with SLT and shared with team. New roles appointed in Business Support. Synergy database training completed and implemented with Intelligence team. SEN staff feel confident and competent in using Synergy database. All Synergy workflows support SEN activity.	Director for Education Services & AD SEND		May 2019 February 2019 Synergy deadline May 19 Feb 19 July 19		New posts appointed. Meeting with Systems agreed to January 2019 all team revisit Synergy basic training, followed by floor walking and individual support Business Systems Analyst / EHC Coordinator Assistants Team Leader. School input from schools and SEN team – triaged Years 5, 9 & 12 completed by December 2018.
	AfC Specialist school nurses to undertake training on using the Client information system – Care Notes to ensure care notes are regularly updated and uploaded.	Children and young people's health needs are identified in Care Notes and then reflected in the EHCP so their health needs are met. Audit indicates that 95% of care plans completed within timescale and are of good quality.	Associate Director of Health, AfC	K&R Integrated Quality Governance Committees in Common. AfC PQI Board	February 2019 June 2019		Your Healthcare providing training programme to all health staff in Integrated Service for Children with Disabilities.

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/Lead	Timescale	RAG Initial	Progress update January 2019
		Specialist School nursing staff are competent and capable to upload information on Care Notes.					
	AfC to employ a Healthcare/Administration Assistant to upload backlog of Care Plans held by specialist school nurses.	100% of Child and young people's care plans uploaded on the Care Notes system.	Associate Director of Health	K&R Integrated Quality Governance Committees in Common.	June 2019		Healthcare/admin Assistant employed and Backlog care plans currently being uploaded
Quality assurance processes are embedded and used to drive service improvement	Review and further develop quality assurance overarching framework which will enable all partners to evaluate statutory duties and the impact of EHC assessment on children and young people's outcomes. Designated Clinical Officer role established to provide strategic health leadership of SEND agenda. A key task will be to ensure that the health contribution is included in all new plans. Designated Clinical Officer to work with Director for Education Services to agree content and roll out following evaluation from quality assurance process and next steps, using wide group of health professionals based on issues	Current quality assurance model updated and in place in partnership with Health and Social care. 50% audited plans containing health information of the required standard set out in the quality assurance framework by June 2019 and 70% by September 2019. 95% of audited plans containing social care information of the required standard by September 2019. New staff structure in place across AfC and KCCG so that quality assurance process is embedded.	KCCG Director of Quality Designated Clinical Officer Associate Director for Referral and Assessment Director for Education Services		2019 Once appointed – April 2019 Ongoing and once quality assurance agreed in March 2019		Programme of quality assurance agreed across SEN and school seconded staff. Initial discussions held with the Council for Disabled Children and agreed that local area will receive the support in developing its approach to quality assurance.

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/Lead	Timescale	RAG Initial	Progress update January 2019
	identified in quality assurance process.	Findings from quality assurance feed into fortnightly staff training and ongoing CPD.					
	Local Area quality assurance of existing EHCPs	Monthly reports highlighting key lessons/areas for improvement for managers, the Health SEND Panel, Performance Quality and Innovation Board and SEND Transformation Board. KCCG Executive Management Team and Integrated Governance Committee.	Designated Medical Officer Designated Clinical Officer Director of Children's Social Care Head of SEN Service	CCG Executive Management Team. AfC SLT and PQI Performance Board K&R Integrated Quality Governance Committees in Common			
	Ensure implementation of the revised process to obtain health (AfC Therapies, HV and SN) input into EHCPs.	Health advice is provided in a timely manner that achieves the 6 week timescale.	Designated Medical Officer	K&R Integrated Quality Governance Committees in Common.			The revised process for obtaining advice was developed in November 2018. The revised questionnaire was implemented from December 2018. The revised health form is now included as part of the EHCP application process as well as incorporated into the annual review form

Significant concern 2: The timeliness of leaders in ensuring that the annual review process and any subsequent amendments to EHC plans are consistently made in line with the SEN code of practice

Aim of this programme of work:

Annual reviews and subsequent amendments for EHC plans will be completed effectively and in line with the statutory duties of the 2014 Children and Families Act

KPIs / Targets for assessing overall success of the programme:

- Annual reviews completed in required timescale
- All partners understand their responsibilities for the annual review process and are confident and competent to complete the process
- Subsequent amendments made and final, revised EHC plans are completed within timescale
- The annual review process is used to evaluate the impact of the EHC plan on children and young people's progress towards agreed outcomes

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/lead	Timescale	RAG Initial	Progress update January 2019
Annual reviews and subsequent amendments are completed within statutory timescale	Synergy upgraded to support overview of annual review process, numbers and dates. Use this to triage all annual reviews and establish model for prioritising to include independent and out of borough schools.	Data will provide intelligence to enhance effectiveness and timeliness of annual reviews.	Director for Education Services	Head of Intelligence, AfC SEND Partnership Board	Spring term 2019		
	Initial priority for years 5, 9 and 11 to be completed by Annual Review officers and KS2/3 Transition Teacher. Expand to other year group using same process of triage and then activity Y7, 8	All annual reviews completed and Plans amended for Y5/9/12. All annual reviews have been completed and where appropriate EHC Plans amended within statutory timescale	Director for Education Services & AD SEND	SEND dataset PQI Board	Triaged by January 2019 Actions completed by March 2019		Triage completed, all plans have been RAG rated and actions now prioritized

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/lead	Timescale	RAG Initial	Progress update January 2019
	Y2, 3 Y4, 11	By September 75% By January 2010 – 95%					
	Develop and lead annual review training for school SENCOs, SEN Team and health / social care partners. Evaluate impact on confidence and competence of school colleagues.	Annual review training programme agreed and in place. Summer 2019 evaluation identify increased confidence.	SEN Team, Educational Psychology Team	Workforce Board – Workstream Process	Programme to run from November 2018 - June 2019		Training session 1 completed November 2018
	Establish evaluation model for annual reviews to assess impact of provision on children and young people's outcomes.	Evaluation indicates increased confidence, knowledge of annual review process. Of those randomly audited 80% of plans meet the standards set out in the quality assurance framework for reviews. Quality assurance sample identifies impact on outcomes for children and young people and review the health and social care provision made for the child or young person and its effectiveness in ensuring good progress towards outcomes.	AfC and CQC to agree model for evaluating impact and checking statutory process.	SLT AfC PQI Board	February 2019		
	Produce feedback model for 'post annual review' to gather views of children, young people and parents and education settings.	Feedback model in place 70% positive feedback from parents who feel that they have been fully and engaged and listened to Education settings giving feedback state that the		RBK Transformation Board	September 2019		

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum/lead	Timescale	RAG Initial	Progress update January 2019
		review has been helpful in ensuring access to learning and that is has impacted positively on pupil outcomes.					
	Evaluate impact of 2 new annual review officer roles and use to inform potential growth bid for additional posts.	Number of annual reviews attended impact measures.		RBK Transformation Board	October 2019 January 2020		System devised to assess numbers attended and impact
	Improve the timeliness and quality of health advice for the Annual Review process.	95% of audited annual reviews demonstrate health advice has been reviewed, amended and updated as appropriate in line with the SEN Code Of Practice.	Designated Clinical Officer	K&R Integrated Quality Governance Committees in Common.	January 2020		

Significant Concern 3 - The strategic leadership and monitoring of the CCG's work in implementing the 2014 reforms

Aim of this programme of work:

To ensure the CCG effectively discharges its responsibilities under the Children and Family Act and demonstrates its contribution to improving outcomes for children and young people with SEND

KPIs / Targets for assessing overall success of the programme:

- Improvements in the quality health information of the health sections of EHCPs (see KPI for the EHCP section of the WSoA
- Reductions in waiting times for therapy services
- Increases in the number of children and young people accessing therapy services through a reduced threshold
- Feedback from stakeholders on the accessibility and timeliness of health support
- Increased use of personal health budgets
- Compliance with the NICE neurodevelopmental pathway and a reduction in waiting times for diagnostic services
- Improved access to equipment

Significant Concern 3 - The strategic leadership and monitoring of the CCG's work in implementing the 2014 reforms

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
There will be effective strategic leadership and oversight of the health implementation and ongoing delivery of the SEND reforms by the CCG Governing Body	Agree and appoint the Governing Body SEND Executive to be accountable for the SEND reforms	CCG SEND Executive appointed and ensures regular bi-monthly reports are provided to the KCCG Governing Body on progress of compliance with SEND Statutory responsibilities	KCCG Managing Director	KCCG Governing Body RBK Transformation Board	January 20 19 Bi-monthly thereafter		Role specification in the process of being finalised.
	KCCG Governing Body to agree a formal statement of commitment to improving outcomes for children and young people with SEND	Formal statement agreed and used to drive SEND service improvement and delivery	KCCG Managing Director	KCCG Governing Body	January 2019		The formal statement of commitment to improving outcomes for children and young people with SEND was agreed at the January 2019 KCCG

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
							Governing Body meeting
	KCCG Governing Body to agree internal governance arrangements to ensure strategic oversight and operational delivery of SEND reforms	Governance framework established evidencing standing SEND agenda item with the governance committee structure	KCCG Managing Director	KCCG Governing Body	March 2019		
	The Kingston CCG to receive regular progress reports on the SEND Written Statement of Action, the SEND Transformation programme and KCCG health specific SEND progress reports	Agreed SEND partnership framework for monitoring delivery of the SEND WSoA and for oversight of service delivery • CCG performance review framework/dashboard based on balanced score card developed • Agreed improvement in partnership trajectories for the provision of Health advice, annual reviews and EHCPs completed within the 6 week timescale by June 2019 • Evidence from feedback from quality assurance audits have led to service improvements by September 2019 • Increased parental confidence in EHCPs needs assessment and annual review processes by September 2019 • Improvement in the knowledge and skills of health professionals about delivering the SEND reforms and service offers	KCCG Managing Director	RBK Transformation Board KCCG Governing Body K&R Integrated Quality Governance Committees in Common	March 2019 Bi-monthly thereafter		January 2019 KCCG Governing Body received SEND report on progress with drafting the WSoA. First progress update report will be discussed at March KCCG Governing Body meeting

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
		• Improved access to therapy services by April 2020 • Examples of positive engagement activity with parent/carers and children and young people					
	Arrange a KCCG Governing Body seminar on the SEND reforms	CCG Governing body members attending the seminar report improved understanding of their SEND strategic leadership responsibilities	Director of Commissioning, KCCG	KCCG Governing Body	March 2019		Provisional date for seminar agreed
	CCG SEND Annual Report to be received by KCCG Governing Body	CCG SEND Annual Report produced and evidences short improvements in delivering the SEND agenda	CCG SEND Executive Governing Body/Designated Clinical Officer	KCCG Governing Body	July 2019		Annual report format in the process of being finalised
Improved quality, effectiveness and performance of SEND Health services that ensure local and national performance targets are met							Funding approved for increase in Designated Medical Officer sessions at December 2018 K&R Finance Committees in Common. Designated Medical Officer providing increased sessions from January 2019
	Increase the number of weekly Designated Medical Officer sessions from one to two	Increased capacity to fulfil DMO SEND strategic responsibilities	Director of Quality KCCG	K&R Integrated Quality Governance Committees in Common			
	DMO to undertake joint working with the Designated Clinical officer	Oversight and quality assurance evidences health services input into EHCPs and annual reviews are of good quality	Director of Quality		January 2019		
	Establish regular meeting between CCG SEND Executive lead, Designated Clinical Officer, Designated Medical Officer and Lead Children's Health Commissioner	KCCG has strategic/operational assurance and oversight of the implementation of the SEND reforms			April 2019		

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
	Implementing a Peer Support Programme that includes • Joint working between Kingston and Richmond Designated Medical Officers • South West London Peer support network • Access to the Council for Disabled Children's on line network • Participation in the Designated Medical Officer/Designated Clinical Officer London Forum	Four Peer reviews completed with South West London CCGs	Designated Clinical Officer		October 2020		
	Support the training and development of the Designated Medical Officer and Designated Clinical Officer	Training and development needs of the Designated Medical Officer and Designated Clinical identified as part of the annual appraisal cycle	Director of Quality		May 2019		
	Appoint a Designated Clinical Officer (DCO) 1wte post to provide overarching leadership across both Kingston and Richmond CCGs to ensure delivery of the SEND reforms	Substantive DCO in place reporting to the Director of Quality to ensure strategic and operational implementation of the SEND reforms 0-25 years.	Director of Quality	K&R Integrated Quality Governance Committees in Common	April 2019		Funding approved for 1.0wte DCO to work across Kingston and Richmond CCGs at Dec 18 K&R Finance Committees in Common. Agreed DCO to report to the Director of Quality. Job Description completed. Recruitment Commenced.

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
	DCO to lead the quality assurance of the health contribution of all new plans and annual reviews	Oversight and quality assurance evidences health services input into EHCPs and annual reviews are of good quality 50% audited plans containing health information of the required standard set out in the quality assurance framework by June 2019 and 70% by September 2019	Director of Quality Designated Clinical Officer		September 2019		
		Increased parental confidence in EHCPs measured through feedback gained after final plan agreed: %ge who felt that the plan accurately reflected their child's health care needs					
		Feedback from key health professionals gained after final plan agreed by • %ge who felt that the plan accurately reflected the child/young person's health needs • %ge who felt that the health provisions in the plan would succeed in ensuring that the child / young person reached the outcome set out in the plan	Designated Clinical Officer				
	Develop tracking systems to ensure consistent monitoring and delivery of health advice for the EHC Needs assessment and annual review processes	• Health advice for EHCPs is provided within the 6 week timescale – 95% by September 2019 and maintained at that higher level. • Health advice is provided for	Designated Clinical Officer		June 2019		

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
		annual reviews within statutory timescales					
	Undertake tracking, analysis and monitoring of children and young people on SEN Support	• Evidence of plans to address the needs and outcomes of CYP on SEN support • Recommendations from analysis of SEN support plans informs KCCG SEND 2020/21 Commissioning intentions	Designated Clinical Officer/Lead Children's Health Commissioner		September 2019		
	Undertake regular audits of health professionals' knowledge, confidence and competence on implementing the SEND reforms	%ge of Health colleagues identify increased confidence and competence in their role and contribution to the EHC process	Designated Clinical Officer		Programme of audits to commence from June2019		
	Provide advice and support to professionals across Health, Education, Social care, parents and carers	% of schools, education, health, social care, professionals including parents and carers expressing positive feedback about the support provided by the Designated Medical Officer and Designated Clinical Officer By July 2019 - 50% By December 2019 - 75% By March 2020 - 95%	Designated Clinical Officer/Designated Medical Officer		From January 2019		Designated Medical Officer is now able to provide advice to professionals following increase in sessions
	Undertake a review of the health transition pathway to adult health services	Health transition pathway reviewed and improvement recommendations identified and implemented % stepped improvement of young people, parents and carers reporting a positive experience of transition to adult health services	Designated Clinical Officer		November 2019		

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
		to be based on an agreed partnership baseline					
	Establish a SWL Designated Medical Officer/Designated Clinical Officer network to develop peer review, provide benchmarking opportunities and share good practice	Benchmarking data informs service improvement supported by operational plan. Local benchmarking is informed by strategies, information and support from the London DCO/DMO forum Peer Challenge reviews are used to inform learning and improve local decision making.	Director of Quality Designated Clinical Officer Designated Medical Officer/ Designated Clinical Officer	K&R Integrated Quality Governance Committees in Common	July 2019 October 2020		. First meeting of the benchmarking network being planned for June 2019
	Refresh the Council for Disabled Children SEND self-evaluation Audit tool	Risk areas identified for the CCG and co-designed improvement plan developed with parents/carers	Director of Quality Designated Clinical officer	K&R Integrated Quality Governance Committees in Common	January 2020		Previous CDC audit currently being reviewed
Health commissioned services demonstrate improved outcomes for children, young people with SEND and compliance with reforms	Utilise the Joint Strategic Needs Assessment to ensure that data informs commissioning and service specifications	JSNA informs the 2020/21 Commissioning intentions for SEND service	Consultant in Public Health/Director of Commissioning	K&R Integrated Quality Governance Committees in Common/K&R Finance Committees in Common	January to March 2019		A refresh of the Kingston SEND JSNA was published in 2018
	Establish regular SEND Provider Forum led by the DCO to ensure SEND reforms are fully embedded in all health SEND provider services	Provider Forum established with 100% representation from SEND providers resulting in driving service improvement	Designated Clinical Officer	K&R Integrated Quality Governance	From May 2019		

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
		95% of provider health inputs into EHCP's are quality assured prior to receipt by the SEN team % parent/carers and children report that SEND services responsive to meeting needs of CYP with SEND Effective CCG oversight of SEND services.		Committees in Common			
	Review CCG SEND commissioned service specifications and provider contracts to ensure internal quality assurance processes and pathway in place to meet statutory requirements of EHC needs assessments	Named SEND leads identified in all SEND provider contracts 100% SEND Provider contracts include a EHCP quality assurance pathway 100% SEND provider contracts to include SEND KPIs including the provision of monthly tracking information of EHCP requests	Director of Commissioning Children's Lead Commissioner	K&R Integrated Quality Governance Committees in Common	April 2019		Timetable of service specifications developed and programme of service specification reviews due to commence Designated Medical Officer draft service specification completed
	Review and update the joint commissioning arrangements for SEND Section 75 Agreement with the Royal Borough of Kingston Upon Thames	• Section 75 updated and includes documented agreement of the SEND Joint commissioning agreements including Service Specifications • Service monitoring provides assurance and evidence of improved outcomes	Director of Commissioning	K&R Integrated Quality Governance Committees in Common	January to March 2019		

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
		• SEND providers are held to account through quarterly contract monitoring meetings					
Commissioning budgets are used more effectively to improve service access and reduce waiting times thereby improving user experience	Consider the findings from the Children's therapy services review (SALT, Occupational Therapy and Physiotherapy) across Health and Education to inform the CCGs and Councils' commissioning of SEND therapy services	Children's therapy services plan developed and agreed by all partners to inform 2020/21 commissioning intentions	Director of Commissioning/AfC	K&R Integrated Quality Governance Committees in CommonK&R Finance Committees in Common	September 2019		A meeting took place between the CCG Managing Director, AFC CE and Director of Children Services to discuss and agree next steps regarding
	SEND Transformation Commissioning workstream to establish project to: • Consider the findings of review of therapy services • Undertake review of best practice service models • Complete demand and capacity modelling • Therapy thresholds • Reviewed and refresh where appropriate • Co-design service improvement and required outcomes with parent/carers, Children and young people • Business Case developed • Approval of Business Case by KCCG and Kingston Council • Commission re-design services	A new therapies service offer agreed by September 2019 Planned reduction in existing waiting times for therapy services in line with agreed trajectory following agreed outcomes of service review		RBK Transformation Board			

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
	• Additional therapists recruited to support waiting • Waiting times monitored at contract monitoring meetings						
	Co-design and co- deliver a workshop to review and improve the 0-5 neuro-development pathway with parents, carers, children, young people and key professionals	75% of attendees at the co-design workshop report positive engagement and involvement NICE compliant pathway in place by January 2020 • Assessment and diagnostic waiting time is reduced in line with the agreed trajectory • 75% families report that they are able to access pre and post diagnostic information and support at the right time • X% increase in families reporting satisfaction with the revised neuro-development pathway • Revised Service specification developed and implemented by April 2020	Director of Commissioning	K&R Integrated Quality Governance Committees in Common	March 2019		Fast track assessment process developed by DMO
	Improve the uptake of personal health budgets (PHB)	% increase in the numbers of personal health budgets agreed for families in receipt of Continuing Health Care packages	Director of Quality Designated Clinical Officer	K&R Integrated Quality Governance Committees in Common	March 2020		Currently implementing actions to increase uptake of PHBs
Primary Care is responsive to the needs of children and young people	Discuss outcomes of the SEND Inspection at Council of Members meeting in February 2019	Primary care GPs are aware of the CCG SEND strategic leadership responsibilities	Lead Children's Health Commissioner	KCCG Governing Body	February 2019		

Outcome	Actions	Success measure(s)	Lead Officer	Governance Forum	Timescale	RAG Initial	Progress update
with SEND	Organise CCG Council of Members seminar/learning events on SEND reforms to include clarification of roles and responsibilities	Feedback reports evidence GPs understanding of SEND responsibilities	KCCG Managing Director	KCCG Governing Body	April 2019		
	Organise quarterly primary care feedback on SEND issues through CCG communication channels	Feedback reports evidence GPs understanding and implementation of SEND responsibilities	Director of Primary Care	KCCG Governing Body	April, July, October 2019, January 2020 ongoing		
	Undertake mapping survey of Kingston GPs to collate primary care SEND issues	80% response rate to mapping exercise from GP practices to inform commissioning of SEND services	Director of Primary Care/ CCG SEND Executive Governing Body	K&R Integrated Quality Governance Committees in Common	May 2019		

Significant Concern 4: To ensure that there is a productive and positive relationship between parents and parent representatives, including a parent carer forum.

Aim of this programme of work:
To develop effective and proactive partnerships with parents, parent representatives and a Parent Carer Forum that facilitates effective engagement and co-production in the implementation and embedding of the SEND reforms.

KPIs / Targets for assessing overall success of the programme:

- Feedback on EHCP and EHCP reviews (which overlap with the success measures in sections 1&2 of the WSoA e.g. % of parents who were satisfied with their level of engagement in preparing the EHCPs and feel their views were taken into account)
- Feedback from parents of children and young people receiving SEND support e.g. % parents who were satisfied with level of engagement in preparing the APDR cycle and felt their views were taken into account
- Feedback on the quality of service provision (which overlap with success measures in section 3 on health services)
- % of parents who feel the information, support and advice they receive helps them to participate in the assessment of their child's need and the planning of provision to meet these needs
- Number of service developments and processes each year that have been co-produced with parents
- Number of service improvements that have been made as a result of parental feedback and suggestions each year
- Number of parents from under-represented groups who give feedback and are engaged in the development of services

Outcome	Actions	Success Measure(s)	Lead Officer	Timescale	RAG Initial	Progress update
There will be a productive and positive relationship between the local authority and CCG and parents/ carers and parents representatives, including a parent/ carer forum	Positively engage with parents and their representatives to scope and develop a local model which facilitates effective engagement in co-production and developments. Set up 'drop in' sessions for parents and carers to meet senior leaders. Develop wider models to seek views of parents and carers through a variety of activities	Feedback from parents and their representatives will be mostly positive, with examples of good co-production and engagement activities. % of parents of children and young people receiving SEND support are satisfied with their level of engagement in the ADPR cycle.	Lead Children's Health Commissioner and Director for Education Services AfC Business Support	February 2019 March 2019 From February 2019		Initial meeting booked with 'Contact A Family' for November 2018

Outcome	Actions	Success Measure(s)	Lead Officer	Timescale	RAG Initial	Progress update
	which includes a parent panel, ongoing feedback, and a parent carer forum. Develop effective and proactive partnership with SENDIASS through monthly meetings, use of quarterly feedback to inform service improvement. Establish consistent approach and model for collecting regular feedback across all partners for all parental engagement activities e.g. transition meetings, coffee mornings.	% of parents who feel the information, support and advice they receive helps them to participate in the assessment of their child's needs and the planning of provision to meet these needs. Co-production will result in 8 activities across the year which are examples of services and activities developing to meet the needs of children and young people. 80% of parents attending drop-in sessions report that they have been positive and informative. Number of parents from under-represented groups e.g. Tamil and Korean who give feedback and ae engaged in the development of services.	SENDIASS SEN Service Manager SEN Leaders/KCCG	April 2019 Evaluation ongoing – review improvement January 2020		
The local offer will provide an accurate and up to date description of the available health services that include clear referral and access information.	Review and refresh the health information on the local offer website Work with Public Health to include health visiting and school nursing	Stakeholder reference group established including parents/carers/CYP Increased 'hits' to the health section of the Local Offer pre and post improvements	Lead Childrens Health Commissioner KCCG Patient and Public Engagement Team	April to May 2019		Terms of Reference and membership of the group yet to be established**.**

Outcome	Actions	Success Measure(s)	Lead Officer	Timescale	RAG Initial	Progress update
	Develop a model for parental engagement and co-production that applies for Policy and service development e.g. service reviews and design, commissioning. Individual levels for parents about EHC process and review and transition activities Enhance opportunities for participation e.g. drop-in sessions,	Increased attendance and activity – 75% of SEN and commissioning activity involves parents	AD SEND SEN Service Manager Lead Childrens Health Commissioner KCCG Patient and Public Engagement Team	April 2019		**Initial meeting with parents took place in January 2019**
Increased opportunities for parents and carers to participate and give feedback on provision to inform future activity and development of services	SEN evaluate and update current models of seeking feedback and enhance opportunities for parents to give feedback on quality of services they receive • Post initial EHCP assessment • Transition meetings and information sessions • Early intervention activity e.g. SCIP, Earlybird • SEN support – school to support consultation at Parent's Evening • Specific activities to engage under-represented groups – use children's centres and education settings, NHS SWL Grass roots engagement programme	80% of parents attending SEN meetings feedback that it has been informative and helpful Number of families from under-represented groups who give feedback and are engaged in the development of the Service	SEN Manager Director of Education Services Participation team KCCG Patient and Public Engagement Team	September 2019		
Establish a new Parent Carer Forum for Kingston	• Work with Contact to explore all local options for new Parent Carer Forum • Contact to lead local drop in sessions to gauge interest	New Parent Carer Forum established with clear terms of reference and working protocol which works alongside Parent	Contact A Family AfC KCCG	June 2019		

Outcome	Actions	Success Measure(s)	Lead Officer	Timescale	RAG Initial	Progress update
	• Set up Parent Panel in first instance to work alongside the SEND Partnership Board • Work with Education Settings to identify new families who could be interested and keen to be involved	Panel and other engagement activity				

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	Dementia Diagnosis Action Plan		
Lead Director (Name and Role)	Julia Travers, Director of Commissioning		
Clinical Sponsor (Name and Role)	Dr Phil Moore, Chair (Clinical)		
Author(s) (Name and Role)	Rachel Rowan, Mental Health Commissioner Dr Nerida Burnie, Dementia Lead and Kingston GP		
Agenda Item No.	2.3	**Attachment No.**	F

Purpose (Tick as Required)	Approve	Discuss	Note
			✓

Executive Summary

A presentation on the CCG's performance against the national dementia diagnosis standard was made at the January governing body meeting which highlighted that the CCG was not achieving the standard of 66.7%.

CCGs are expected to encourage timely diagnosis of patients with dementia. To this end, the dementia diagnosis standard was introduced, and is monitored by NHS England. The measure calculates the dementia diagnosis rate by using the number of people aged 65 and over with a diagnosis of dementia recorded within GP practice systems, over the estimated number of people aged 65 and over expected to have dementia in the population.

The governing body requested a recovery action plan be produced for their consideration.

Background

The rate of diagnosis for dementia within Kingston CCG at 31st January 2018 has risen to 64.7% against the national target of 66.7%. The rate of people diagnosed with dementia has increased for the last three months, most notably between December 2018 and January 2019, which has shown a rise of 2.2%.

The CCG has had an action plan in place to support achievement of the 66.7% target within 2018/19, incorporating the following actions:

• A dementia specialist nurse has been employed to visit the lowest performing practices initially and assess patients that have been identified with cognitive impairment to be included on the registers. They will then move on to support other practices that require support. The dementia specialist nurse is working with the memory assessment service (MAS) and has agreed a standard set of tools and templates with which to conduct the dementia screening reviews to ensure it dovetails with the MAS processes.

• A dedicated clinician is assessing the cognition of patients in nursing homes and will notify their GP of the diagnosis if found to have dementia.

Following a presentation regarding the level of dementia diagnosis rates to the January 2019 governing body a revised action plan was requested - attached Appendix 1.

The revised action plan once agreed will be monitored through the integrated quality and governance committee.

Purpose
To provide an update on dementia diagnosis performance and receive the revised action plan to improve performance of the dementia standard against the targeted level.

Reason for Committee Review

To make the governing body aware of the ongoing and additional actions related to delivering the dementia diagnosis standard.

Key Issues:

1. As of January 2018, the diagnosis rate in Kingston is 64.7%. This is an improvement of 2.2%.
2. Kingston CCG is in the minority of CCGs that are not achieving the standard.
3. The rate of nursing home beds and the proportions of people that are expected to have dementia are not outliers within Kingston, compared to South West London and the England average.
4. Kingston CCG meets with NHS England regularly for support to increase the proportion of people diagnosed with dementia.
5. The CCG has had an action plan in place with dedicated resources supporting its implementation

Conflicts of Interest:
None

Mitigations:
None

Recommendation:

The Committee is asked to consider the action plan

Corporate Objectives This document will impact on the following CCG Objectives:	Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care

Risks This document links to the following CCG risks:	There is a risk of failing to meet some of the national performance targets, based on previous performance
Mitigations Actions taken to reduce any risks identified:	The performance is monitored monthly, and reported to the Kingston CCG Integrated Governance Committee and to the governing body

Financial/Resource/ QIPP Implications	There may be a financial implication relating to some recovery actions.

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A

Patient and Public Engagement and Communication	N/A

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	Integrated Governance Committee	Tuesday, 16 October 2018	The Report was noted.
	Integrated Governance Committee	Tuesday, 18 December 2018	The Report was noted.
	Kingston Governing Body Meeting	Monday, 07 January 2019	A recovery action plan requested

Supporting Documents	Action Plan

Appendix 1.

DEMENTIA ACTION PLAN		
Area of work	**Actions in progress/to be implemented**	**Implementation**
Practice-Based Active Case Finding Work	**Provide additional support into practices to support the proactive and on-going identification of patients** • At risk groups (diabetics, smokers, history of CVA), • house bound patients, • those not seen for 18 + months	Additional support to practices - 1st April 2019
	Memory Nurse to work with practices and undertake assessments of identified patients specifically • follow up assessments of MCI clients, • follow up DNAs • those identified from practice-based case finding, • community referrals	
Targeted Active Case Finding Work	**Care Homes** Practices to work with care homes in the identification and assessment of residents.	1st April 2019
	Your Healthcare CIC Establish robust pathways from Community health services i.e. via impact team, rapid response team, district nursing service for referral, assessment and support into pre- assessment and memory services	18th March - 6th April 19
	Kingston Hospital Trust Build on the existing work with KHT to include • identification of patients at discharge with dementia /MCI who require follow up by practices, • identification of patients suitable for direct referral from the hospital geriatricians to the Memory Assessment Service • review of care for patients with Parkinson's disease and how dementia in Parkinson's is identified and managed, • explore whether Alzheimer's Society worker at KHT could support pre-assessment counselling for those diagnosed with cognitive impairment during admission, • employment of Neuropsychologist within the stroke service	On-going

	Awareness Raising with Targeted Populations • Work with Senior Community Development Coordinator in RBK to explore approaches for connecting with Kingston Community groups e.g. Korean Community. • Liaise with voluntary sector e.g. Refugee Action Kingston and community groups to run dementia awareness sessions to the groups.	Quarter 1 of 19/20
Support from Local Dementia Organisations	Work with local voluntary organisations e.g. Staywell & Alzheimer's Society to develop and deliver support services to including • pre-dementia assessment counselling, • dementia awareness support • training to practices	Quarter 1 of 19/20
Complete Joint procurement with RBK to Secure Dementia Support Services	Dementia Support Services are being re-procured by the CCG and RBK for commencement from 1st June 19 to • Support adults with dementia (and their carers) to receive the services and advice that will allow them to live well with dementia in their own homes for as long as they choose. • Support adults during dementia assessment in the form of pre-assessment counselling, advice and support. • Work with Kingston practices to improve dementia diagnosis. • Work with agencies in ensuring adults with dementia receive a seamless service along the dementia care pathway. • Progress work on Dementia Friendly Kingston	1st June 19
Ongoing Liaison with the Memory Assessment Service	**Memory Assessment Service** • MAS consultant attends CCG dementia meetings. • On-going liaison with MAS to monitor pathway processes. • Build relationships between MAS and practices by MAS consultant running sessions at the GP educational event (1st session planned for Jun 19). • On-going review and monitoring of the CT scanning pathway to ensure there are no delays within pathway. • Ongoing review of accuracy of MAS diagnosis list against practices dementia registers	On-going

Kingston Clinical Commissioning Group Governing Body Meeting in Public	
Date	Tuesday, 05 March 2019

Document Title	Integrated Quality Governance Committee Report		
Lead Director (Name and Role)	Fergus Keegan, Local Director of Quality		
Clinical Sponsor (Name and Role)	Dr Phil Moore, Governing Body, Deputy Chair		
Author(s) (Name and Role)	Brian Roberts, Performance and Information Lead		
Agenda Item No.	2.4	**Attachment No.**	G

Purpose (Tick as Required)	Approve	Discuss	Note
		✓	✓

Executive Summary:

This report includes the South West London performance report and feedback from the 22nd January and the 19th February 2019 meetings of the Kingston CCG Integrated Quality Governance Committee (IQGC). It contains a summary of the:

- Latest Performance Assurance Report, including the position against plan for the 2018-19 Operating Plan supporting activity metrics
- Latest Improvement and Assessment (IAF) Dashboard
- Latest Quality Premium Dashboard

South West London (SWL) Performance Highlight Report (at Month 7):

The month 7 report includes the performance against the key indicators for all six SWL CCGs. Highlighted Constitutional Standards for Kingston CCG:

A&E – All type performance at Kingston Hospital	**91.88%**
18-week referral to treatment	**93.03%**
Diagnostic waits over 6 weeks	**99.55%**
Cancer 2 week waits	**98.85%**
Cancer 62 day waits	**96.88%**
IAPT Access Rate (3 month rolling)	**4.87%**

Background:

The recently formed IQGC meets monthly to scrutinise and assure the performance of the CCG, and to support the quality of services provided to the registered population of Kingston. The report attached summarises this position.

Purpose:

To describe the position, risks and concerns for key NHS targets, constitutional standards and other areas of performance for Kingston CCG. To assure areas of quality.

Reason for Governing Body Review:

For the governing body to note the performance of Kingston CCG, and actions to maintain or improve performance.

Key Issues:

The key points in the report that the governing body needs to be made aware of are as follows:

- Accident & Emergency waiting time performance at Kingston Hospital has improved throughout 2018-19 compared to 2017-18, but has yet to reach the 95% standard.
- Mental Health Improving Access to Psychological Therapies performance for access and recovery remain above target for April – December 2018.
- Dementia diagnosis rates remain challenging for Kingston CCG, although have seen an improvement in January 2019.
- All Referral to Treatment (18 Weeks) and diagnostics targets are being met.
- All activity performance is within the 2018-19 Operating Plan expectations.

Conflicts of Interest:
There are no elements of the paper that could lead to potential conflicts of interest.

Mitigations:
Not applicable.

Recommendation:
The governing body is asked to discuss and note the report.

Corporate Objectives This document will impact on the following CCG Objectives:	2. Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care 3. Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities 4. Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership, and effective membership & staff engagement

Risks This document links to the following CCG risks:	921 There is a risk of failing to meet some of the national performance targets, based on previous performance.

Mitigations Actions taken to reduce any risks identified:	There are actions relating to the improvement of the A&E standard and preparation for winter through the Kingston, Richmond & Surrey Downs (East Elmbridge) Local A&E Delivery Board. There is a programme of work to recover the dementia standard in Kingston.

Financial/Resource/ QIPP Implications	There is a financial implication related to the 2018-19 quality premium and any activity required to reduce the RTT PTL.

Has an Equality Impact Assessment (EIA) been completed?	Not applicable.
Are there any known implications for equalities? If so, what are the mitigations?	Not applicable.

Patient and Public Engagement and Communication	Not applicable.

	Committee/Group Name:	Date Discussed:	Outcome:
Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Kingston Integrated Governance Committee	Tuesday, 18 December 2018	The report was received and noted.
	Integrated Quality Governance Committee	Tuesday, 22 January 2019	The report was received and noted.
	Integrated Quality Governance Committee	Tuesday, 19 February 2019	The report was received and noted.

Supporting Documents	Detailed below.

Introduction

This report highlights issues from the Integrated Quality Governance Committee meeting held on 19th February 2019.

1a. Integrated Performance Report

NHS England monitors performance of CCGs against the following constitutional Standards:

1. Dementia Diagnosis Rate
2. Referral to Treatment (18 Weeks) and Diagnostics
3. Access to Cancer Services
4. Mixed Sex Accommodation breaches
5. Mental Health/ Improving access to Psychological Therapies (IAPT)
6. Health Outcome Frameworks (MRSA and C Difficile Breaches)
7. Urgent Care (A&E and Ambulance Response Times)
8. Cancelled Operations
9. Health Visitor Numbers
10. Winterbourne View

The scorecard overleaf shows performance against these targets except for:

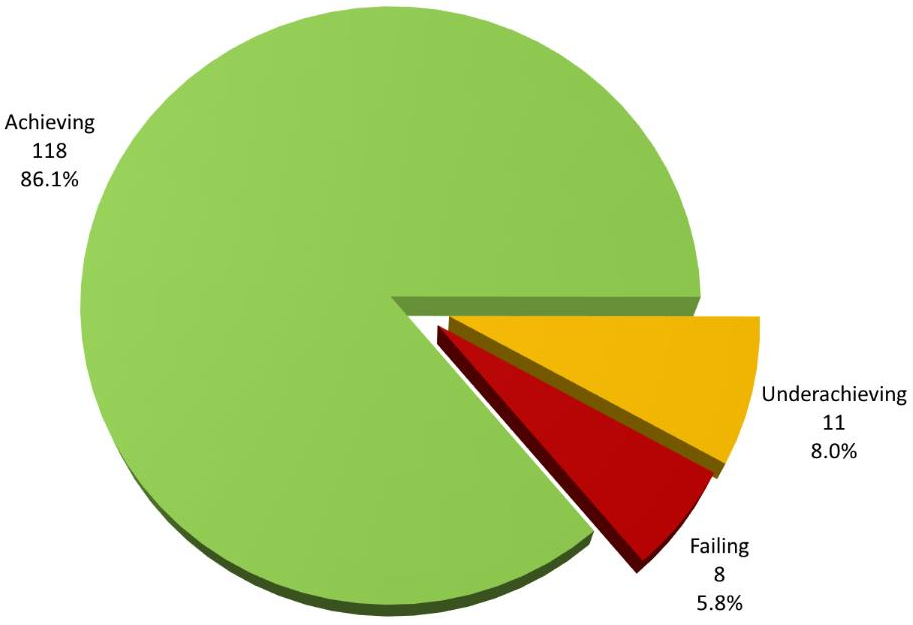
- Health Visitor numbers – this is the responsibility of Public Health and
- Winterbourne, which is monitored on a STP footprint

A full scorecard, showing all the standards and CCG outcomes framework measures is available upon request. The full scorecard includes the following:

- CCG outcomes framework (includes diabetic structured education and the friends and family test)
- Local contract measures (includes South West London and St George's and Your Healthcare)
- Financial measures (includes QIPP, and financial spend against plan)
- Organisational indicators (includes freedom of information requests, and sickness absence rate)

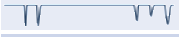
Financial measures are included within the finance report. Measures relating to the CCG outcomes framework and other local standards and contractual measures are due to be discussed at the Integrated Quality Governance Committee.

As at 15th February 2019 Kingston CCG was showing an overall position of achieving 118 (86.1%) of the indicators in the areas listed above:



NHS Kingston Clinical Commissioning Group

Performance against Constitutional and Local Standards

Indicator	Reporting Frequency	Latest Actual	Latest target	YTD Actual	YTD Target	Period	Trend/ Direction
Constitutional Standards							
Dementia Diagnosis Rate							
Estimated diagnosis rate for people with dementia (NHS OF 2.6i)	Monthly	64.7%	66.7%	64.7%	66.7%	Jan-19	
Referral to Treatment (18 Weeks) and Diagnostics							
RTT 18 weeks incomplete pathways	Monthly	93.3%	92.0%	93.3%	92.0%	Dec-18	
Number of 52 week Referral to Treatment Pathways: incomplete pathways	Monthly	0.00%	0.05%	0.02%	0.05%	Dec-18	
Diagnostic tests waiting less than 6 weeks	Monthly	99.5%	99.0%	99.4%	99.0%	Dec-18	
Access to Cancer Services							
Cancer 1st treatment 62 days: GP Urgent Referral	Monthly	100.0%	85.0%	94.7%	85.0%	Dec-18	
Cancer 1st treatment 62 days: Screening Referral	Monthly	88.9%	90.0%	97.2%	90.0%	Dec-18	
Cancer 1st treatment 62 days: Consultant upgrade	Monthly	100.0%	75.0%	97.8%	75.0%	Dec-18	
Cancer 1st treatment 31 days	Monthly	100.0%	96.0%	99.3%	96.0%	Dec-18	
Cancer subsequent treatment within 31 days for surgery	Monthly	100.0%	94.0%	100.0%	94.0%	Dec-18	
Cancer subsequent treatment within 31 days for cancer drugs	Monthly	100.0%	98.0%	98.9%	98.0%	Dec-18	
Cancer subsequent treatment within 31 days for radiotherapy	Monthly	94.4%	94.0%	97.01%	94.0%	Dec-18	
All cancer 2 week waits	Monthly	98.0%	93.0%	98.5%	93.0%	Dec-18	
Cancer 2 week for breast symptoms (cancer not initially suspected)	Monthly	100.0%	93.0%	97.0%	93.0%	Dec-18	
Mixed Sex Accommodation							
Mixed Sex Accommodation (MSA) Breaches	Monthly	0	0	2	0	Jan-19	
Mental Health/ Improving access to Psychological Therapies (IAPT)							
Care Programme Approach Follow Up	Quarterly	97.9%	95.0%	97.5%	95.0%	18/19 Q3	
IAPT - proportion accessing treatment	Monthly	1.57%	1.52%	14.37%	13.15%	Dec-18	
IAPT – proportion moving to recovery	Monthly	56.6%	50.0%	55.9%	50.0%	Dec-18	
Proportion waiting 6 weeks or less from referral to entering a course of IAPT treatment	Monthly	93.3%	75.0%	93.3%	75.0%	Dec-18	
Proportion waiting 18 weeks or less from referral to entering a course of IAPT treatment	Monthly	98.1%	95.0%	98.0%	95.0%	Dec-18	
Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	Monthly	50.0%	53.3%	55.8%	53.3%	Dec-18	
Health Outcome Frameworks							
Incidence of healthcare associated infection: MRSA (NHS OF 5.2.i)	Monthly	0	0	3	0	Jan-19	
Incidence of healthcare associated infection: C Difficile (NHS OF 5.2.ii)	Monthly	2	2	49	25	Jan-19	
Urgent Care							
A&E waiting time >4 hours (Kingston Hospital) - Latest actual is 4 week rolling average	Monthly	84.1%	95.0%	89.4%	95.0%	10-Feb	
Trolley waits in A&E	Monthly	0	0	0	0	Jan-19	
Ambulance Response Programme - Category 1 (Mean)	Monthly	00:06:16	00:07:00	00:06:31	00:07:00	Nov-18	
Ambulance Response Programme - Category 1 (90th Centile)	Monthly	00:10:29	00:15:00	00:10:51	00:15:00	Nov-18	
Ambulance Response Programme - Category 2 (Mean)	Monthly	00:18:46	00:18:00	00:18:31	00:18:00	Nov-18	
Ambulance Response Programme - Category 2 (90th Centile)	Monthly	00:38:13	00:40:00	00:37:30	00:40:00	Nov-18	
Ambulance Response Programme - Category 3 (90th Centile)	Monthly	02:06:11	02:00:00	02:00:30	02:00:00	Nov-18	
Ambulance Response Programme - Category 4 (90th Centile)	Monthly	02:52:13	03:00:00	03:08:06	03:00:00	Nov-18	
Cancelled Operations							
Cancelled Operations not treated within 28 days of cancelation (Kingston Hospital)	Quarterly	0.0%	10.0%	9.4%	10.0%	18/19 Q2	
Other Standards							
Delayed Transfers of Care							
Bed days lost to Delayed Transfers of Care (Average Daily Health Delays)	Monthly	4.53	6.50	4.45	6.50	Dec-18	

1.1 Estimated diagnosis rate for people with dementia

The CCG's reported position against the national dementia diagnosis rate target of 66.7% was 64.7% in January 2019, which demonstrates an improvement of 2.2% compared to the rate achieved in December 2018. The distance between the current diagnosis rate and compliance with the standard is now 35 patients. A recovery plan is in place to achieve the 66.7% target by July 2019, incorporating the following actions:

- Targeted work in care homes where practices have patients to identify and assess residents who have signs of dementia but haven't been diagnosed.
- Support to practices with searches to identify potential people for assessment by a memory nurse. These include those people in at-risk groups (history of stroke, peripheral vascular disease, diabetes, smoking), house bound patients and those patients that have not been seen within practice for over 18 months.
- Support from voluntary sector and community providers in increasing dementia awareness and establishing pathways to the specialist dementia nurse.

An updated action plan was presented to the February 2019 meeting of the IQGC, and at the March 2019 Kingston CCG Governing Body. Delivery of the action plan will continue to be monitored by the IQGC.

1.2 Referral to Treatment (RTT) and Diagnostic Waits

Kingston CCG has achieved the incomplete RTT standard for the period April to December 2018 with performance of 93.3%. The 6-week diagnostic standard has been achieved in every month within 2018-19 with performance in December 2018 of 99.5% against the 99% standard. There were no patients waiting over 52 weeks in December 2018.

In addition to meeting the 92% RTT standard, the 2018/ 19 Operating Plan states that CCGs and providers must ensure that the size of the incomplete RTT waiting list is lower in March 2019 than the March 2018 position. In December 2018, the RTT waiting list was 9,285 patients, compared to 7,963 patients in March 2018 (a difference of 1,322 patients). Most of this increase is related to Kingston Hospital, which has seen a 10% growth in demand, including marked rises in cancer related work. The trust has a programme in place to reduce the waiting lists, which also includes "clock-restarts", which are increasing the numbers on the RTT incomplete list. The governing body has previously received detailed reports regarding this performance.

There are 17 people waiting over 40 weeks (which equates to 0.18% of the total waiting list), compared to 25 people waiting over 40 weeks in March 2018. This number also includes patients transferred from St George's Hospital to support the RTT backlog clearance. Kingston Hospital has detailed the drivers behind the increase in waiting list size, which in summary are:

1. Temporary reduction in outpatient follow up capacity at the beginning of the financial year.
2. Validation work undertaken at the trust (where new pathways were included in the waiting list management process).
3. Increases in cancer 2 week wait referrals for certain tumour groups.

1.3 Cancer Standards

All nine cancer standards have been achieved for the period April – December 2018. The 62-day screening standard was not achieved for the month of December 2018, which was the result of one person breaching the standard.

1.4 Mixed Sex Accommodation Breaches

There were no Mixed Sex Accommodation breaches reported in December 2018. So far in 2018-19, there have been two breaches. The first was in June 2018 at Charing Cross Hospital (part of Imperial College Healthcare NHS Trust), and the second breach was in October 2018, at Royal Sussex County Hospital (part of Brighton And Sussex University Hospitals NHS Trust). Both breaches were related to bed pressures.

1.5 Mental Health/ Improving Access to Physiological Therapies (IAPT)

The proportion of people on the Care Plan Approach (CPA) being followed up within 7 days of discharge was 97.9% for Quarter 3 2018-19, an improvement on the follow-up rate in 2017-18. The year to date position is 97.5%.

While the percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral for the period April – December 2018 is above the 53.3% standard, the target has not been achieved for October – December 2018, due to a reporting error at South West London and St George's Mental Health Trust (SWLStG). The data has been validated, and performance is now expected to return to close to 100% from January 2019. SWLStG is resubmitting the data to NHS Digital for the months that were in error.

Kingston CCG is achieving all four access, recovery and waiting times standards for IAPT for the period April – December 2018.

1.6 Healthcare Acquired Infections

There have been three MRSA healthcare associated infections for year to date, January 2019. There have been 49 c. difficile infections for year to date December 2018 against a year to date plan of 25 (the c. difficile ceiling target for 2018-19 is 29). While the numbers of cases of c- difficile is above planned levels, there has been a reduction compared to the first quarter.

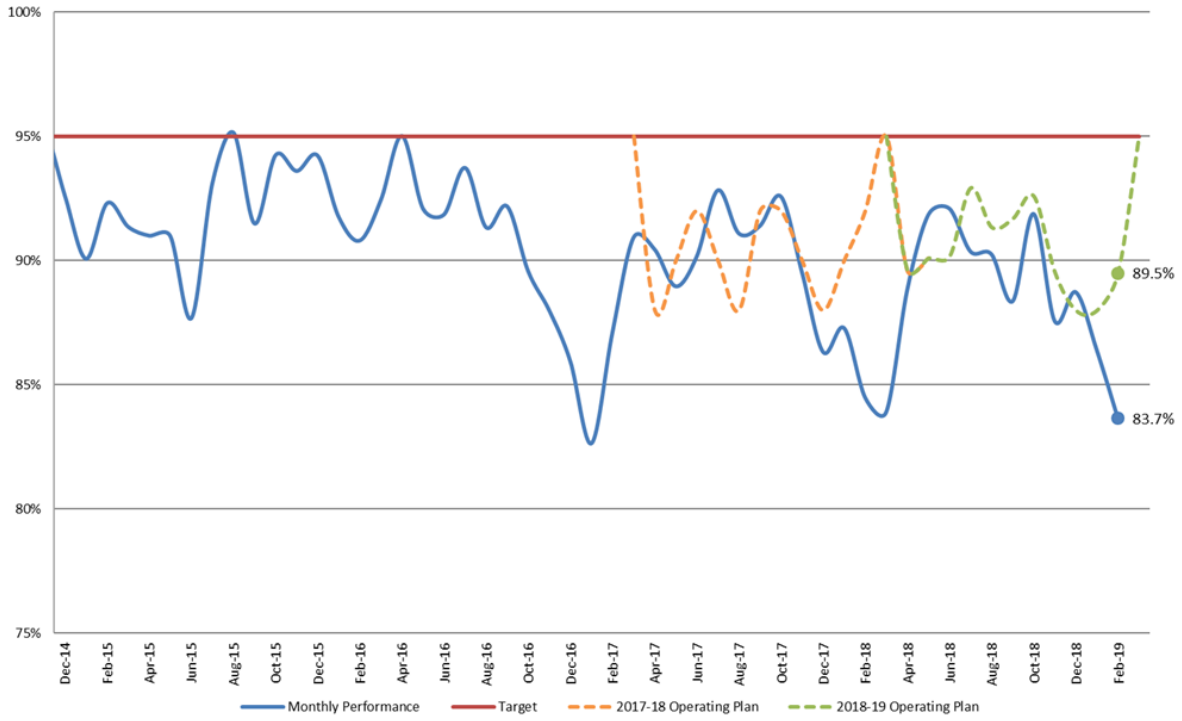
For each case a post-infection review is carried out by the north-east London Commissioning Support Unit (NEL CSU) Infection Control Team, on behalf of the CCG. The NEL CSU team meets with provider trusts monthly to assure Infection Prevention and Control (IPC) compliance and lessons learned are being embedded. The NEL CSU Infection Prevention and Control Report for Quarter 2 2018/ 19 was presented at the Kingston CCG IGC in December 2018. There were no specific actions for the CCG to take to support further reductions identified.

1.7 Accident and Emergency waiting times:

Kingston Hospital has not met the standard of 95% of patients spending less than 4 hours between arrival in the A&E department and admission, transfer or discharge in any month to date during 2018/ 19. Kingston Hospital is slightly behind the year to date Sustainability and Transformation Fund plan trajectory, with performance up to Sunday 10th February 2019 of 89.4% against a year to date target of 90.3%. Whilst the standard has not been achieved, the Winter planning undertaken through the

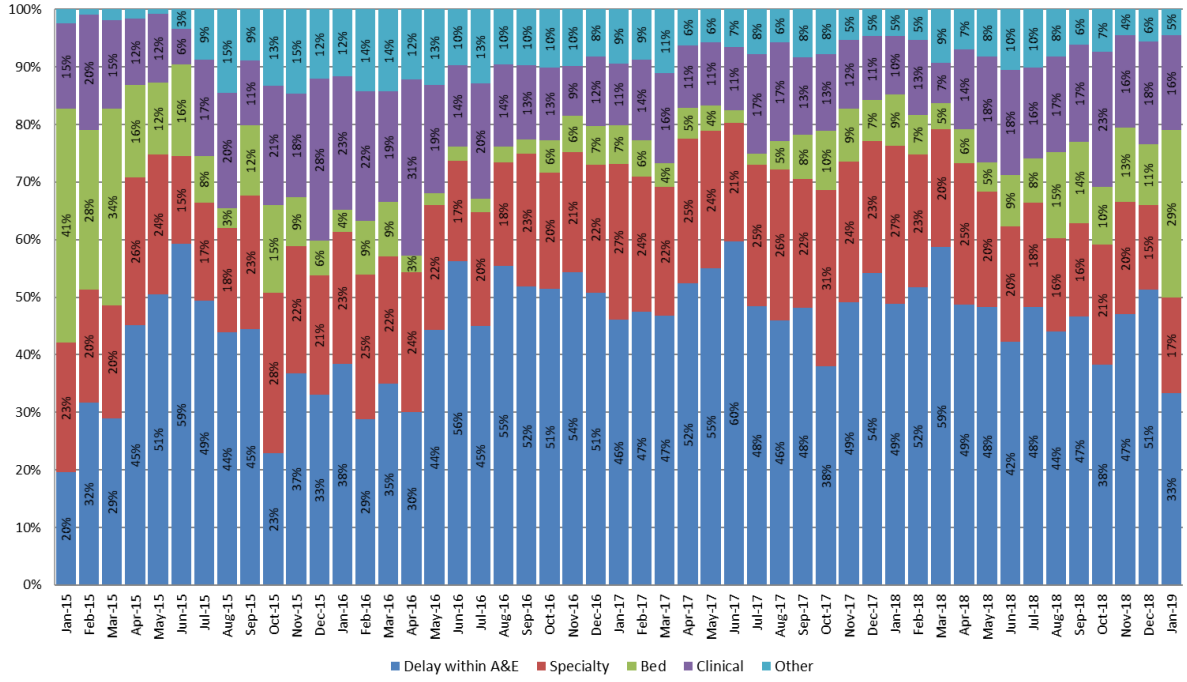
Kingston, Richmond & Surrey Downs (East Elmbridge) Local A&E Delivery Board has proven effective in ensuring minimal levels of escalation beds, excellent ambulance turnaround times and reduced delayed transfers of care.

Kingston Hospital Monthly % A&E Waits against Target (as at 10th Feb 2019)



Below are the breaches shown as a proportion of total monthly breaches. The main causes from August 2015 onwards are delays within the Emergency Department and breaches relating to specialties.

Kingston Hospital Proportional A&E Breach Causes by Month
February 2015 to January 2019



1.8 *Ambulance clinical quality – Category A response times and Ambulance Handover time (Global London Ambulance Service performance)*

The performance of the London Ambulance Service (LAS) has improved significantly in 2018-19, despite staffing issues, and high demand across London. There are a range of actions being managed on a weekly basis by North West London Collaboration of Clinical Commissioning Groups, reported back to senior commissioners and performance leads in CCGs. A range of new measures has been introduced, and are reported in the scorecard.

1.9 *Cancelled Operations (Kingston Hospital)*

The proportion of operations not treated within 28 days of cancelation at Kingston Hospital for Quarter 2 2018/ 19 was 0% against the 10.0% standard. The year to date position is 9.4%.

1.10 *Average days delayed for Delayed Transfers of Care (Health Delays)*

For 2018/ 19, the Delayed Transfers of Care (DTOCs) metric is now shown as the average number of days delayed and NHS England have set targets from historic performance across 2018/ 19. This has set Kingston CCG an upper limit of a daily average of 6.5 health related bed days.

For the period April – December 2018, there were 1,403 health delays, which gives 4.45 average daily DTOCs. This is an improvement from the position reported for the first two months of 2018/ 19 and is in line with the second half of 2017/ 18. The average days delayed for the month of December 2018 were 4.53.

The table below shows the monthly position for health and social care. Most of the social care delays within December 2018 were related to moving people into residential care from SWLStG.

KINGSTON POSITION AGAINST PROVISIONAL DAILY DTOC EXPECTATION FOR 2018-19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	2018-19
NHS Kingston Average Daily Delay Trajectory	6.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5
Royal Borough of Kingston Average Daily Delay Trajectory	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Days lost to DTOCs (Health)	272	155	138	165	142	120	120	130	161	1,403
Days lost to DTOCs (Social Care)	23	45	12	10	5	4	10	7	21	137
Actual NHS Kingston Average Daily Delays	7.90	4.36	4.01	4.64	3.99	3.49	3.37	3.78	4.53	4.45
Actual Royal Borough of Kingston Average Daily Delays	0.77	1.45	0.40	0.32	0.16	0.13	0.32	0.23	0.68	0.50

1b. Operating Plan Supporting Activity – to December 2018

Kingston Clinical Commissioning Group	Latest Period			Year To Date			Period	Trend/ Direction	Year end forecast
	Actual	Plan	Growth/ Plan	Actual	Plan	Growth/ Plan			
Total Referrals (General and Acute)	3,834	4,502	-14.8%	42,014	42,768	-1.8%	Dec-18		56,167
Total GP Referrals (General and Acute)	2,560	3,134	-18.3%	29,420	29,772	-1.2%	Dec-18		39,330
Total Other Referrals (General and Acute)	1,274	1,368	-6.9%	12,594	12,996	-3.1%	Dec-18		16,837
Consultant Led First Outpatient Attendances	7,659	7,925	-3.4%	76,307	75,285	1.4%	Dec-18		102,009
Consultant Led Follow-Up Outpatient Attendances	7,159	7,712	-7.2%	73,424	73,262	0.2%	Dec-18		98,158
Total Elective Admissions	1,177	1,376	-14.5%	12,177	13,068	-6.8%	Dec-18		16,281
Total Elective Admissions - Day Cases	954	1,074	-11.2%	10,127	10,200	-0.7%	Dec-18		13,539
Total Elective Admissions - Ordinary	223	302	-26.2%	2,050	2,868	-28.5%	Dec-18		2,741
Total Non-Elective Admissions	1,688	1,604	5.2%	14,065	14,228	-1.1%	Dec-18		18,670
Total Non-Elective Admissions - 0 LoS	691	624	10.7%	5,440	5,536	-1.7%	Dec-18		7,223
Total Non-Elective Admissions - +1 LoS	997	980	1.7%	8,625	8,692	-0.8%	Dec-18		11,447
Total A&E Attendances excluding Planned Follow Ups	6,089	6,311	-3.5%	55,832	55,987	-0.3%	Dec-18		74,105

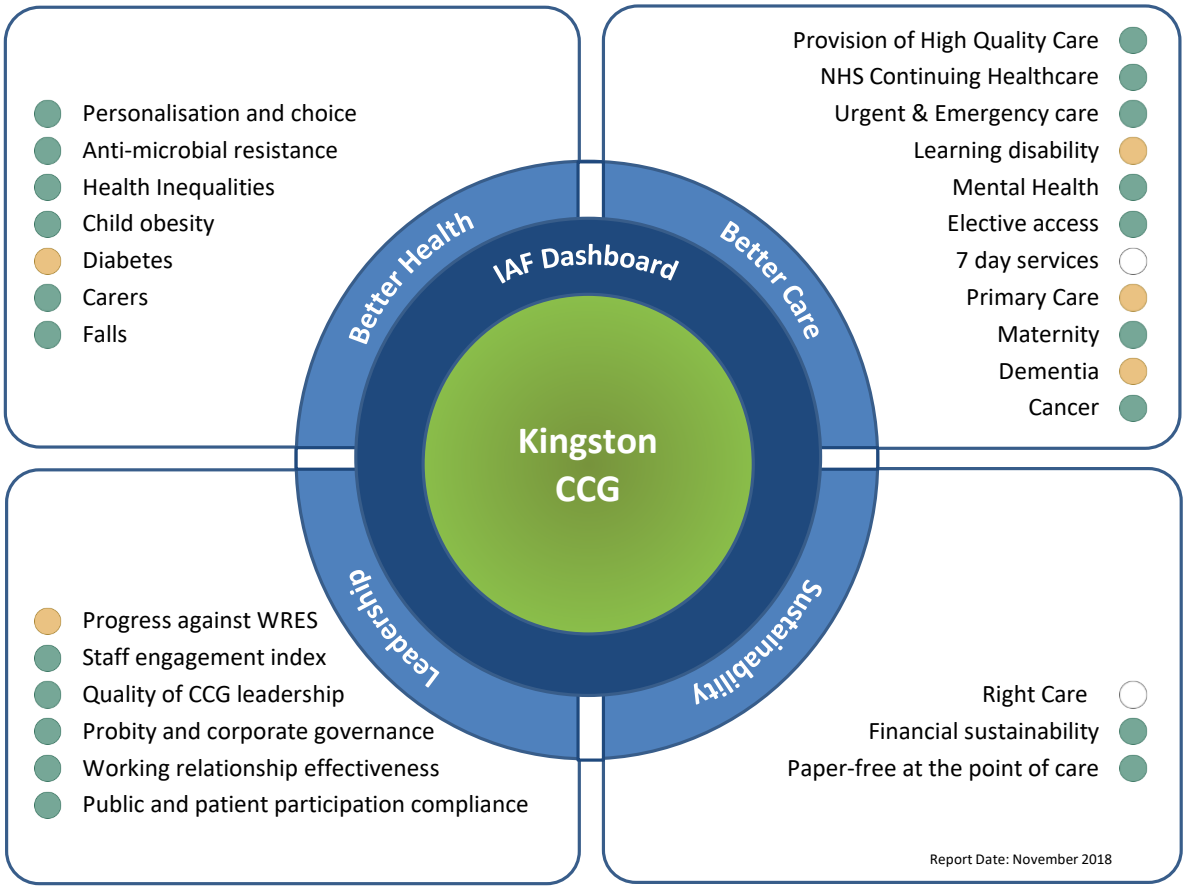
The table above shows the year to date activity position against the 2017-19 Operating Plan, with areas greater than 2% shown as either amber or red.

For the period April – December 2018, there were no areas where Kingston CCG was higher than the 2% threshold.

However, 0-day Length of Stay (LOS) Non-elective admissions are 10.7% (67 admissions) above plan for the month of December 2018, relating to Kingston Hospital and St George's University Hospital, related to adults of working age with musculoskeletal or digestive disorders. Children admitted to the Paediatric Assessment Unit have fallen during this period.

2. Improvement and Assessment (IAF Dashboard) for 2018-19

The 2018-2019 IAF Dashboard for Kingston CCG is below, showing the areas where Kingston CCG is in the best, worst and interquartile ranges benchmarked with all CCGs in England.



The areas where Kingston is in the worst quartile nationally are:

Better Health	Better Care
Attendance at diabetic structured education (Diabetes)	Completeness of the GP learning disability register (Learning Disability)
	Dementia diagnosis rate (Dementia)
	% of deaths with 3+ emergency admissions in last three months of life (Urgent and Emergency Care)
	Primary care transformation investment (Primary Care)
Sustainability	**Leadership**
[No areas in the bottom quartile]	Progress against WRES

Better Health

People with diabetes diagnosed less than a year who attend a structured education course

This measure focuses on the number of registered patients with diabetes attending a structured education course within 12 months of diagnosis. The data is taken from practice systems as part of the national diabetes audit (latest data 2016-17). The number of patients attending structured education courses is lower than the expectation when benchmarked with comparative CCGs.

The CCG is ensuring that structured education is captured in practice systems, reviewing delivery of the primary care treatment standards and aligning with the diabetes locally commissioned service. The CCG has been supporting the acute providers in developing the multi-disciplinary team foot health model and the diabetic specialist nursing services approach.

Better Care

Completeness of the GP Learning Disability register

This measure focuses on the number of people on a GP learning disability register, used as a comparison against expected numbers (latest data 2016-17). There are currently less patients with learning disabilities registered with Kingston practices than expected for a CCG population of circa 210,000 patients.

There is work underway to appoint a clinical lead GP for learning disabilities and to ensure that the registers held by Kingston and Richmond local authorities and health partners, are jointly reviewed to ensure that all patients are registered with local GP practices and are supported to attend annual health checks. CCG primary care facilitators are supporting general practice in this area of focus.

Dementia Diagnosis Rate

See section 1.1 above.

Percentage of deaths with 3+ emergency admissions in last three months of life

This measure links Hospital Episodes Statistics – Office of National Statistics (HES-ONS) mortality data (in addition to full ONS death certificate data for total numbers of deaths) to show the proportion of deaths with 3 or more emergency admissions in last three months of life. This position is mirrored within Kingston CCG's risk stratification data, where the level of emergency admissions for those on the palliative care registers has increased from a year ago.

Work is continuing through the Kingston and Richmond End of Life Care (EoLC) Steering Group, which has promoted the use of advanced care plans via the Co-ordinate My Care (CMC) system to enable whole system management of end of life care.

Primary care transformation investment

This measure counts the total investment in primary care transformation made by CCGs. CCGs are assessed as green if they can demonstrate that the requirements of the GP Forward View £3 per head investment requirement have been met. CCGs which have not met the requirement will be assessed as red.

Kingston CCG is currently identified within the worst quartile; however, this is a reporting artefact, and Kingston will become compliant as the financial reporting progresses. The planned investment has been made into Kingston Medical Services.

Sustainability

There are no areas where Kingston CCG is in the bottom quartile of CCGs.

Leadership

Progress against Workforce Race Equality Standard (WRES)

The WRES indicator is calculated by looking at the difference between BME and White NHS Staff survey response to questions in four areas for providers in the NHS footprint of the CCG:

- Experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- Experiencing harassment, bullying or abuse from staff in the last 12 months
- Believing that trust provides equal opportunities for career progression or promotion.
- Personally experiencing discrimination at work from any of the following - manager/ team leader or other colleagues

Higher scores indicate higher average inequality in the four areas between BME and White staff, 0 indicates equality (on average).

For each provider, the WRES score is calculated from the NHS staff survey as the sum of the difference between the BME and White findings in each of the four areas above. The CCG score is the weighted average of provider scores, with weights being total CCG spend with the provider(s). All CCGs in South London were in the lowest quartile for Progress against WRES (latest data 2016).

The Kingston Hospital Equality and Diversity Board has a range in actions to reduce the experience of groups of staff members. The KHFT E&DB feeds into the Kingston Hospital Board, and the actions and progress are scrutinised by the Kingston and Richmond CCGs' Engagement and Equalities Lead.

NHS Kingston Clinical Commissioning Group

3. Draft Quality Premium Dashboard 2018-19

Emergency Demand Management Indicators 2018-19	QP Percentage	Latest Actual	Latest target	YTD Actual	YTD Target	Period	Trend/ Direction	Year end forecast	R / G	Quality Premium % Forecast
Type 1 A&E attendances	50%	5,055	5,101	45,227	45,249	Dec-18		60,303	G	50.0%
Non elective admissions with zero length of stay		691	624	5,438	5,536	Dec-18		7,220		
Non elective admissions with length of stay of 1 day or more	50%	997	980	8,641	8,692	Dec-18		11,468	G	50.0%
Total Emergency Demand Management Indicators	100%									100.0%

Quality Premium Measures 2018-19		QP Percentage	Latest Actual	Latest target	YTD Actual	YTD Target	Period	Trend/ Direction	Year end forecast	R / G	Quality Premium % Forecast
1. Cancers diagnosed at early stage	Demonstrate a 4% improvement in the proportion of cancers diagnosed at stages 1 and 2 in the 2017 calendar year compared to the 2016 calendar year, or achieve greater than 60% of all cancers that are diagnosed at stages 1 and 2 in the 2017 calendar year.	17%	55.9%	59.9%	55.9%	59.9%	2016		55.9%	R	0.0%
2. Overall experience of making a GP appointment	Achieve a level of 85% of respondents who said they had a good experience of making an appointment, or a 3 percentage point increase from July 2017 publication on the percentage of respondents who said they had a good experience of making an appointment.	17%	71.0%	71.9%	71.0%	71.9%	Jul-18		71.0%	R	0.0%
3. NHS Continuing Healthcare	**Part a**: To achieve the Quality Premium for this part, CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility)	8.5%	83.3%	80.0%	73.2%	80.0%	Jan-19		73.2%	R	0.0%
	Part b: To achieve the Quality Premium for this part, CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting.	8.5%	0.0%	15.0%	7.3%	15.0%	Jan-19		7.3%	G	8.5%
4. Mental Health Menu: Equity of Access and outcomes in to IAPT services	Recovery rate of people accessing IAPT services identified as BAME; improvement of at least 5% or to same level as white British, whichever is smaller.	17%	-0.1%	5.0%	0.9%	5.0%	18/19 Q2		0.9%	R	0.0%
	Proportion of people accessing IAPT services aged 65+; to increase to at least 50% of the proportion of adults aged 65+ in the local population or by at least 33%, whichever is greater in 2018/19.		32.5%	50.0%	37.1%	50.0%	18/19 Q2		37.1%		
5. Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups	**Part a**. 10% reduction (or greater) in all E coli BSI reported at CCG level based on 2016 performance data.	5.1%	0	8	65	76	Jan-19		35	G	5.1%
	Part bi: 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater	5.1%	2,282	2,994	2,282	2,994	Nov-18		2,994	G	5.1%
	Part bii: Sustained reduction of inappropriate prescribing in primary care (must be equal or below 1.161 items per STAR-PU)	5.1%	0.853	1.161	0.853	1.161	Nov-18		1.161	G	5.1%
	Part bii: Additional reduction of inappropriate prescribing in primary care (must be equal or below 0.965 items per STAR-PU)	1.7%	0.853	0.965	0.853	0.965	Nov-18		85.3%	G	1.7%
6. Local Right Care measure	Maternity & Reproductive Health - A&E attendance rate per 1,000 population aged 0-4 years (Year to date figure is 12-month rolling average)	15%	50.6	32.2	507.2	504.5	Dec-18		505	R	0.0%
Total Forecasted Acheivement against the Quality Premium Measures		100%									25.5%

NHS Constitution rights and pledges	Potential adjustment	Latest Actual	Latest target	YTD Actual	YTD Target	Period	Trend/ Direction	Year end forecast	R / G	Forecasted adjustment
The number of patients on an incomplete pathway not to be higher in March 2019 than in March 2018	-50%	9,285	7,963	9,285	7,963	Dec-18		9,285	R	-50.0%
Cancer 1st treatment 62 days: GP Urgent Referral	-50%	100.0%	85.0%	94.7%	85.0%	Dec-18		0.9	G	0.0%
Total Forecasted Adjustment against the NHS Constitution rights and Pledges	-100%									-50.0%

Forecast Quality Premium Percentage Achievement	12.75%

4. Reporting from the Clinical Quality Review Groups:

The committee received reports from the following Clinical Quality Review Group meetings (the main issues highlighted below):

Kingston Hospital Foundation Trust

- Corporate learning from adverse incidents
- Falls – the number of falls rose from 5 in October to 16 in November 2018 largely due to repeated falls in Surgery and Urology
- Antenatal Guidelines – circulated to GPs with the GP Newsletter
- Nursing, Midwifery and Care Staffing Establishment (six-month report). The KMPG audit that took place in July 2018 for safe staffing was positive and made several recommendations which are underway
- Adult Safeguarding (exceptions) Quarterly Report

SWL Integrated Urgent Care

- Corporate learning from adverse incidents
- Calls answered in 60 seconds: 80.81% calls answered in 60 seconds, which remains below the 95%target
- Out of Hours patient survey uptake for Q3: increase of response from Q2 to Q3
- CQC Inspection - 111: Update on progress of action plan going well. Working on evidence gathering for action. Anticipate re-inspection in 12 months or sooner.
- CQC- OOH: CQC inspection of all 7 bases across SWL result came out in January 2019 as “Good” overall.

Progress reports for the following areas were received:

Cancer Services:

The provider Annual Assessment Outcomes for CCG Commissioned Cancer Services 2018/19 were received for Kingston Hospital, St George’s Hospital and the Royal Marsden Hospital. All three trusts were in the “most assured” raking requiring no formal monitoring.

Reviews following the death of a child:

The committee received a progress report. The Children and Social Work Act 2017 outlined new statutory responsibilities for both CCGs and local authorities regarding child death reviews. The purpose of these bodies coming together as ‘Child Death Review Partners’ (CDRP) is to maximise the potential system learning and improvements as a result of child deaths that occur within the geographical footprint. The main aim of a CDR is to facilitate learning through analysis of larger numbers of child deaths. The guidance states that there should be a minimum of 60 deaths annually to be discussed at each CDR. The new CDRs will bring together multiple CCGs and local authorities (the new CDR partners) with approximately 100 deaths a year to review. At the time of writing, it is anticipated that the 6 CCGs in the SWL STP are in scope for the SWL CDR approach. A final update will be provided to the committee in the next two months.

Quarter 3 Risk Register Report:

The report was received and the additional risk relating to Brexit was noted.

Quarter 2 2018/19 Safeguarding Adults report:

The report was received and the following key achievements noted:

- Training rates remain high
- Learning Disability Mortality Review (LeDeR) local steering group and London steering group performance was better than the required standard
- South West London Safeguarding Health Outcomes Framework (a new monitoring and performance document developed by the SW London CCG safeguarding adults leads) has been implemented.
- Court of Protection Deprivation of Liberty Safeguards (DoLS) – a future report will be needed to identify the impact of the new safeguards (currently under review by the Law Commission, with Royal Assent in spring 2019 anticipated).
-

Quarter 3 2018/19 Safeguarding Children Report

The report was received and the following key areas for CCG consideration noted:

- Safeguarding children arrangements (changes in personnel)
- At the end of Quarter 3, 85% of Kingston CCG staff were compliant with safeguarding children training, this is a decline on the previous quarter
- Progress in the recruitment of a Safeguarding Children Named GP (which now include vulnerable adults responsibility)
- Agreement from the Executive Management Team to recruit to a new Named Nurse post for Children Looked After (CLA) in the Boroughs of Richmond and Kingston
-

Q3 2018/19 Serious Incident Report

The report was received and the following key issue noted:

- Development of working relationship with NELCSU management of serious incidents

Continuing Health Care – focus on Personal Health Budgets (PHBs)

The report was received and the following key issue noted:

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG). The increased number of PHBs awarded by the CCG is anticipated to meet the national target by the end of the year.

The SWL CCGs' auditors have been requested to complete audits focussing on CHC and PHBs during 2019/ 20 and to recommend local structures and process required to support governance (including rewriting policies and procedures to be aligned across SW London).

Annual Report Children Looked After Health Team

The Annual CLA Health Report complies with the reporting mechanism to Local Safeguarding Children's Board and CCG and other partner agencies in demonstrating the work of the CLA Health team in assessing the health needs of CLA and improving their health outcomes. The report also:

- Outlines achievements and challenges for CLA (April 2017 – March 2018)
- Highlights good working practices
- Shows profile and demography of CLA
- Shows service direction and ambition of AfC
- Way forward for 2018/ 2019

There is a need to ensure all initial health assessments are carried out within 20 working

days to achieve greater than 85% for timeliness (to meet national standards). A programme of work has been agreed to improve performance and will be monitored by the IQGC.

South West London Performance & Quality Highlight Report

2018-19 Month 7

For: South West London Senior Management Team

Sponsor:	Director of Commissioning Operations, South West London Alliance
Author:	NELCSU / SW London Performance Management & Pressure Surge Team
Version:	DRAFT (1.4 02.01.19)

Headline Messages

Successes

- Diagnostics: All 6 SWL CCGs were compliant against the 6 weeks diagnostic standard for the first time since January 2018. All 4 acute providers were also compliant. Overall at SWL level provider performance was reported at 99.6%, and commissioner level at 99.4%.
- All SWL CCGs continued to achieve the 2WW Cancer standard with an outcome of 96.9% in October, improving further on the September position of 95.5%. SWL STP achieved the 62 day cancer standard with a performance outcome of 88.6% at CCG level. London CCG level performance was 81.5% and National level performance was 78.3%. SWL STP was the highest performing STP in London for both of these standards.
- RTT performance across the STP increased in October to 91.5%, continuing the trend of SWL being the highest performing STP in London. However it should be noted that St. George's Hospital Trust is yet to return to reporting. Croydon and Kingston CCGs have maintained RTT performance above the national standard since April 2018.
- 52 Week waits: The number of patients waiting over 52 Weeks on an incomplete pathway has continued to decrease with 26 in October down from 33 in September, 41 in August and 51 in July. Out of the 26 breaches 15 were at KCH.

Exceptions

- SWL A&E performance was 87.1% in November down 3.3% on October and below the operating target of 92.1%. All providers saw a decrease as a result of winter pressures, London wide All Type performance for November 2018 was 88.1%, while the national figure was 87.6%
- The number of patients waiting on the incomplete RTT PTL across SWL has grown by approximately 6,500 since March 2018 with a variance of 4,737 against plan for the month. Variances against both measures increased in month.
- Sutton IAPT performance has recovered following a data quality reporting issue, Q2 performance to date has surpassed the Q1 deficit. The recovery plan continues to be closely monitored by the CCG. Merton CCG and Croydon CCG have been carefully monitoring their respective providers, with improvement gathering pace in Croydon and early progress in Merton CCG, though weekly scrutiny is required given the performance improvement needed in Q4.
- IUC provider performance against both clinical assessment and calls answered within the national standards remain challenged.
- Care Programme Approach Follow Up standard has not been achieved after a period of consistent delivery. SWL & St Georges Mental Health Trust was not compliant in Q2 but is expected to recover in Q3. Kingston CCGs Dementia Diagnosis rate is now more than 5% below the standard.
- Further work is required to identify progress on new IAF metrics recently published and ongoing areas of challenge such as PHBs

Highlight Constitutional Standards

(London Commissioners STP comparison)

A&E- All Type Performance by STP (M8)

STP	Aug-18	Sep-18	Oct-18	Nov-18	KEY
South West London	90.21%	90.18%	90.38%	87.10%	
South East London	88.48%	85.87%	86.80%	84.94%	>= 95%
North East London	89.00%	87.95%	87.54%	86.30%	90%-95%
North Central London	90.84%	88.14%	89.01%	88.01%	< 90%
North West London	92.80%	92.91%	92.88%	91.51%	

N.B. South West London STP position includes all type performance for KHFT,ESTH,CHS and SGH Hospital Trusts only.

Other STPs include all sites within footprint.

Diagnostics- Waits within 6 Weeks by STP

STP	Aug-18	Sep-18	Oct-18
South West London	98.95%	99.36%	99.42%
South East London	97.24%	96.82%	96.18%
North East London	95.77%	95.75%	95.88%
North Central London	98.95%	98.95%	98.95%
North West London	99.03%	99.08%	99.26%

Cancer- 2 week wait by STP

STP	Aug-18	Sep-18	Oct-18
South West London	96.30%	95.53%	96.94%
South East London	91.30%	88.80%	94.10%
North East London	93.10%	94.00%	95.20%
North Central London	91.60%	89.20%	91.00%
North West London	91.00%	91.65%	92.90%

RTT Incomplete Pathways by STP (waiting list against March-2018)

London STPs	Mar-18	Aug-18	Sep-18	Oct-18	Variance to Mar-18	Trend
South West London	71,917	78,347	78,139	78,397	6,480	
South East London	124,325	151,586	149,711	148,938	24,613	
North East London	72,744	148,871	148,554	148,496	75,752	
North Central London	103,179	111,563	110,042	109,538	6,359	
North West London	172,346	184,518	182,368	183,186	10,840	

RTT Incomplete Pathways > 52 weeks by STP

London STPs	Aug-18	Sep-18	Oct-18
South West London	41	33	26
South East London	361	362	333
North East London	38	44	29
North Central London	41	55	54
North West London	76	83	77

18 Week Referral to Treatment (RTT Incomplete) Performance by STP

STP	Aug-18	Sep-18	Oct-18
South West London	91.27%	91.25%	91.48%
South East London	85.06%	84.05%	84.16%
North East London	87.87%	86.82%	86.98%
North Central London	85.87%	84.69%	84.64%
North West London	85.39%	84.88%	85.22%

Cancer- 62 day GP referral by STP

STP	Aug-18	Sep-18	Oct-18
South West London	86.94%	85.71%	88.63%
South East London	77.56%	78.70%	75.90%
North East London	83.88%	81.50%	86.00%
North Central London	79.15%	80.10%	71.20%
North West London	86.00%	83.90%	84.50%

Highlight Constitutional Standards (By CCG)

A&E- All Type Trust Performance by Lead Commissioner (M8)

CCG	Aug-18	Sep-18	Oct-18	Nov-18	KEY
Croydon	84.95%	87.04%	88.71%	85.12%	
Plan	89.00%	90.00%	90.00%	91.75%	>= 95%
Kingston	90.25%	88.37%	91.88%	87.57%	
Plan	91.34%	91.69%	92.60%	89.54%	
Merton	-	-	-	-	
Plan	-	-	-	-	
Richmond	-	-	-	-	90% to 95%
Plan	-	-	-	-	
Sutton	95.19%	94.84%	91.54%	90.66%	
Plan	95.00%	95.00%	94.00%	93.50%	
Wandsworth	91.09%	90.26%	90.11%	85.49%	< 90%
Plan	94.00%	95.00%	93.00%	93.00%	
SWL STP	90.21%	90.18%	90.38%	87.10%	
Plan	92.40%	92.98%	92.31%	92.11%	

RTT Incomplete Pathways by CCG (waiting list against March-2018)

SWL CCGs	Mar-18	Aug-18	Sep-18	Oct-18	Variance to plan	Trend
NHS CROYDON CCG	23,071	24,662	24,385	24,275	911	
NHS KINGSTON CCG	7,963	9,291	9,162	9,575	1,659	
NHS MERTON CCG	7,518	7,837	7,842	7,830	-450	
NHS RICHMOND CCG	9,911	12,171	12,124	12,067	2,158	
NHS SUTTON CCG	12,891	13,047	13,273	13,045	409	
NHS WANDSWORTH CCG	10,563	11,339	11,353	11,605	50	
SWL Total	71,917	78,347	78,139	78,397	4,737	

RTT Incomplete Pathways > 52 weeks by CCG

SWL CCGs	Aug-18	Sep-18	Oct-18
NHS CROYDON CCG	15	15	8
NHS KINGSTON CCG	4	1	1
NHS MERTON CCG	9	4	2
NHS RICHMOND CCG	1	2	1
NHS SUTTON CCG	3	4	6
NHS WANDSWORTH CCG	9	7	8
SWL Total	41	33	26

Diagnostics- Waits within 6 weeks by CCG

CCG	Aug-18	Sep-18	Oct-18
Croydon	98.39%	99.50%	99.15%
Plan	99.06%	99.05%	99.05%
Kingston	99.50%	99.71%	99.55%
Plan	99.03%	99.01%	99.01%
Merton	99.32%	99.25%	99.56%
Plan	99.00%	99.03%	99.03%
Richmond	99.22%	98.90%	99.27%
Plan	99.01%	99.03%	99.02%
Sutton	98.73%	99.10%	99.50%
Plan	99.13%	99.11%	99.09%
Wandsworth	99.31%	99.49%	99.67%
Plan	99.08%	99.05%	99.07%
SWL STP	98.95%	99.36%	99.42%
Plan	99.06%	99.05%	99.05%

18 Week Referral to Treatment (RTT Incomplete) Performance by CCG

CCG	Aug-18	Sep-18	Oct-18
Croydon	93.01%	92.60%	92.76%
Plan	92.19%	92.41%	92.39%
Kingston	93.06%	93.00%	93.03%
Plan	92.00%	92.01%	92.00%
Merton	89.55%	89.47%	89.94%
Plan	90.80%	90.76%	90.76%
Richmond	91.35%	91.78%	91.63%
Plan	92.00%	92.00%	92.00%
Sutton	89.68%	89.83%	90.11%
Plan	89.60%	91.93%	90.38%
Wandsworth	88.95%	89.28%	89.92%
Plan	89.25%	89.25%	89.24%
SWL STP	91.27%	91.25%	91.48%
Plan	91.08%	91.55%	91.27%

Cancer- 2 week wait by CCG

CCG	Aug-18	Sep-18	Oct-18
Croydon	96.72%	93.59%	96.89%
Plan	93.08%	93.07%	93.04%
Kingston	98.71%	99.13%	98.85%
Plan	93.13%	93.23%	93.20%
Merton	96.06%	95.95%	98.31%
Plan	93.03%	93.10%	93.00%
Richmond	95.43%	93.66%	95.99%
Plan	93.04%	93.04%	93.06%
Sutton	97.27%	98.06%	96.95%
Plan	93.16%	93.05%	93.12%
Wandsworth	94.56%	95.56%	95.52%
Plan	93.09%	93.09%	93.08%
SWL STP	96.30%	95.53%	96.94%
Plan	93.08%	93.09%	93.07%

Cancer- 62 day GP referral by CCG

CCG	Aug-18	Sep-18	Oct-18
Croydon	82.42%	85.00%	81.16%
Plan	85.53%	85.51%	86.08%
Kingston	91.67%	97.06%	96.88%
Plan	87.50%	86.21%	85.29%
Merton	92.11%	80.00%	84.21%
Plan	87.10%	85.71%	87.50%
Richmond	95.35%	90.91%	97.06%
Plan	87.18%	85.71%	85.37%
Sutton	82.14%	78.13%	88.24%
Plan	86.49%	85.29%	87.18%
Wandsworth	87.18%	82.14%	93.55%
Plan	86.11%	87.88%	86.84%
SWL STP	86.94%	85.71%	88.63%
Plan	86.45%	85.96%	86.31%

Highlight Constitutional Standards (By CCG)

Period: M7 2018/19
Report: Date: 13/12/2018

CCG Level Narrative

CCG level narratives have been provided for the four Constitutional Standards that receive the most focus. Further detail is provided in subsequent pages including Trust level performance and any associated key actions.

Croydon CCG

Successes: The CCG continues to achieve the RTT (Referral to Treatment) performance standard with an outcome of 92.76% in October against an operating plan trajectory of 92.39%. Compliance was maintained with improved performance in the cancer 2 week wait standard. Diagnostic performance also remained compliant at 99.15%. **Croydon achieved 90.0% for Early Intervention in Psychosis and remains compliant against the Dementia Diagnosis standard in M7. IAPT Access and Recovery have been compliant since September.**

Exceptions: The CCG did not meet the cancer 62 day standard with an outcome of 81.6% having passed in September, the CCG also missed the 31 day Sub Chemo standard, however this was as a result of a single breach. A total of eight 52 week waiters were reported, although this is a decrease from 15 the previous month. RTT incomplete pathways stand at 24,275 and remain above plan by 911 and the March-18 position by 1,204. The national A&E performance standard was not achieved at CHS with performance of 85.1% in November, below the operating plan trajectory of 91.75% for the month.

Kingston CCG

Successes: The performance standard for RTT and Diagnostics was achieved in October with outcomes of 93.0% and 99.55% respectively. All the Cancer standards were achieved with 2 week wait at 96.9% and 62 day at 96.9%. The Kingston IAPT Service is working well, achieving above the expected standards.

Exceptions: Despite achieving the RTT performance standard, in terms of reducing the waiting list against the March 18 outcome of 7,963 incomplete pathways, the position at the end of October 2018 was 9,575 (and increase of 413 against September 2018). This was a variance of 1,659 patients against the operating plan expectation. There was 1x 52 week waiter in month. A&E performance at Kingston Hospital was 87.6% in November 2018, below the 89.5% operating plan trajectory for the month.

Merton CCG

Successes: The CCG achieved both 2WW cancer standards and all 31 day standards recovering 31 day Chemo and RT in month. Merton's Incomplete RTT PTL stood at 7,830 this is 450 ahead of target although still behind the March-18 position of 7,518. Diagnostic performance remains compliant improving 0.31% on the previous month to 99.56%.

Exceptions: RTT had a performance outcome of 89.9% against an operating plan trajectory of 90.76% although this was an improvement on Septembers position. ESTH, a large provider to the CCG also did not achieve the standard in October delivering performance of 87.3% which is just below the Trust's trajectory of 87.4% for the month. The CCG had 2x 52 week waiters, one each at ESTH and Moorfields. Cancer 62 day performance was reported at 84.2% missing the standard, however this was an improvement on 80.0% the previous month.

IAPT Merton Latest data available (M6/Sep-18) shows a marked improvement in the uptake of people entering treatment in comparison with the historic performance trend, the monthly position missed target by 17 clients (360 clients / 377 target). The CCG commitment to NHSE to achieve a Sep-18 'exit run rate' of 87 clients per week was exceeded by achieving an average of 88.5 clients (extrapolated, this equates to an exit rate equivalent of 4.18%). **DTOC Merton** M6 (Sep-18) shows that delayed days attributable to NHS did not meet target for this reporting period (188 delayed days / BCF target: 131 delayed days). There was a high volume of delayed days from SGH (100 delayed days) which do not reconcile with CCG local data (this issue also affects ASC delayed days). Further data validation will be required and it is likely that a challenge for amendment will be made.

Richmond CCG

Successes: The diagnostic standard recovered in October to 99.3%. The CCG achieved the 2WW and 62 day cancer standards at 96.0% and 97.1%. Richmond continues to exceed the IAPT access target, achieving the position expected in quarter 4 2018-19.

Exceptions: The RTT standard remained non compliant in October 2018 with performance of 91.6%, a slight deterioration on the previous month. Performance has not been achieved since April 18 driven mainly by non achievement of the standard for CCG patients at Imperial, Moorfields and GSTT.

In terms of reducing the waiting list against the March 18 outcome of 9,911 incomplete pathways, the PTL in October 2018 was 12,067 against a plan of 9,909. This variance of 2,158 patients is primarily caused by shifting referral patterns away from St. George's who have not been reporting RTT since June 2016. The visibility of waiting times facilitated by e-RS has driven this movement and the rise in the waiting list is primarily related to 0-4 weeks waiting on the incomplete RTT PTL. The CCG had 1 patient waiting over 52 weeks for treatment.

Sutton CCG

Successes: The Diagnostic target was met in October with an outcome of 99.5%, the second consecutive month an improvement was recorded having not achieved in July and August. As well as continuing to achieve the cancer 2WW standard, the 62 day standard recovered in October to 88.2% having been reported at 78.1% in September.

Exceptions: RTT performance of 90.1% for the CCG is a slight increase on recent months. In terms of reducing the waiting list against March 18 outcome of 12,891 incomplete pathways, Octobers outcome was 13,045. This was a variance of 409 patients against a target of 12,636, mainly due to an increase at the Royal Marsden. Reported under-performance on the 92% incomplete standard is mainly due to non-achievement at ESTH and Moorfields for the CCG. ESTH, a large provider to the CCG also did not achieve the standard in October delivering performance of 87.3% which is just below the Trust's trajectory of 87.4% for the month. The CCG had 6x 52 week waiters all of which were at ESTH, the Trust having seen an increase overall from 8 in September to 12 in October.

Wandsworth CCG

Successes: Diagnostics performance has been maintained with an outcome of 99.7%. As well as continuing to pass the cancer 2WW standard, the 62 day standard recovered in October to 93.6% having been reported at 82.1% in September. In terms of reducing the waiting list against March 18 outcome of 10,563 incomplete pathways, October's outcome was 11,605 a variance of 50 patients against the plan of 11,555. The CCGs RTT performance of 89.92% is an improvement on the previous month's outcome, and is above the operating plan trajectory of 89.24% for the month. Wandsworth is achieving IAPT access and waiting time targets and is looking to improve data quality in practice providing IAPT services by providing IAPTUS software to four practices. IAPT recovery is at 53.2% for October and 49.8% for the year to date. There has been a significant reduction in DTOCs in October (187 days compared to 399 in September. Weekly escalation calls have been re-instated to reduce numbers. The CCG are Increasing enablement capacity to support hospital discharges including a plan to facilitate weekend discharges into Enablement Service. Also Mitigating delays by using step-down beds and 24-hour enablement packages / care packages in patients' homes

Exceptions: The CCG had 8 patients waiting over 52 weeks for treatment in October one more than in September. SGH A&E performance of 85.5% in October was below the performance trajectory of 93.0% for the month.

A&E - 4 Hour Standard

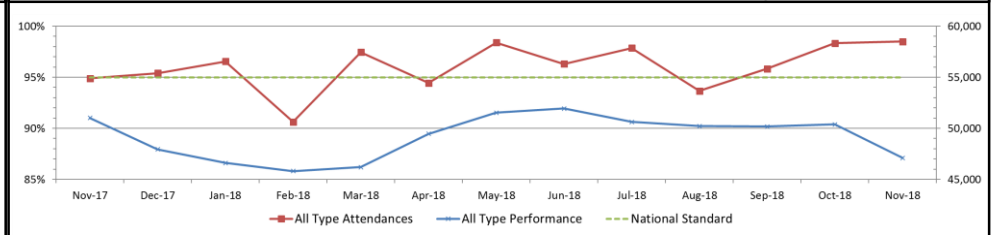
Lead LDU:Sutton | Named Lead:Sean Morgan | Period: M8 2018/19 | Report: Date: 13/12/2018

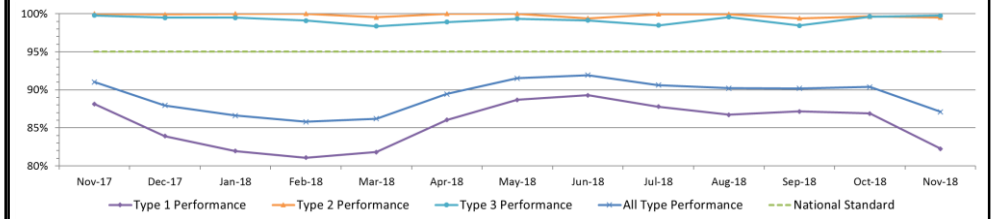
A&E Performance

Provider	A&E Type	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Croydon Health Services NHS Trust	Croydon UH - T1	83.0%	74.3%	66.9%	69.0%	71.8%	70.9%	70.1%	67.9%	62.5%	62.0%	70.1%	70.9%	60.9%
	Urgent Care Centre - T2/T3	99.7%	99.4%	99.4%	98.9%	98.0%	98.7%	99.2%	98.9%	98.2%	99.4%	98.0%	99.5%	99.7%
	Provider All Type	93.0%	89.4%	86.8%	87.1%	88.1%	87.9%	88.2%	87.7%	85.0%	85.0%	87.0%	88.7%	85.1%
Epsom And St Helier University Hospitals NHS Trust	*Epsom - T1*	94.0%	88.7%	87.2%	89.1%	89.7%	93.5%	94.6%	95.9%	95.0%	96.3%	94.8%	91.1%	88.8%
	St Helier - T1	92.4%	88.2%	89.2%	83.7%	88.7%	91.2%	91.2%	93.9%	93.7%	92.8%	91.5%	89.6%	89.1%
	Sutton - T2/T3	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Epsom - T2/T3	N/A	N/A	N/A	N/A	100%	100%	100%	100%	98.9%	100%	100%	100%	100%
	Provider All Type	93.8%	90.3%	89.6%	87.3%	90.2%	93.0%	93.5%	95.3%	94.7%	95.2%	94.8%	91.5%	90.7%
Kingston Hospital NHS FT	Kingston - T1	88.3%	85.0%	85.8%	83.0%	82.1%	87.5%	90.8%	91.1%	89.3%	89.0%	87.1%	90.9%	86.1%
	Kingston REU - T2/T3	100%	100%	100%	100%	99.4%	100%	100%	99.2%	99.9%	99.9%	99.3%	99.5%	99.3%
	Provider All Type	89.5%	86.3%	87.3%	84.8%	83.9%	88.9%	91.9%	92.1%	90.4%	90.2%	88.4%	91.9%	87.6%
St George's University Hospitals NHS FT	St George's - T1	85.9%	83.5%	81.3%	81.8%	79.7%	87.1%	92.6%	92.8%	92.6%	90.2%	89.3%	89.1%	83.9%
	Q Mary Roe'ton - T2/T3	100%	99.8%	99.9%	100%	100%	100%	100%	99.9%	99.9%	100%	99.9%	100%	100%
	Provider All Type	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%
South West London Total All Type		91.0%	87.9%	86.6%	85.8%	86.2%	89.5%	91.5%	91.9%	90.6%	90.2%	90.2%	90.4%	87.1%

N.B. ALL DATA IS NHSE PUBLISHED DATA EXCEPT ESTH AT SITE LEVEL, WHICH IS BASED ON DAILY RETURNS AND NOT MONTHLY RETURN.

A&E Performance vs Attendance and Performance by TYPE





	Narrative	Owner	Due
SWL	**Overall A&E All Type performance decreased in November by 3.3% with an outcome of 87.1% across the 4 SW London providers, moving further from of the Operating Plan trajectory for the month of 92.1%. All SWL providers saw a decrease in performance compared to October. London wide All Type performance for November 2018 was 88.1%, while the national figure was 87.6%.**		
CHS	**Current position** A&E All Type performance was 85.12% in November a drop on the 88.72% achieved in October, All-type performance did not achieve the operating plan trajectory of 91.75%. A&E Type 1 performance was 60.9% a significant decrease on the 70.94% achieved in October. The month saw continued pressure in ED and on beds throughout the hospital, paediatric demand was especially challenged with high numbers of respiratory presentations. Key areas for deterioration in performance were: 1) Paediatric demand, 2) ED medical staffing, 3) Lack of escalation of the site/emergency department challenges, 4) Mental health patients in ED. The Trust has routinely been starting the days with high numbers of DTAs, combined with inadequate discharges impacting on performance.	CEO, CHS and Chair of the Croydon A&EDB	90% in Mar–19
	Current Actions: Launch of the new ED on the 2nd December 2018 went smoothly. However, a significant increase in attendances the following day put pressure on the system, with recovery continuing through the week. A number of new processes have been introduced: *Ambulance Handover:* Single point of clinical handover with LAS streamer (now 24/7) with removal of RATT and placing of patients directly into cubicles and entry of handover PIN in cubicle. Handovers under 15 minutes increased from 13.92% to 37.27% for the periods Sunday to Thursday before and after the move. Further improvements expected as crews adjust to the new process. *Zoning:* Cubicles will be zoned with a named Doctor and Nurse for each Zone. These would receive, treat and manage the patient through their entire pathway. This is expected to reduce ED blockages. *ISTAT*: Integrated See, Treat and Triage, will serve as front door triage, managed by a senior decision maker, focused on supporting provision of ambulatory care. *Opening formal ring-fenced assessment* capacity in late December, early January, to allow a more efficient staffing model compared to the current approach		
ESTH	**Current position:** Performance for All Type attendances was not achieved with an outcome of 90.7% in November, down from 91.5% in October. The Operating Plan trajectory for November was set at 93.5%. Both sites have been in escalation capacity and have found it difficult to sustain flow. SECAMB activity has been high on the Epsom site. The number of >21 day long stays has seen a significant decline from mid-Nov, the Trust is achieving the system long stay reduction target.	COO, ESTH Sutton Director of Commissioning	Ongoing
	Current Actions: Current Actions: the focus across the system is on flow, a "deep-dive" of the patient group with a length of stay of over 21 days is in progress with NHSI collaboration. Mapping of winter stocktake findings against the seven "pillars" for delivery for winter planning completed and reported the AEDB. Priorities are, patient flow to meet the long stay reduction target by Dec 2018 - process mapping session with all system partners held in July and a scenarios based exercise held at the October AEDB meeting, new rapid assessment hub (opened July) with a medical registrar to assess patients, work with the Trust to review the ambulatory care pathway ongoing. Other actions include: 1. Front Door Streaming made more robust via a navigator to support triage (commenced 10th Dec). 2. Review of processes underpinning patient flow out of the organisation. 3. Estates improvement in ED to see and treat patients arriving by ambulance (now completed). 4. Increase in medical staff (middle grade doctors) to support peaks in demand & review of EPN rota. 5. Additional consultant on Saturday and Sundays to help rapid clinical assessment. To manage the risk around breaching 4 Hour AE Target over winter, the CCG is working with the trust to hold a weekly systems lead call to implement four winter initiatives: Supporting Front Door of A&E/Discharge to Assess model on ward B5/Targeted communication plan/Frailty Advice Line. Surgical Assessment Unit has gone live which should improve flow and support reduction in >21 day long stay patients.		
KHFT	**Current position:** A&E All Type performance was reported at 87.57% in November, down from 91.88% in October. The Operating Plan trajectory for November 2018 was set at 89.5%. The main reasons for breaches were from issues relating to specialty response times, bed availability and breaches emanating from within the Emergency Department. Paediatric capacity became an issue in late November for the Trust in common with the rest of SWL.	Chair, A&EDB	95% in Mar–19
	Current Actions: Actions to address the recovery are part of the Emergency Care Programme Plan (ECPP) monitored via the Kingston and Richmond AEDB. The hospital to home work stream through Kingston Co-ordinated Care is being rolled out throughout Q4 2017-18, with a similar locality team model planned in Richmond. Update reports on the 8 pillars of the ECPP are scrutinised at the K&R A&E Delivery Board. GP hubs are working well and utilisation has increased through the winter period, which has meant the numbers into A&E are stable. Plans for 2018/19 being developed as part of winter review, a Joint Agency Discharge team and a focus on actions to reduce stranded patients.		
SGH	**Current position:** A&E All Type performance of 85.5% in November has fallen from the 90.1% achieved in October 2018. Performance was also below the Operating Plan trajectory for November of 93.0%. Challenges for the Trust have been bed availability and staffing in ED, particularly the variances between different ED shifts. The Trust is implementing a 15 point plan which contains actions for both admitted and non-admitted patients. This plan is monitored at a weekly cross divisional meeting. The Trust is also focusing on shift leadership within ED to minimise the inconsistent performance between shifts.	COO SGH M&W ECDB Chair	Ongoing 95.0% In June 18 Ongoing June 18
	Current Actions: Trust continues to implement its Unplanned and Admitted Patient Care programme, (U&APC Programme) a Trust wide approach to improving flow for non-elective and admitted patients.1. Winter plan has been fully developed together with a new November action plan. 2. The new Ambulatory and Acute Assessment (AAA) unit (currently operational 14 hours a day / 7 days a week. 3. The Trust is implementing actions from 15 Point Plan for the Four Hour Emergency Care Standard. In addition to this, St. George's have introduced a plan to reduce overcrowding in the ED, simplify processes to improve triage and decision making and have clear escalation processes in case of surges in demand.4. The AEDB working with NEL and SGH to explore potential for a 'predictive' element to the nascent Emergency Care Dashboard. The trust have also implemented a 'Command and Control' structure under the leadership of the Chief Operating Officer with immediate effect in order to reduce bed occupancy and support the recovery of flow and emergency care performance. This structure is set up to run Mon-Fri in standard working hours with an agreement for it to be extended to overnight shifts (26/11 to 28/11 initially) to access further actions to deliver improved flow and patient care. The plan will be supported by clinical, nursing and managerial leaders who will provide oversight of actions across 3 key areas of unplanned and admitted patient vary pathway, including Emergency Department, Inpatient processes and discharge processes.		

Referral to Treatment (RTT) – 18 week Incomplete

Lead LDU: Merton and Wandsworth | Period: M7 2018/19
Named Lead: John Atherton | Report: Date: 13/12/2018

NEL

RTT- By Trust

Provider	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
KHFT	94.00%	94.63%	94.47%	94.77%	94.35%	93.19%	94.04%	94.44%	94.17%	93.89%	93.55%	93.15%	93.34%
CHS	92.03%	92.01%	92.01%	92.55%	92.61%	92.74%	92.76%	92.92%	93.12%	93.19%	93.30%	93.01%	93.24%
ESTH	89.05%	89.30%	88.03%	86.73%	85.91%	86.11%	86.73%	87.98%	87.71%	87.29%	86.90%	86.67%	87.32%
SGH	-	-	-	-	-	-	-	-	-	-	-	-	-
RMH	97.30%	97.15%	95.87%	96.00%	97.27%	97.75%	98.23%	98.48%	98.51%	98.03%	97.98%	97.37%	98.09%
Total	91.44%	91.65%	90.96%	90.61%	90.23%	90.15%	90.76%	91.54%	91.51%	91.30%	91.08%	90.78%	91.21%

RTT waiting list against March-18 (providers)

Provider	Mar-18	Aug-18	Sep-18	Oct-18	Variance to Mar-18	Trend
KHFT	16,376	19,741	19,474	20,060	3,684	
CHS	20,285	23,055	22,928	23,251	2,966	
ESTH	28,781	27,847	27,663	27,290	-1,491	
SGH	-	-	-	-	-	-
RMH	1,826	2,378	2,476	2,354	528	
Total	67,268	73,021	72,541	72,955	5,687	

	Narrative	Owner	Due
SWL	**At CCG level in SW London:** October performance was reported at 91.5% which represents a 0.2% rise on September. Croydon and Kingston CCGs have achieved the RTT performance standard consistently since April 2018. Of the four non compliant CCGs three improved their position on September with only Richmond declining in month.		
	At provider level in SW London: Aggregate RTT Performance was 91.2% in October higher a 0.4% rise on September. The RTT performance standard remains non compliant at ESTH with October 2018 performance of 87.3% marking the first increase in performance since May 2018. Both CHS and KHFT also posted performance increases in month.		
CHS	**Current position:** CHS continues to achieve the performance standard with an outcome of 93.24% in October. Dermatology , Oral Surgery, Plastic Surgery and T&O were below the 92% standard, however ENT returned to compliance at 92.3%. Overall the Trust continues to perform above its trajectory. One patient was reported waiting over 52 weeks at the Trust in October.		
	Current Actions: CHS has rolled out its new PTL allowing the teams live access to a more granular level of detail concerning patients pathways, they continue to work on building additional reporting functionality. The Trust continues to focus on long waiters and report that all patients above 35 weeks are currently dated.		
ESTH	**Current position:** Performance was 87.3% in October 2018, marginally behind trajectory by 0.1%. The waiting list size target was achieved with 27,290 patients waiting against a plan of 27,800 for the month. Incomplete 52 week waiters increased to 12 in October from 8 in September.	ESTH / Director of Planned Care	Apr-18 /on-going
	Current Actions: Activity to maintain the RTT incomplete waiting list has been agreed in the 2018/19 contract. The Trust has agreed business cases for additional Consultant staff in several specialties, and is putting in place a range of actions in the interim until those staff are in post including use of Locums, in-sourcing and additional ad hoc sessions to increase capacity in the short term. Work is being expedited to consider a range of outpatient transformation initiatives, as alternative approaches to traditional follow-ups including virtual reviews.		
SGH	**Current position:** The Trust is ahead of trajectory on its shadow reporting both in terms of performance and PTL size, and remains on course to hit 84% incomplete pathway performance by March 2019 as forecast. The Trust is ensuring that ASI patients are booked and added to the main PTL. Plans are in place to deliver the aim of eliminating the longest waits by the end of March through additional internal capacity, along with outsourcing to other providers notably bariatric patients to Ashford and St. Peters and also independent sector providers. Work continues to improve data quality reducing unknown clock starts, and duplicate registrations on the PTL, while RTT awareness training sessions continue to be delivered to key staff groups. MBI are currently engaged to review fitness to return to reporting, a report focussing on data quality is due to be submitted in December with a full report going to the Trust board in January for review.	SGH/ Elective Care Recovery Board	Ongoing Dec 18 March 19
	Current Actions: Incomplete and planned PTLs are now in place and being used by operational teams. Validation continues and the Trust is currently meeting performance against trajectory. The Joint Referral Unit hosted by CHS continues to take patients from SGH waiting list for treatment at CHS and KHFT. SGH have begun shadow reporting RTT data for SGH site with a view to returning to national reporting in Q4. In terms of external validation of the return to reporting process a consultant team has been appointed to look at the systems in SGH with an aim to provide an assessment by mid December 2019, which will inform the Trust on readiness to return to reporting.		

RTT Incomplete Pathways > 52 weeks
SW London CCGs by Trust

Provider	NHS CROYDON CCG	NHS KINGSTON CCG	NHS MERTON CCG	NHS RICHMOND CCG	NHS SUTTON CCG	NHS WANDSWORTH CCG	SW London Total
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST		1					1
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST			1		6		7
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST						1	1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	8			1		6	15
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST			1				1
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST						1	1
CCG Total	8	1	2	1	6	8	26

52 Week Waits: At SW London CCG level there were 26 patients reported waiting over 52 weeks in October 2018, This continues the downward trend seen in recent months and is a decrease of 8 patients on the September position.

Croydon CCG had 8 patients waiting over 52 weeks for treatment in October, all of which occurred at KCH. There were 4x General surgery and 4x T&O. 4 patients have since been treated (2x T&O, 2x General Surgery), 2x T&O patients have been removed from the waiting list due to patient fitness, 1x General Surgery has a TCI in December and 1x General Surgery is awaiting a TCI date.

Kingston CCG had 1 patient waiting over 52 weeks at East Kent University FT in Gynaecology. The patient has a TCI date of the 8th December.

Merton CCG had 2 patients waiting over 52 weeks in October. 1 X Dermatology patient at ESTH following admin error in referral to SGH, the patient has an Outpatient appointment in November, 1x Ophthalmology patient at Moorfields who's treatment plan was due to be finalised following an appointment on the 30th November.

Richmond CCG had 1 patient waiting over 52 weeks for treatment at KCH in General Surgery, patient treated in November.

Sutton CCG had 6 patients waiting over 52 weeks in October (an increase on the 4 reported in September), all at Epson & St. Helier. 3x ENT, (2x discharged, 1 Referred to SGH for treatment), 1x General Surgery - treated 19th November, 1x Neurology treated 21st November and 1x T&O – currently awaiting diagnostic and referral to community physio.

Wandsworth CCG had 8 patients waiting over 52 weeks, one more than the previous month. There were a total of 6 patients at KCH, 3x T&O, 1 patient has a TCI in December, 2 are awaiting TCI (1 declined offer of date in September). 2x General Surgery both awaiting TCI (1 has elected to defer their treatment until the new year) and 1x other who had a TCI booked for 29th November. 1x patient waiting for a TCI at GSTT under 'other. One further patient was reported as a 52 week waiter at Liverpool Women's NHS Foundation Trust.

Cancer -Two week wait (2WW) & 62 Day

Lead LDU: SWL Alliance
Named Lead: Clare Wilson
Period: M7 2018/19
Report: Date: 10/12/2018

2 Week Wait (Provider)

Provider	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
CHS	97.71%	96.82%	95.91%	96.32%	97.25%	97.61%	95.11%	98.37%	98.32%	97.96%	97.16%	95.04%	97.48%
ESTH	96.10%	96.70%	97.60%	94.00%	97.19%	97.41%	96.05%	97.19%	98.97%	97.82%	96.38%	98.29%	96.71%
KHFT	97.72%	98.50%	98.95%	97.61%	98.91%	98.53%	99.27%	98.39%	99.08%	99.03%	99.24%	99.23%	99.00%
SGH	96.05%	97.35%	98.51%	94.76%	96.72%	96.80%	93.08%	93.34%	82.99%	93.11%	95.00%	95.48%	96.26%
RMH	97.88%	95.74%	96.68%	89.98%	93.32%	94.49%	89.47%	81.20%	82.27%	90.83%	88.12%	84.69%	84.36%
Total	96.95%	97.16%	97.62%	95.00%	97.01%	97.26%	95.11%	95.25%	93.11%	96.23%	95.97%	95.91%	96.21%

2 Week Wait (CCG)

CCG	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Croydon	97.40%	96.76%	95.47%	95.91%	97.28%	97.34%	95.25%	97.87%	97.72%	97.20%	96.72%	93.59%	96.89%
Kingston	96.94%	98.34%	99.73%	97.85%	97.64%	98.89%	98.59%	96.69%	98.53%	99.11%	98.71%	99.13%	98.85%
Merton	96.72%	97.90%	98.59%	95.24%	98.05%	97.84%	95.27%	94.89%	89.07%	95.09%	96.06%	95.95%	98.31%
Richmond	96.17%	95.79%	96.08%	95.21%	96.81%	96.86%	95.25%	96.39%	94.80%	95.65%	95.43%	93.66%	95.99%
Sutton	96.89%	97.73%	98.32%	92.83%	97.67%	97.22%	96.52%	93.16%	97.68%	97.37%	97.27%	98.06%	96.95%
Wandsworth	95.61%	97.19%	98.58%	95.05%	95.88%	96.83%	94.50%	95.19%	84.83%	93.75%	94.56%	95.56%	95.52%
Total	96.64%	97.16%	97.49%	95.38%	97.15%	97.43%	95.67%	95.96%	93.46%	96.23%	96.30%	95.53%	96.94%

62 Day Wait (Provider)

Provider	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
CHS	83.02%	93.91%	92.19%	87.34%	90.36%	93.07%	93.14%	96.81%	89.73%	83.02%	88.28%	90.72%	85.45%
ESTH	80.00%	85.00%	85.27%	76.92%	80.61%	90.76%	87.76%	90.18%	87.68%	86.71%	87.41%	86.29%	90.30%
KHFT	88.18%	91.43%	89.00%	90.99%	92.93%	92.37%	91.40%	99.26%	97.64%	97.18%	94.87%	96.75%	95.93%
SGH	85.60%	80.61%	86.24%	78.38%	80.81%	88.07%	92.31%	85.91%	89.58%	85.71%	85.53%	80.58%	87.79%
RMH	73.17%	79.31%	64.38%	70.45%	77.21%	80.99%	74.24%	80.74%	79.08%	73.33%	76.27%	75.74%	76.67%
Total	81.85%	86.08%	82.52%	80.00%	83.69%	88.91%	87.32%	90.10%	88.42%	84.93%	85.61%	85.76%	87.04%

62 Day Wait (CCG)

CCG	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Croydon	78.67%	90.41%	87.80%	83.67%	83.93%	89.47%	88.73%	94.12%	85.87%	78.26%	82.42%	85.00%	81.16%
Kingston	86.11%	82.93%	89.66%	87.88%	90.63%	91.67%	86.21%	97.50%	93.33%	93.48%	91.67%	97.06%	96.88%
Merton	83.87%	93.55%	88.46%	76.47%	70.00%	85.19%	82.14%	96.67%	85.29%	77.27%	92.11%	80.00%	84.21%
Richmond	91.18%	93.75%	86.36%	80.56%	86.21%	86.84%	93.02%	92.68%	97.78%	96.88%	95.35%	90.91%	97.06%
Sutton	85.71%	89.74%	76.47%	77.78%	73.33%	87.80%	87.88%	92.00%	85.11%	89.80%	82.14%	78.13%	88.24%
Wandsworth	91.18%	84.38%	93.55%	78.38%	88.89%	93.33%	84.85%	93.18%	86.96%	95.83%	87.18%	82.14%	93.55%
Total	84.90%	89.11%	87.05%	80.89%	83.25%	89.08%	87.76%	94.14%	88.44%	86.74%	86.94%	85.71%	88.63%

SW London Narrative

The 2WW Performance Standard:

At SW London CCG level: The 2WW performance standard was achieved at aggregate level with performance of 96.9%. The 2WW standard was achieved at all CCGs. The 2WW Breast Symptomatic performance standard was achieved with performance of 96.6% (19 breaches out of 555 pathways). The Breast Symptomatic standard was not achieved at Richmond CCG 92.4% (5 breaches out of 66 pathways).

At SW London provider level: The 2WW performance standard was achieved at aggregate level with an outcome of 96.2%. London wide performance was achieved with 93.7% and National performance was not achieved with 92.3% in month. The Breast Symptomatic standard was achieved at aggregate level with performance of 96.7%. London performance was compliant in month with 95.0% and the National performance was non-compliant with 91.9%. The Royal Marsden did not achieve the Urgent GP 2WW standard with 84.4% (76 breaches out of 486 pathways). At The Royal Marsden following on from a significant increase in 2WW referrals in recent months for Breast and Sarcoma there were 23 breast breaches and 40 sarcoma breaches. 13 of the 23 breast breaches were the result of patient choice and 8 were the result of outpatient capacity challenges (2 resulted from other delays). 7 of the 40 sarcoma breaches were the result of patient choice and 29 were the result of capacity challenges (4 resulted from other delays). The Breast Symptomatic target was achieved at aggregate level with 96.7%.

The 62day Performance Standard:

At SW London CCG level: The performance standard was achieved at aggregate level with performance of 88.6% (29 breaches out of 255 pathways) in October. The standard was not achieved at Croydon CCG 81.2% (13 breaches out of 69 pathways) and Merton CCG 84.2% (6 breaches out of 38 pathways). The London performance was not compliant in month with 81.5% and the National performance was non-compliant with 78.3%.

At SW London Provider level: The performance standard was achieved in October with performance of 87.0% (44 breaches out of 339.5 pathways). The standard was not achieved at RMH 76.7% (17.5 breaches out of 75 pathways). The internal performance at The Royal Marsden was 91.7 %. London performance was not compliant in month with 80.7% and the National performance was non-compliant with 78.4%.

Forward view for November 2018

Provisional data for November 2018 shows that the SW London sector is likely to be non-compliant with the 62 day standard. However this will be subject to change and validation as more data becomes available.

Key Actions

Action	Narrative	Owner	Due
Compliance with 2 Week Wait Standard	At The Royal Marsden, November saw a high number of sarcoma and breast breaches, as the services manage the backlog resulting from the significant increases in 2WW referrals received in recent months. Further additional clinics are scheduled to take place in December. Additional sarcoma clinics are also planned in December to help address the current backlog. Performance is expected to remain low whilst the waiting list initiatives are undertaken to address the reported backlog. The Trust is due to receive £34,000 funding which has been awarded to help address the current 2WW capacity challenge.	The Royal Marsden	Jan-19
Improved performance against 38 day trajectories within SWL	SWL are collecting data on specialist diagnostics to identify average times from referral to reporting. This work is being supported by RMP at the CWT Task & Finish Group. Shadow reallocation and 38/24 day activity data is now being published from TCST and this is being reviewed at various cancer performance meetings. TSCT are delivering training across providers on the new ITT policy and 28 day Faster Diagnosis. Sessions are planned at Epsom and RMH in January.	RM Partners SLF/RMP/ TCST TCST	Jan-19 Dec-18 Jan-18
Diagnostics	CHS are working towards a one-stop FNA service for Head & Neck in Q4. SWL were successful in receiving additional monies to support diagnostics in specific areas that will have an impact on reducing backlogs and improving turnaround times.	CHS SWL	Jan-18 Mar-19
Cancer Transformation in supporting performance. **(RM Partners Cancer Alliance Projects)**	RMP are working with the System Leadership Forum better understand the lung pathway. The Cancer System Leadership Forum are reviewing data on CT turnaround times. Epsom & St Helier and Sutton CCG have established a working group to focus on implementing the optimal lung pathway and pathway improvements. SWL Providers Q2 breach review was presented to the Cancer System Leadership Forum and key areas of focus have been identified. These actions will form part of the ongoing agenda for SLF to continue to improve services across the sector.	RMP/SLF RMP/ESTH SLF	Jan-19 Ongoing Ongoing

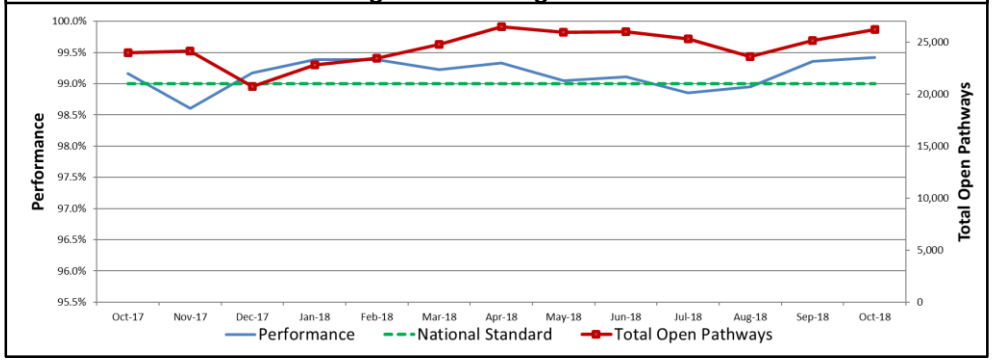
Diagnostic waits

Lead LDU: Merton and Wandsworth
Named Lead: John Atherton
Period: M7 2018/19
Report Date: 13/12/2018

SW London Diagnostic Performance (By CCG)

SWL CCG	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
NHS CROYDON CCG	99.6%	99.2%	99.3%	99.4%	99.5%	98.9%	99.2%	98.9%	98.5%	98.4%	98.4%	99.5%	99.1%
NHS KINGSTON CCG	99.4%	99.0%	99.4%	99.6%	99.5%	99.7%	99.7%	99.7%	99.6%	99.7%	99.5%	99.7%	99.6%
NHS MERTON CCG	99.6%	98.9%	99.2%	99.8%	99.5%	99.5%	99.7%	99.3%	99.3%	98.9%	99.3%	99.3%	99.6%
NHS RICHMOND CCG	96.3%	95.9%	98.0%	99.3%	98.5%	98.6%	98.6%	98.8%	99.1%	99.2%	99.2%	98.9%	99.3%
NHS SUTTON CCG	99.4%	98.9%	99.2%	99.5%	99.6%	99.4%	99.4%	98.5%	99.5%	98.3%	98.7%	99.1%	99.5%
NHS WANDSWORTH CCG	99.5%	98.7%	99.4%	99.0%	99.3%	99.4%	99.4%	99.4%	99.5%	99.3%	99.3%	99.5%	99.7%
Total	99.2%	98.6%	99.2%	99.4%	99.4%	99.2%	99.3%	99.1%	99.1%	98.9%	98.9%	99.4%	99.4%

SW London Diagnostic Waiting List and Performance



SW London Narrative

At CCG Level in SW London:
Performance was achieved in October with an outcome of 99.4% at SW London CCG level with Richmond's position recovering from September. All 6 CCGs met compliance this month, this is the first time this has occurred since January 2018.

At South West London CCG level, there were 152 breaches out of 26,222 waits of which Endoscopy accounted for 77 breaches, Non Obstetric Ultrasound breaches more than halved from 57 in September to 25 in October.

Richmond CCG returned to compliance in October 2018 achieving 99.3%, with 19 breaches down from 32 the previous month. This was mainly driven by improvement of the position at Chelsea and Westminster Hospital NHS foundation Trust.

At Provider level in SW London:
Performance was achieved in October with an outcome of 99.62% at SW London provider level with 104 breaches out of 27,397 waits. All four providers achieved compliance for the first time since April 2018. This is an improvement in performance and a reduction of 41 breaches on the September position. Non Obstetric Ultrasound contributes the highest number of these breaches at 23, however across the four tests endoscopy accounts for 50 breaches.

ESTH: The Trust returned to compliance in October achieving 99.5% up 0.6% on September. A total of 42 breaches were reported for 7,981 waits. Much of this improvement was in non obstetric Ultrasound where no breaches were recorded in October completely recovering the position from 45 breaches the previous month, non compliance in Non Obstetric Ultrasound had been driven by Sonographer and Consultant vacancies.

Of the Trusts 42 breaches 35 were in Endoscopy, a slight rise by 4 on September. The reasons for non-compliance have remained the same since July. Primarily the growth in demand for the numbers of scopes has outstripped permanent capacity. The increase in Two Week Referrals and urgent referrals is placing considerable challenge into the system and affecting management of planned (DM01 and surveillance) procedures.

SW London Diagnostics Waits < 6 Weeks (SWL CCG level By Test)

Diagnostic Test Name	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	October CCG Pass Rate
Audiology Assessments	98.9%	99.9%	100.0%	99.7%	99.6%	99.8%	99.6%	99.9%	99.6%	98.8%	99.3%	99.0%	99.8%	5/6
Barium Enema	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1/1
Colonoscopy	98.0%	99.0%	98.6%	98.3%	96.5%	98.0%	95.7%	98.5%	98.7%	92.7%	94.9%	96.8%	96.4%	3/6
CT	99.6%	99.7%	99.5%	99.9%	99.5%	98.2%	99.8%	99.8%	99.8%	99.9%	100.0%	99.7%	99.8%	6/6
Cystoscopy	94.4%	95.1%	97.1%	94.0%	94.3%	93.0%	95.8%	94.8%	94.0%	93.4%	94.0%	95.1%	94.9%	0/6
DEXA Scan	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.8%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	6/6
Echocardiography	99.7%	99.2%	99.4%	99.5%	99.8%	99.1%	99.7%	98.1%	96.1%	95.9%	95.9%	99.6%	99.2%	5/6
Electrophysiology	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	2/2
Flexi Sigmoidoscopy	98.8%	99.0%	98.1%	97.7%	98.8%	98.9%	98.3%	98.7%	99.3%	97.2%	97.5%	98.8%	97.5%	1/6
Gastroscopy	98.2%	97.9%	96.9%	97.8%	97.9%	98.3%	96.9%	98.5%	99.0%	96.6%	97.5%	98.5%	97.7%	3/6
MRI	99.3%	99.3%	99.6%	99.7%	99.7%	99.6%	99.6%	98.0%	99.5%	99.8%	99.5%	99.9%	99.8%	6/6
Non Obstetric Ultrasound	99.3%	99.1%	99.4%	99.7%	99.9%	99.9%	99.9%	99.9%	99.7%	99.7%	99.6%	99.5%	99.8%	6/6
Peripheral Neurophys	99.4%	99.8%	99.6%	99.6%	99.6%	99.8%	99.8%	99.4%	99.8%	100.0%	99.4%	99.3%	99.4%	3/6
Sleep Studies	96.8%	73.6%	93.8%	92.7%	94.9%	92.9%	92.1%	92.2%	95.5%	98.4%	97.2%	100.0%	99.6%	5/6
Urodynamics	93.8%	95.5%	97.4%	93.4%	92.7%	92.7%	93.0%	91.8%	93.9%	91.2%	96.1%	92.5%	94.9%	1/6
Total	99.2%	98.6%	99.2%	99.4%	99.4%	99.2%	99.3%	99.1%	99.1%	98.9%	98.9%	99.4%	99.4%	6/6

SW London Diagnostic Performance (By Provider)

Provider	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
KHFT	99.27%	99.21%	99.85%	99.68%	99.48%	99.84%	99.85%	99.86%	99.71%	99.64%	99.74%	99.75%	99.51%
CHS	99.88%	99.78%	99.44%	99.55%	99.66%	99.09%	99.62%	99.13%	98.57%	98.65%	98.63%	99.75%	99.69%
ESTH	99.54%	99.58%	98.98%	99.43%	99.47%	99.04%	99.02%	98.80%	99.40%	97.59%	98.61%	98.84%	99.47%
SGH	99.69%	98.11%	99.91%	99.85%	99.96%	99.76%	99.81%	99.83%	99.68%	99.68%	99.78%	99.61%	99.78%
Total	99.62%	99.11%	99.49%	99.63%	99.66%	99.37%	99.53%	99.34%	99.31%	98.77%	99.12%	99.45%	99.62%

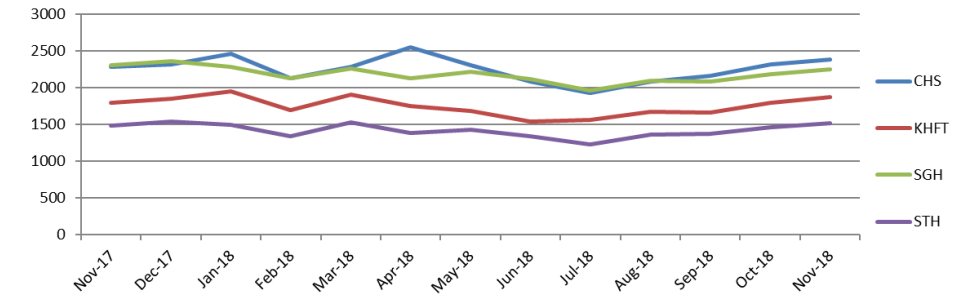
Key Actions

Objective	Actions Narrative	Owner	Due
ESTH Endoscopy	In Endoscopy the Trust has used additional sessions and has completed a demand and capacity exercise for Endoscopy and has additional funding for insourcing in December.		Dec-18

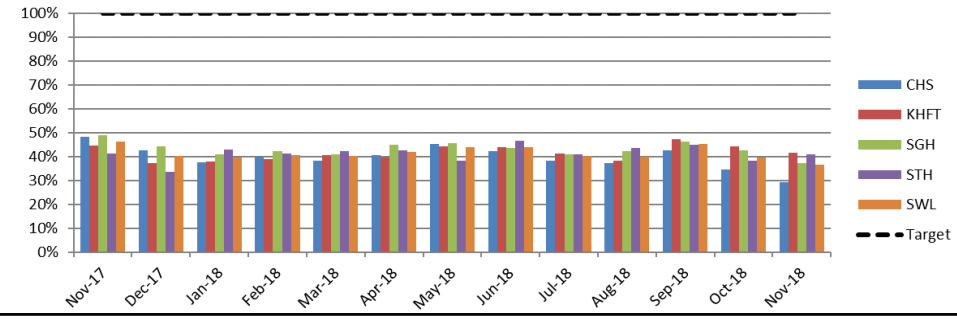
Ambulance Handovers - London Ambulance Service (LAS)

Lead LDU: Croydon
Named Lead: Elaine Clancy
Period: M8 2018/19
Report: Date: 18/12/2018

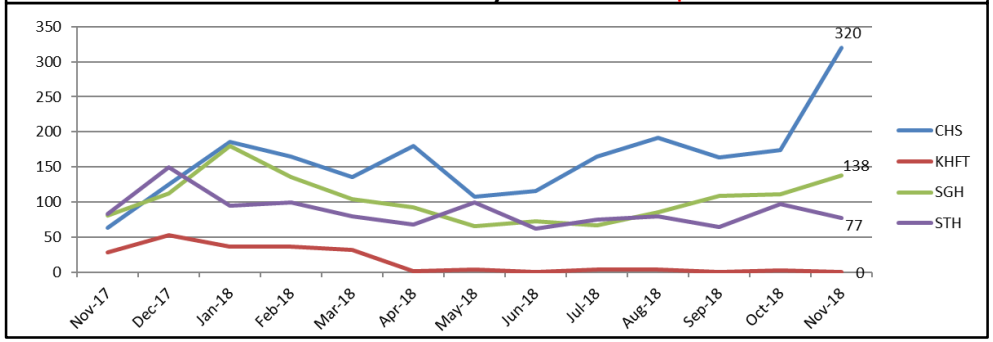
LAS Conveyances by Provider



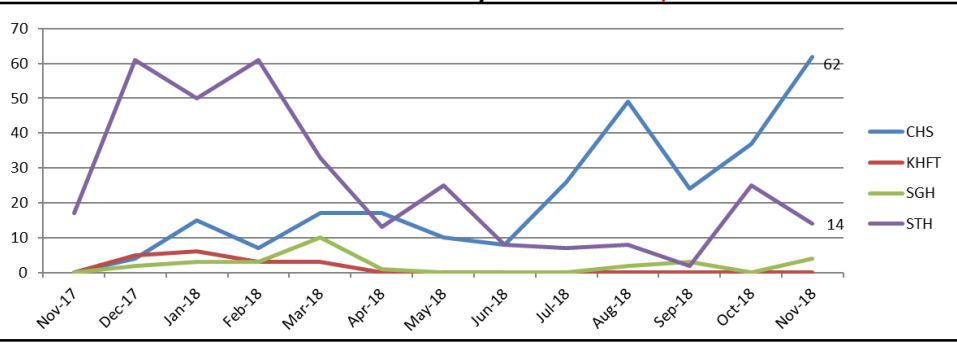
LAS patient handover within 15 minutes Data is not validated



LAS 30 Minute Breaches By Provider Data is post validation



LAS 60 Minute Breaches By Provider Data is post validation



This section reports upon and considers London Ambulance Service (LAS) conveyances only. Some Hospital sites will also have conveyances from SECAMB and/or others, however these are not included in the above data.

SW London Narrative

Handover Breaches (November)
The SWL total of 30 min breaches in November was 535 in compared with 384 for October. There were 80 x 60 minute breaches in November compared with 62 x 60 min breaches October.

Handovers within 15 minutes (November)
SEL achieved 57.1%
NEL achieved 30.7%
NWL achieved 56.2%
NCL achieved 47.0%
SWL achieved 36.7%.

Estates work at the St Helier hospital site completed in mid-November providing additional capacity for handovers.

Key Actions

Trust	Actions Narrative	Owner	Due
Croydon Health Services	Single point of clinical handover with LAS streamer (now 24/7) with removal of RATT and placing of patients directly into cubicles and entry of handover PIN in cubicle. Handovers under 15 mins increased from 13.92% to 37.27% for the periods Sunday to Thursday before and after the ED move. Further improvements expected as crews adjust to the new process.	Chief Operating Officer	Ongoing
Kingston Hospital	Handovers are monitored via daily information provided by KHFT, including conveyances, % handover within 15mins, >30 minutes, >60 minutes and data completeness. The Trust wishes to work more closely with SECAMB on delays, which will be progressed via the A&E DB.	AD Emergency Care	Ongoing

Ambulance Response Programme –
Response times by Ambulance Trust and STP

Period: M7 2018/19
Report: Date: 18/12/2018

NEL

Ambulance Response Programme Overview

Category	% of calls per Category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	•7 minutes mean response time •15 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •30 seconds from the call being connected	The first emergency vehicle that arrives on scene stops the clock.(There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	•18 minutes mean response time •40 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being •dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 3	34%	•60 minutes mean response time •120 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being •dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first emergency vehicle arriving at the scene of the incident stops the clock.
Category 4	10%	•180 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being •dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Clinical criteria for Ambulance Response Call Categories

Category	Types of calls	Response standard	Likely % of workload	Response details
Category 1 (Life-threatening event)	Previous Red 1 calls and some Red 2s, including: • Cardiac arrests • Choking? • Unconscious • Continuous fitting • Not alert after a fall or trauma • Allergic reaction with breathing problems	7 minutes mean response time 15 minutes 90th centile response time	Approx 250 incidents a day (8% of total workload)	• Response time measured with arrival of first emergency responder • Will be attended by single responders and ambulance crews • The only category that rest breaks will be interrupted to attend
Category 2 (Emergency – potentially serious incident)	Previous Red 2 calls and some previous C1s, including: • Stroke patients • Fainting – not alert • Chest pain • RTCs • Major burns • Sepsis	18 minutes mean response time 40 minutes 90th centile response time	48%	• Response time measured with arrival of transporting vehicle (or first emergency responder if patient does not need to be conveyed) • Some Category 2 calls will be attended by single responder if an ambulance is not available for dispatch within eight minutes of call being received
Category 3 (Urgent problem)	• Falls • Fainting – now alert • Diabetic problems • Isolated limb fractures • Abdominal pain	Maximum of 120 minutes (120 minutes 90th centile response time)	34%	• Response time measured with arrival of transporting vehicle
Category 4 (Less urgent problem)	• Diarrhoea • Vomiting • Non-traumatic back pain • HCP admission	Maximum of 180 minutes (180 minutes 90th centile response time)	10%	• Maybe managed through hear and treat • Response time measured with arrival of transporting vehicle

SW London Narrative

Provider Wide (M7 - October)

LAS were green against all measures except the C2 Mean, C3 Mean and C3 90th centile response times in October.

South West London

At a SWL STP level in October performance was compliant across all measures.

- C1 mean response time was 6:10 against the 7 min target.
- C2 mean performance was 17:05 min against the 18 min target.
- C2 90th centile performance was 34.00 against the 40 min target.
- C3 mean performance was 0:44:23 against the 1hr target
- C3 90th percentile was 2:29:52 against the 3hr target.

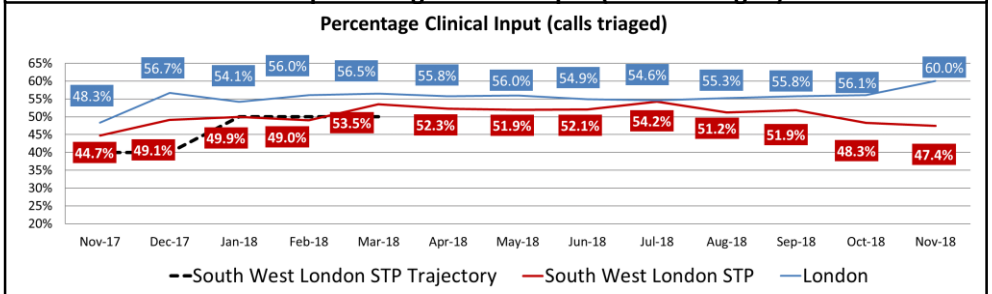
LAS response times profiled by STP

October 2018 STP Position	C1 Mean (00:07:00)	C1 90th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90th Centile (00:40:00)	C3 Mean (01:00:00)	C3 90th Centile (02:00:00)	C4 90th Centile (03:00:00)
North Central	00:06:05	00:10:19	00:19:04	00:37:59	01:00:33	02:21:48	02:31:01
North East	00:06:24	00:10:30	00:18:05	00:36:33	00:48:11	01:55:30	02:40:06
North West	00:06:10	00:10:16	00:17:52	00:35:42	00:53:38	02:09:22	02:54:20
South East	00:06:11	00:10:10	00:15:44	00:31:50	00:41:18	01:37:14	01:57:08
South West	**00:06:10**	**00:09:58**	**00:17:05**	**00:34:00**	**00:44:23**	**01:43:49**	**02:29:52**

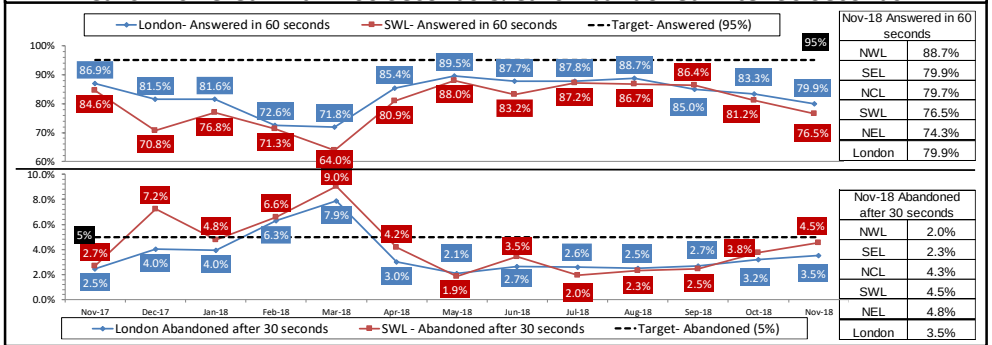
NHS 111 service

Lead : SWL Alliance
Named Lead: Jonathan Bates
Period M8 2018/19
Report: Date: 13/12/2018

NHS 111 percentage Clinical Input (of calls triaged)



Calls Answered Within 60 Seconds & Calls Abandoned After 30 Seconds



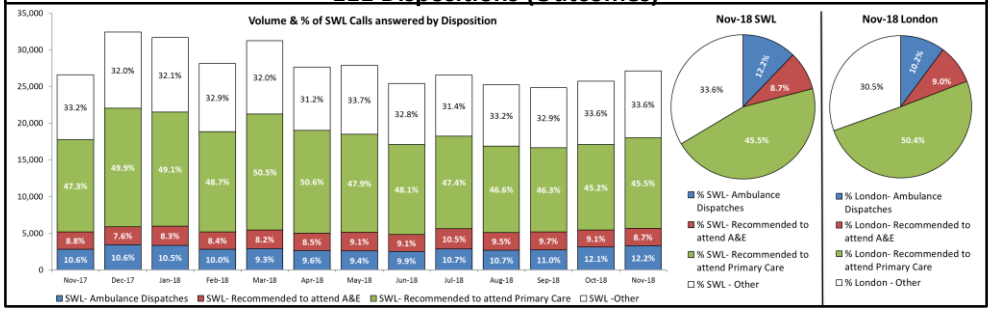
Nov-18 Answered in 60 seconds	
NWL	88.7%
SEL	79.9%
NCL	79.7%
SWL	76.5%
NEL	74.3%
London	79.9%

Nov-18 Abandoned after 30 seconds	
NWL	2.0%
SEL	2.3%
NCL	4.3%
SWL	4.5%
NEL	4.8%
London	3.5%

Volume of Calls

	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
London- Calls Offered	147,155	186,031	183,598	165,298	190,928	159,640	162,430	150,649	149,424	148,178	150,838	159,830	171,049
London- Calls Answered	142,106	177,051	174,769	153,317	174,012	153,475	157,707	145,467	145,497	141,601	144,418	152,312	162,198
London- Ambulance Dispatches	14,644	17,786	17,635	15,470	16,383	14,317	14,709	14,028	14,515	13,571	14,006	15,287	16,505
SWL- Calls Offered	27,866	35,425	33,830	30,562	34,769	29,164	28,705	26,658	27,394	26,185	25,855	27,166	28,979
SWL- Calls Answered	26,601	32,398	31,653	28,106	31,235	27,651	27,863	25,431	26,541	25,231	24,845	25,724	27,124
SWL- Ambulance Dispatches	2,827	3,423	3,337	2,821	2,911	2,659	2,614	2,521	2,847	2,700	2,742	3,106	3,310
SWL- Recommended to attend A&E	2,352	2,460	2,627	2,349	2,551	2,349	2,537	2,318	2,789	2,408	2,421	2,333	2,370
SWL- Recommended to attend Primary Care	12,581	16,161	15,530	13,681	15,785	14,004	13,336	12,238	12,578	11,754	11,507	11,634	12,340

111 Dispositions (Outcomes)



SW London Narrative

Accessing the SWL IUC service through calls to NHS 111 has seen a drop in performance for November compared to October from 81.2% to 76.5% for calls answered within 60 seconds. However, the abandonment rate remains within the national target of 5% at 4.5% for November. Vocare is performing above other London providers for ambulance validation, which is having a positive impact on the wider UEC system.

Calls answered are not achieving the national target of 95%. Vocare has proposed a number of actions to improve performance and weekly assurance calls continue to take place between Commissioners and Vocare to plan activity and rota fill on 28 day rolling forecast and progressing tasks and trajectories in Vocare's Recovery Action Plan (RAP).

A new Contract Performance Notice (CPN) was issued to Vocare on 06.04.18, after the previous one was withdrawn on 03.04.18. The new CPN focus on key activity measures, includes call answering within 60 seconds, but also includes a number of quality measures to support patient safety. A Recovery Action Plan was agreed between Commissioners and Vocare.

A meeting was held in November between SWLA and Vocare to discuss continued failure under the RAP to meet the success criteria trajectories for a number of key KPIs within the CPN. Vocare were requested to deliver a refreshed set of actions by the end of November. This was received on 16.12.2018 and is being reviewed by commissioners with a view of agreeing w/e 21.12.2018.This process is overseen by the IUC Steering Group, who ultimately will take responsibility for securing a safe and timely 111/IUC service for SWL patients.

Performance as at Month 8:

- **% Calls transferred to Clinical Contact:** 47.4% of calls were transferred and received clinical contact in October. This fails to meet the 50% target set by NHSE.
- **% Calls Abandoned after 30 seconds**: 4.5% of calls were abandoned after 30 seconds in October. This is a positive performance and meets the national target of 5%.
- **% Calls Answered within 60 seconds**: 76.5% of calls were answered within 60 seconds in October below the 95% national target.
- **Ambulance validation October 2018**:
  - % of triaged call with ambulance disposition validated 89.99% (2,382)
  - Down graded 64.99% (1,548)
  - Same outcome 29.97% (714)
  - Upgrade 5.08% (121)

Key Actions

Action	Action narrative	Owner	Completed/on-going
New CPN issued	The new CPN issued on 06.04.18 reflects Commissioners escalating concerns regarding performance. Director of Commissioning Operations discussed performance with the MD of Vocare on 20th April following issuing of CPN.	Commissioners	Apr-18
Root Cause Analysis to be completed	A detailed RCA undertaken by Vocare which identifies drivers for under performance. This has been agreed by commissioner prior to it becoming the basis for actions needed to improve performance.	Vocare & Commissioners	Apr-18
Recovery Action Plan	Monthly check point RAP Meeting with SWL Alliance and Vocare Exec SRO to review performance in achieving actions and trajectories.	Vocare Exec Dir & Commissioners	On-going
Operational Monitoring of Provider	Weekly calls continue with Vocare to monitor performance, pursue further in-depth investigation and analysis.	Commissioners	On-going
Agree new set of actions in RCA	Vocare were requested to deliver a refreshed set of actions by the end of November. This was received on 16.12.2018 and is being reviewed by commissioners with a view of agreeing w/e 21.12.2018.	Commissioners & Vocare	Dec -19
Monitoring of Recovery Plan	Commissioners will review the recovery plan on a weekly basis to monitor progress, identify areas which are not progressing in line with the plan, support the provider to address these and meet the standards required.	Commissioners & Vocare	Mar - 19

Improving Access to Psychological Therapies (By CCG)

Lead LDU: Kingston and Richmond | Period: M7 2018/19
Named Lead: Fergus Keegan | Report Date: 24/12/2018

Rolling Quarterly Access Rate (4.20% for 2017-18, Increasing to 4.75% for 2018-19)

IAPT Access Rate (Rolling Quarter)	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Croydon CCG	2.44%	2.39%	2.50%	2.63%	3.50%	3.57%	3.75%	3.30%	3.44%	3.58%	4.12%	4.41%	4.82%
Kingston CCG	4.15%	3.96%	3.99%	4.10%	4.80%	4.62%	4.62%	4.36%	4.78%	5.07%	5.12%	5.12%	4.87%
Merton CCG	3.12%	3.31%	3.23%	3.31%	3.49%	3.27%	3.25%	3.20%	3.40%	3.63%	3.78%	4.06%	4.18%
Richmond CCG	4.91%	4.66%	4.52%	4.02%	4.55%	4.41%	4.59%	4.93%	4.95%	4.89%	4.41%	4.94%	5.13%
Sutton CCG	5.30%	4.79%	5.07%	5.11%	5.41%	5.32%	5.11%	5.02%	5.11%	5.34%	5.36%	5.55%	5.19%
Wandsworth CCG	4.49%	4.32%	4.42%	4.48%	4.66%	4.42%	4.38%	4.43%	4.51%	4.54%	4.61%	4.85%	4.91%
South West London	3.89%	3.75%	3.82%	3.83%	4.29%	4.16%	4.19%	4.08%	4.23%	4.36%	4.48%	4.74%	4.83%

% Waited Less than 6 Weeks for Treatment (75% threshold)

IAPT 6 Week Waiting Time	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Croydon CCG	91.4%	93.9%	94.6%	94.7%	96.2%	97.0%	96.2%	96.4%	96.8%	97.2%	97.1%	99.2%	98.2%
Kingston CCG	91.7%	96.3%	93.3%	90.9%	90.6%	91.7%	92.0%	93.5%	89.3%	96.6%	90.9%	96.2%	92.5%
Merton CCG	61.1%	73.7%	75.0%	84.6%	89.3%	92.9%	86.5%	92.9%	97.1%	95.6%	95.2%	97.5%	95.4%
Richmond CCG	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	99.4%
Sutton CCG	93.9%	92.0%	95.2%	91.7%	96.9%	96.2%	97.0%	96.4%	97.5%	94.9%	96.4%	98.9%	98.6%
Wandsworth CCG	84.2%	89.4%	88.9%	94.1%	90.3%	96.1%	91.1%	93.0%	90.8%	97.3%	100.0%	99.5%	98.6%
South West London	87.7%	90.7%	90.5%	92.3%	93.0%	95.1%	93.7%	94.6%	94.2%	95.8%	95.6%	98.6%	97.5%

Recovery Rate (50% threshold)

IAPT Recovery Rate	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Croydon CCG	41.9%	50.0%	50.0%	40.0%	51.1%	48.3%	53.2%	51.1%	45.5%	51.6%	53.8%	55.8%	52.5%
Kingston CCG	47.8%	50.0%	53.3%	53.1%	56.7%	50.0%	56.0%	53.3%	46.4%	55.2%	59.4%	54.4%	53.2%
Merton CCG	52.9%	52.9%	44.0%	52.0%	51.9%	50.0%	48.6%	41.5%	53.1%	46.5%	43.6%	41.8%	43.2%
Richmond CCG	61.3%	57.9%	53.3%	57.1%	60.0%	52.6%	48.1%	48.3%	60.7%	61.5%	52.4%	55.2%	54.5%
Sutton CCG	44.8%	43.5%	50.0%	45.5%	58.6%	43.5%	50.0%	44.0%	54.1%	47.2%	42.3%	49.1%	51.1%
Wandsworth CCG	42.6%	46.2%	50.0%	51.7%	52.7%	53.0%	51.4%	44.7%	44.1%	44.6%	47.1%	53.2%	48.6%
South West London	47.8%	49.4%	50.3%	50.0%	54.8%	50.2%	51.1%	46.8%	49.2%	49.8%	49.8%	52.1%	50.8%

% Waited Less than 18 Weeks for Treatment (95% threshold)

IAPT 18 Week Waiting Time	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Croydon CCG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%
Kingston CCG	95.8%	100.0%	96.7%	97.0%	100.0%	95.8%	100.0%	100.0%	96.4%	100.0%	97.0%	98.7%	98.6%
Merton CCG	94.4%	100.0%	92.9%	96.2%	96.4%	100.0%	97.3%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%
Richmond CCG	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	99.4%
Sutton CCG	100.0%	96.0%	100.0%	95.8%	100.0%	100.0%	97.0%	96.4%	100.0%	97.4%	100.0%	100.0%	100.0%
Wandsworth CCG	98.2%	97.9%	98.6%	98.5%	100.0%	100.0%	100.0%	98.8%	98.7%	100.0%	100.0%	100.0%	100.0%
South West London	98.5%	98.8%	98.2%	97.7%	99.6%	99.6%	99.3%	98.9%	99.3%	99.7%	99.3%	99.9%	99.7%

IAPT DATA FROM OCTOBER 2018 IS FROM LOCAL UNVALIDATED DATA RETURNS TO NHS ENGLAND

SW London Narrative

Croydon CCG: The commissioner and South London & Maudsley have a joint action plan to increase IAPT Access, which includes increasing GP and self referrals in to the Croydon Talking Therapies service. The CCG's Comms team undertook engagement events in November to gather insights from potential service users and GPs. The rolling 3 month access rate was 4.41% in October, on target for the national Q3 standard. Provisional data indicates the CCG met the target of 4.75% in November, however, there is likely to be a seasonal dip in December and January. October also saw Off The Record, a voluntary sector provider of IAPT for children and young people submit to the national database for 18 – 25 year olds. These numbers are not yet reflected in Croydon's performance. The CCG has been compliant against the Recovery Rate since August.

Merton CCG: Access rate continues to show a substantial improvement in the uptake of people entering treatment in comparison with the historic performance trend. The average number of clients entering first treatment during Q3 is currently 87.9, this exceeds the average target of 86.9 and shows a substantial annual improvement when comparing the same periods for the previous year which equated to an average of 69.1. Recovery rate: During M6 The main provider undertook a deep dive to investigate the causes of the recent underperformance, their initial findings found that 54% of cases reviewed (with low recovery rates) related to clients with significant complexity which lead to longer treatment times, but the clients not moving to recovery. Additionally, 39% of cases reviewed reflected poor service engagement issues. Following the further deterioration during M7, further analysis was undertaken which showed Step 2 workshops displayed a high move to recovery, however all Step 3 workshops show a high drop-out rate during treatment, this is causing low move to recovery including higher complexity in client presentations.

Wandsworth CCG IAPT Recovery rate has recovered to 48.5% in September and 53.2% in October and 49.8% for the year to date. Talk Wandsworth are addressing this by providing staff with the opportunity to peer review patients finishing treatment to address why they did not recover and offering further treatment or changing practice to improve chances of recovery.

Sutton CCG: The provider notified the CCG in July of an error in access reporting impacting on access levels for '18/19 to M2, the shortfall in access numbers in Q1 was recovered in Q2. There has been an increase in drop-out rates which has contributed to the reduction in the recovery target. There has also been an issue with recruitment, with two vacancies being covered by locums. An audit is underway to look at reasons for drop-outs with focus on those at the point of the last patient measure.

Key Actions

CCG Action	Actions Narrative	Owner	Due
Increasing Access Rate for 2018-19 **(Croydon)**	Reflect insights from focus groups in to improvement plans. Continue to work through joint comms plan. A key development in January will be to have a large billboard in place in East Croydon Station, promoting Croydon Talking Therapies.	Director of Commissioning – Croydon CCG	On-going
Supporting practices with data quality and reporting Recovery Rates **(Wandsworth)**	IAPTUS software has been procured and practice staff trained. We are working with some practices on implementation issues, but expect to have the system operational from 2nd January 2019.	Commissioning Lead – Mental Health (Wandsworth)	Jan 2019
2018/19 re-procurement of IAPT service (Merton)	Re-procurement of IAPT service and commissioning additional interim providers to work alongside Addaction/IESO (the current providers) during 2018/19. Two additional providers have now been mobilised (IESO during Aug-18) and Big White Wall (during Oct-18). Plans are in place for a third provider (Mental Health Matters) to also be mobilised prior to Q4.	Commissioning Lead – Mental Health (Merton)	Ongoing
Increased workforce / capacity **(Sutton)**	Additional funding for the increased IAPT access target for 18/19, has increased capacity and improved recovery rates, long waiters are now the commissioner focus through the contract management process. There has been an increase in the drop out rate which has an impact on the recovery target. A number of additional remedial actions are in place e.g. review of unrecovered cases, extending treatment duration, reminders to those who DNA to maintain the recovery rate.	Director of Commissioning – Sutton CCG	Ongoing

Dementia and Mental Health

Lead LDU: Kingston and Richmond | Period: M7 2018/19
Named Lead: Fergus Keegan | Report: Date: 24/12/2018

Care Programme Approach (CPA) 7 Day (95% followed up after discharge)

	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 17-18	Q2 17-18
Croydon CCG	95.9%	95.5%	95.7%	82.1%	92.0%	93.1%
Kingston CCG	96.0%	97.4%	97.2%	100.0%	97.3%	97.0%
Merton CCG	95.7%	98.8%	96.7%	97.5%	98.4%	97.4%
Richmond CCG	97.8%	95.2%	92.4%	100.0%	94.7%	91.0%
Sutton CCG	98.5%	98.5%	96.7%	100.0%	96.7%	94.5%
Wandsworth CCG	94.4%	95.9%	94.7%	100.0%	96.4%	94.9%
South West London	96.0%	96.8%	95.4%	95.8%	95.8%	94.6%

Estimated Dementia Diagnosis Rate (66.7% threshold)

Dementia Diagnosis	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Croydon CCG	67.6%	67.7%	67.6%	67.4%	66.7%	67.4%	67.2%	67.7%	67.7%	67.8%	67.6%	67.9%	68.1%
Kingston CCG	63.7%	63.2%	63.1%	62.3%	62.3%	61.9%	61.6%	61.5%	61.4%	61.2%	61.3%	61.4%	62.2%
Merton CCG	70.4%	72.0%	70.8%	70.4%	71.0%	70.7%	71.0%	71.1%	73.2%	73.6%	73.6%	73.9%	73.8%
Richmond CCG	67.0%	66.7%	67.5%	67.6%	67.9%	67.9%	67.8%	67.1%	66.9%	66.8%	67.4%	67.8%	67.5%
Sutton CCG	75.8%	74.4%	75.1%	75.1%	75.3%	75.3%	75.1%	75.0%	73.3%	73.2%	72.5%	72.5%	72.3%
Wandsworth CCG	73.8%	73.8%	73.8%	74.7%	74.7%	74.5%	74.9%	75.1%	75.8%	76.2%	78.5%	78.0%	79.3%
South West London	69.5%	69.5%	69.5%	69.4%	69.4%	69.4%	69.4%	69.5%	69.6%	69.7%	70.1%	70.2%	70.4%

Early Intervention in Psychosis (50% of people start treatment within 2 weeks)

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Croydon CCG	55.6%	81.8%	100.0%	37.5%	37.5%	66.7%	58.3%	100.0%	100.0%	88.9%	90.9%	80.0%	90.0%
Kingston CCG	75.0%	80.0%	100.0%	57.1%	66.7%	83.3%	85.7%	80.0%	66.7%	63.6%	83.3%	100.0%	33.3%
Merton CCG	50.0%	42.9%	50.0%	57.1%	50.0%	44.4%	100.0%	57.1%	71.4%	50.0%	0.0%	33.3%	80.0%
Richmond CCG	0.0%	60.0%		75.0%	75.0%	25.0%	33.3%	50.0%	100.0%	100.0%	100.0%	100.0%	80.0%
Sutton CCG	83.3%	75.0%	100.0%	75.0%	100.0%	100.0%	40.0%	66.7%	83.3%	57.1%	25.0%	100.0%	33.3%
Wansworth CCG	57.1%	72.7%	22.2%	33.3%	66.7%	50.0%	50.0%	75.0%	60.0%	41.7%	60.0%	58.3%	37.5%
South West London	58.1%	69.8%	66.7%	52.8%	61.3%	58.1%	61.8%	71.9%	73.7%	63.0%	73.0%	67.7%	64.7%

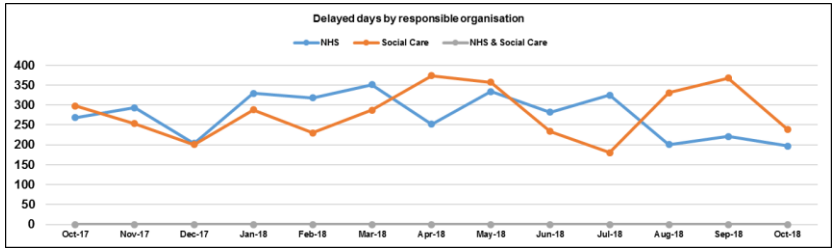
	Narrative	Owner	Due
Kingston	**Dementia:** The Kingston dementia nurse is in post and has reviewed potential dementia patients in all Kingston GP Practices. The nurse has also liaised with Kingston Memory Assessment Service, provided by SWL & St Georges. The dementia nurse has referred a number of people to the Kingston memory assessment service, but these people are still awaiting diagnosis. The clinical leads are re-approaching practices through the council of members and the GP educational events. The CCG is meeting with NHSE in September 18 to review actions to improve performance in this area. **Review of patients in Care Homes.** Dedicated GP resources are assessing patients in care and nursing homes to ensure that they are correctly recorded as having dementia. The dementia nurse is to follow up MCI patients for annual review and follow up clients who declined referral to the MAS to see if they can be re-engaged. Mental Health KPI now being implemented and as part of its roll out the dementia nurse and CCG dementia lead to visit practices to discuss actions tailored to individual practices.	Mental Health Commissioning Team	Continuing
	NHS England Support: The CCG is meeting with NHS England to work through any outstanding areas and themes where there may be scope to increase diagnosis rates. These meetings include the SWL & St Georges Memory Assessment Service and clinical leads from the CCG and NHS England. A further action plan has been formulated from the first meeting and will be signed off in September 2018.	Mental Health Commissioning Team	September 2018
Kingston	**Early Intervention in Psychosis:** There were two breaches of the two week standard over 3 pathways. The year to date October performance is at 56.8%, and this is expected to return to compliance in the month of November 2018.	Mental Health Team	November 2018
Richmond	**CPA 7 day follow-up:** The reasons and themes for any CPA breaches are reviewed as part of the SWL & St Georges performance meetings. Sufficiently robust systems were not in place, and South West London and St Georges MH Trust have updated their systems for following up patients, ensuring that contact details have been updated and timely at discharge. A new team manager for the Richmond service has been appointed. It is expected that these actions will recover the CPA performance within Q3 2018-19.	Mental Health Commissioning Team	November 2018
Croydon	The CCG continues to meet the dementia diagnosis target in October. The EIP standard has been met for seven consecutive months. The CCG underperformed for the first time against the CPA target in Q4 2017/18 and has been below the 95% target 2018/19 year to date. The service had reported a commitment to recover this in Q2, whist a small improvement was seen the CCG remains noncompliant. The service is working through a backlog. Further information has been requested and the indicator will be a standing item on monthly contractual meeting agendas.		
Sutton	**Early Intervention in Psychosis:** the target was missed in October with two breaches out of the three patients who commenced treatment. The CCG has requested breach reasons for each and will raise with provider at the next contracts & performance meeting. **CPA 7 day follow-up:** The CCC did not meet the target in Q2 for the reasons described by Richmond CCG. The CCG continues to monitor progress through the performance meetings with the Trust.		

Delayed Transfers of Care (DTOC) by Provider

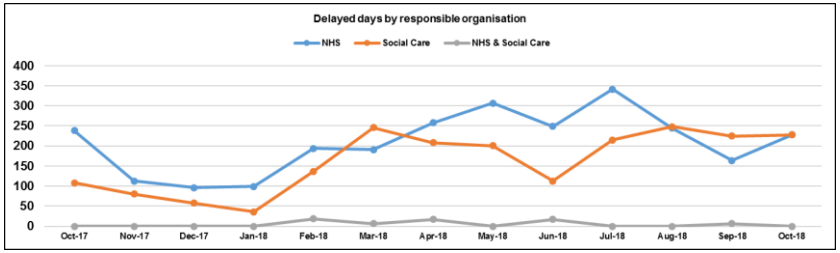
Lead LDU: Sutton CCG
Named Lead: Sean Morgan
Period M7 2018/19
Report Date: 13/12/2018

NEL

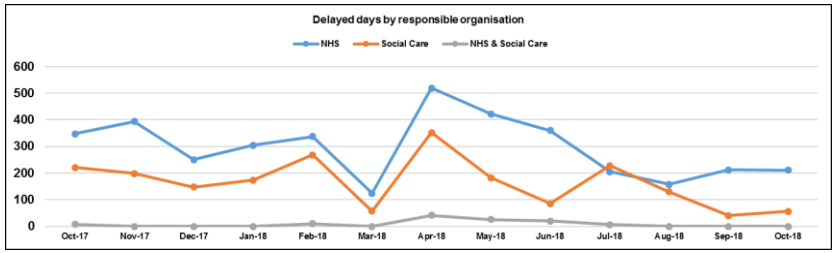
DTOCs - CHS



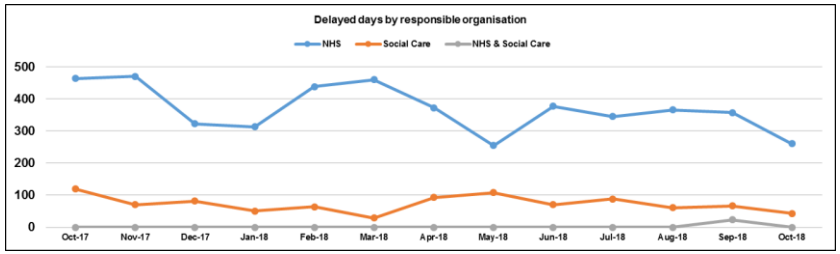
DTOCs – ESTH



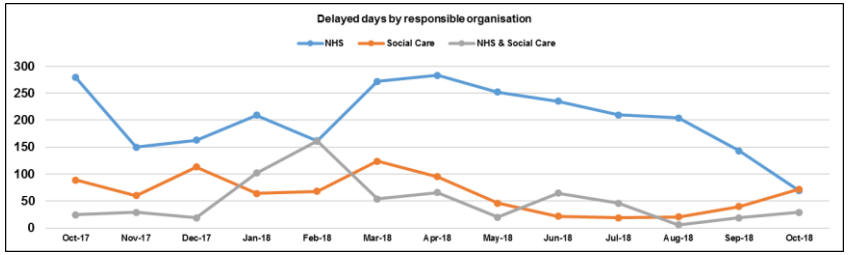
DTOCs - SGH FT



DTOCs - KHFT



DTOCs – SWL STG MH



Delayed Transfers of Care (DTOC) by Provider

Lead LDU:Sutton CCG Period M7 2018/19
Named Lead:Sean Morgan Report Date: 24/12/2018

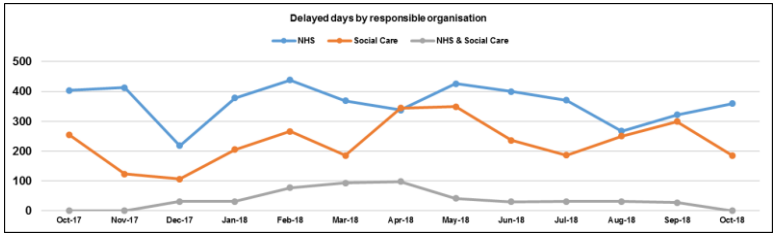
CCG Action	Narrative	Owner	Due
Establish multiagency working group **Croydon:** There has been significant progress in reducing DTOCs with the latest figures (July 2018) showing a reduction to 18.9 delays per day, Croydon's best performance since January 2018. The majority of DTOCs were related to `Awaiting nursing/residential home placement' 245, and "Public funding/Housing" 198.	To support improved patient flow through the hospital stranded and long stay patients require improvement, including DToC and medically optimised patients. 1. December will see a change in the validation process, with data due to be validated weekly. This will provide a clearer picture of DToCs in Croydon and allow more effective and efficient management of their reduction. 2. The development of a therapy-led ward (Fairfield 2) has provided an opportunity to cohort a group of medically optimised patients requiring therapy in a single location. This allows better management of these patients and supports a more rapid discharge for them 3. Regular Multi-Agency Discharge Events (MADE) with CCG and LA providing on-site support 4. Discharge to Assess (D2A) pathway 2 rolled out on all wards 5. Design work on D2A pathway 3 – discussions underway with CCG and LA on 'funding without prejudice'	Chair, Croydon AEDB	1. Dec 2018 2. Dec 2018 3. On-going 4. On-going 5. On-going
CCG/ESTH Task and Finish group has been set up **Sutton CCG:** 'Awaiting home care package' responsible for 214 bed day delays, 'Patient Choice' 100 days and "Awaiting further non-acute NHS care" 77 days	1. High Impact Change Model implementation is in progress. Action plan developed. 2. Improve communication/unblock process issues – twice weekly multi agency, MDT discharge meeting at St Helier Hospital. 3. Weekly Director level escalation meetings (reviews where length of hospital stay over 21 days) 4. LBS and SCCG have agreed to 'place without prejudice' based on checklist outcome with the use of the shorter DST form. 5. New model of homecare provision has been introduced by LBS, which is in-line with locality working identifying a primary and secondary care provider for each area. The care provider is obliged to accept the patient, which should lessen time in setting up the package of care, implementation is in progress. 6. Recruitment to employ additional staff to the SHC@H team, enabling prompt discharge from an acute bed. Support worker roles will be filled by mid-Dec 18. 7. Home First/D2A pilot commenced on the 5th November 2018 and will run for 8 weeks, wider implementation dependent on evaluation.	Chair, Sutton A&EDB	Reviewed at the Sutton A&EDB 3. On-going 5. On-going 6. Mid-Dec 7. On-going
Implement refreshed Joint Delivery Plan 2017-18 **Richmond CCG: :** The majority of DTOCs were related to `Awaiting further non-acute NHS care' 147 days, 'Awaiting residential home placement'64 days and "Awaiting completion of Assessment" 62 days. Richmond Council is ahead of the NHS England winter 2017 DToC trajectory, Richmond CCG is above planned levels.	1. Support the developments against the High Impact Change Model to improve services to support people ready for discharge from hospital, including developing the 'Discharge to Assess' model, 'Better at Home' and enhance equipment provision to support earlier discharges. 2. This includes additional social work posts in the RRR Team to increase capacity to support improvements in transfers of care from hospital, reduce waiting times for assessment and reduction in DToCs. 3. Actions in progress on-going & being closely monitored by the Kingston and Richmond AEDB. Daily DTOC reports from Kingston Hospital in November and December 2018 show a much improved position compared to the summer months.	Chair, Kingston and Richmond Accident and Emergency Delivery Board	Reviewed monthly at the Kingston and Richmond A&EDB
Increase in enablement capacity **Wandsworth:** 'Awaiting further non-acute NHS care" responsible for 39 bed day delays and 'Awaiting Nursing home placement' 73.	1. Increase in enablement capacity to support hospital discharges including a plan to facilitate weekend discharges into Enablement Service Mitigate by step-down beds and 24-hour enablement packages / care packages in own home – investment from the iBCF to increase staff / number of PoC. 2. Weekly escalation call in place from August onwards. Overall numbers of DTOCs has reduced significantly in October 2018.	Chair, Wandsworth and Merton A&EDB	1. Reviewed monthly at the AEDB Completed 2.On-going
Reduce DToCs **Merton CCG**: **Merton CCG**: The number of delayed days decreased across all areas (NHS/ASC/Overall) during M7 and whilst delays attributable to NHS remains above the local target, the position is considerably below the London Av. *Please note that M6 position has been revised by SGH and data re-submitted which has now been correctly published.	1. Improve communication / unblock process issues – A daily conference call between CLCH, CHC and LB Merton to discuss patient discharges. 2. Ongoing weekly escalation call – CLCH and LB Merton and Merton CCG. 3. LB Merton and Merton CCG have agreed to 'place without prejudice' based on checklist outcome with the use of the shorter DST form. Merton CCG delays attributable to NHS fell short of target (163 delayed days / target 131). Despite not meeting target, performance levels remains considerably below the London average of 259 delayed days for the period.	Chair, Wandsworth and Merton A&EDB	1.On-going 2.On-going 3.On-going
Review of DToC information **Kingston CCG**: `Awaiting further non-acute NHS care' 105 days. **Kingston CCG and The Royal Borough of Kingston** are ahead of the NHSE DToC trajectory. CCGs' average daily rate (as per the London expectation) is 5.1, compared to the trajectory of 8.5 for Nov 2017. The RBK average is 0.8 compared to the 1.5 target	Daily Kingston DToC information is sent from Kingston Hospital and is reviewed by community teams and adult social care for response.	Chair, Kingston and Richmond A&EDB	Reviewed monthly at the Kingston and Richmond A&EDB

Delayed Transfers of Care (DTOC) by Local Authority (includes Acute and Non-Acute Descriptions)

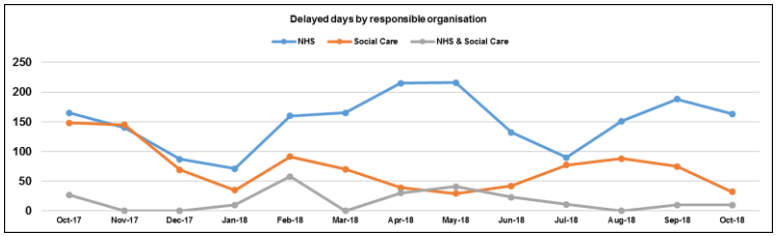
Lead LDU:Sutton CCG
Named Lead:Sean Morgan
Period M7 2018/19
Report Date: 13/12/2018

NEL

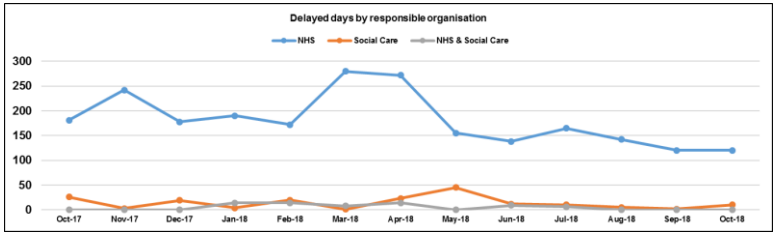
DTOCs - Croydon



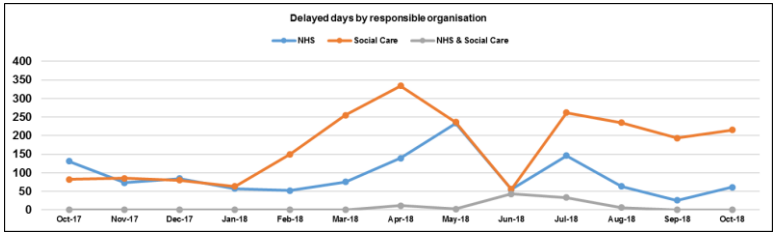
DTOCs – Merton



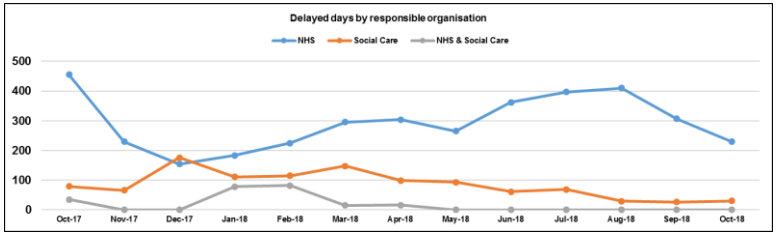
DTOCs – Kingston Upon Thames



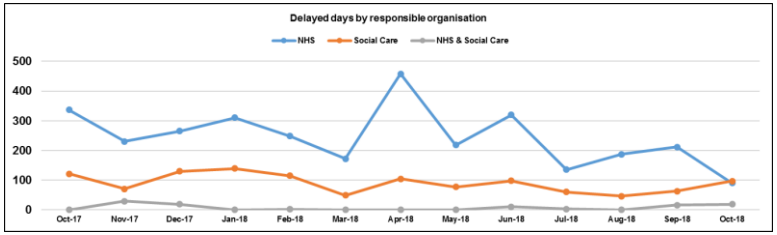
DTOCs – Sutton



DTOCs – Richmond Upon Thames



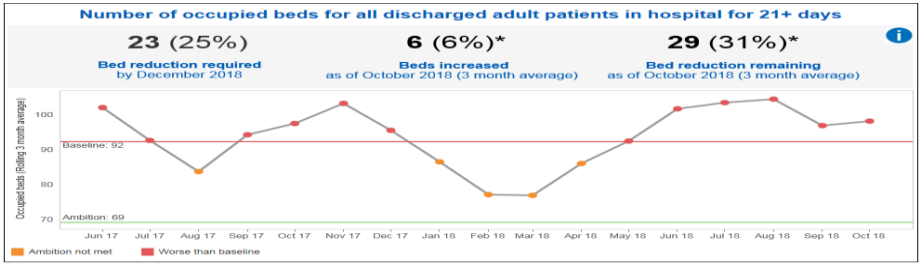
DTOCs - Wandsworth



Reducing long stays in hospital

Lead LDU:
Named Lead:
Period M7 2018/19
Report Date: 17/12/2018

CHS



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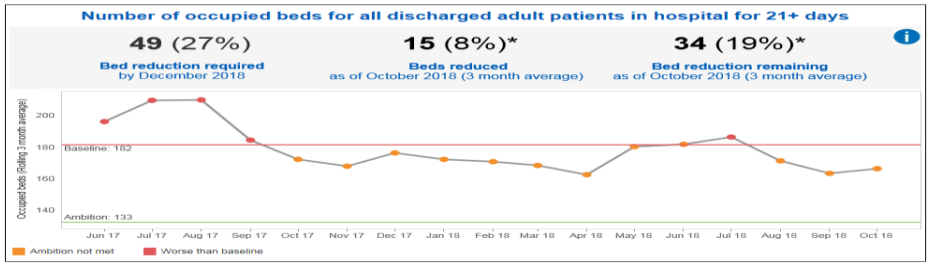

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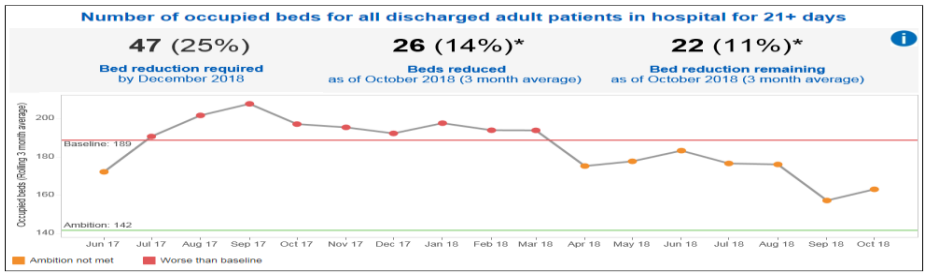

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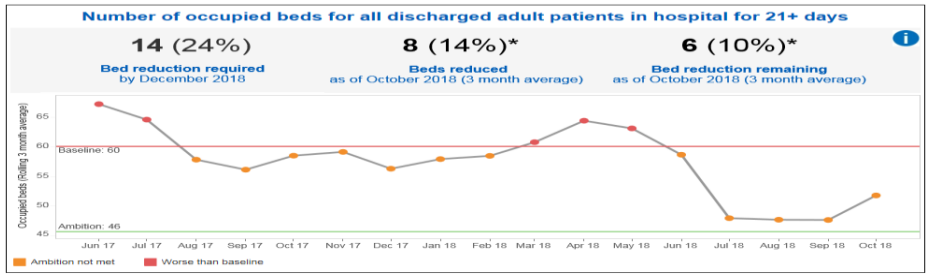

Progress towards ambition (Data table) as of October 2018

Region_Name	Organisation Name	Status	Baseline	Ambition (beds)	Bed reduction required (beds)	Ambition	Bed days per day (3 month rolling)	Beds reduced	Beds reduced %	Beds increased	Beds increased %	Bed reduction remaining	Reduction remaining %
London	Croydon Health Services NHS Trust	Worse than baseline	92	69	23	25%	98	0	0%	6	6%	29	31%
	Epsom and St Helier University Ho..	Ambition not met	182	133	49	27%	167	15	8%	0	0%	34	19%
	Kingston Hospital NHS Foundation..	Ambition not met	60	46	14	24%	52	8	14%	0	0%	6	10%
	St George's University Hospitals N..	Ambition not met	189	142	47	25%	163	26	14%	0	0%	22	11%

CCG Action	Narrative	Owner	Due
Sutton CCG	Weekly Director level escalation meetings (reviews where LOS > 21 days)	Chief Operating Officer	On-going
Sutton CCG	Mapping of winter stocktake findings against the seven "pillars" for delivery for winter planning completed and reported the AEDB. Priorities are, patient flow to meet the long stay reduction target by Dec 2018 - process mapping session with all system partners held in July and a scenarios based exercise held at the October AEDB meeting. Update to the December AEDB included provisional data from the Trust showing a marked decrease in LOS >21 days stays since mid-Nov and the Trust is meeting the system reduction target.	AEDB	On-going
Kingston and Richmond CCGs	Long stays have reduced from spring 2018, and early supported discharge is continuing. DTOC rates have reduced. There is on-going work within pillar 7 of the A&E delivery board is addressing this issue with key themes being delays in accessing inpatient rehab, significant delays in accessing specialist neuro rehabilitation, packages of care not delivered, multiple variations of paper work, equipment request delays and choice (choosing nursing and residential homes)	AEDB	On-going
Merton & Wandsworth	Stranded and super stranded patients are now reviewed in daily meetings for both Merton and Wandsworth, additionally frequent reviews of stranded and super-stranded patients are being initiated to build on the successes already seen in creating capacity by reducing longer stays. Local MADE event for NHS/SSD to clear lines and identify stranded patients awaiting social care to take place 2 weeks before Christmas Break and also 1st Week of January.		On-going
Croydon CCG (in addition to DTOC actions)	System agreed process where Director of Adult Social Care will liaise with counterparts to expedite the discharge of out of borough patients with social care needs (currently 48 patients in CHS) LA agreed funding for short notice non-care related interventions to facilitate discharges Expansion to Integrated Discharge Team over the winter to speed up the discharge & referral processes (supported by both the LA and CHS) GP huddles to receive information on inpatients with a view to supporting discharge where appropriate Referrals to D2A as of M8 YTD = 802 against a target of 758 per year. Forecasting 1200 by year end.	Rick Strang Transformation Advisor, CHS	On-going

NHS Continuing Health Care – overview of October CHC monthly report to NHS England

Lead LDU: Period: M7 2018/19
Named Lead: Report Date: 18/12/2018

	% DSTs COMPLETED IN AN ACUTE HOSPITAL SETTING (performance threshold: <15%)
CROYDON	47%
KINGSTON	10%
MERTON	22%
RICHMOND	7%
SUTTON	15%
WANDSWORTH	9%

	% OF REFERRALS TAKING PLACE WITHIN 28 DAYS (performance threshold: >80%)
CROYDON	68%
KINGSTON	76%
MERTON	40%
RICHMOND	100%
SUTTON	88%
WANDSWORTH	64%

The October reports sent to NHS England are aggregated for SWL here.

% DSTs completed in an acute setting:

- Kingston, Richmond, Wandsworth and Sutton CCGs met performance target in October 2018

- Merton – Discharge to Assess pathway to be agreed with LA colleagues prior to implementation. Discussions ongoing.
- Croydon – There are also discussions with the LA in Croydon to expedite pathway 3 Discharge to Assess. One solution being considered is a 'funding without prejudice' pooled budget.

% Referrals taking place within 28 days:

- Sutton and Richmond are the only CCGs currently meeting this target.

- Kingston - Awaiting availability of social worker, awaiting appointment availability and awaiting additional Information.
- Croydon – the CHC team are making incremental progress, working towards a trajectory of achieving 70% by end of Q3.

- Wandsworth - The reason for the underperformance is due to delays in allocation of social workers. We continue to work closely with our Local Authority (LA) partners to try to resolve but it remains a challenge. The Local Authority have advertised and have now recruited to 2 wte SW posts designated to CHC assessment with start dates at end of November 2018.

- Merton – CHC service has transferred to a new Provider, initial engagement with London Borough of Merton and operational managers commenced. Operational protocols shared and work in progress to agreed revised and jointly agreed processes underpinned by the shared policies and protocols. Draft joint disputes resolution protocol and draft hospital discharge CHC assessment pathway planned sign off December 2018. Data cleanse complete and backlog project in place.

	Total number of incomplete referrals exceeding 28 days as at end of month	Number exceeding by 0 - 2 weeks (1 - 14 days)	Number exceeding by 2 - 4 weeks (15 - 28 days)	Number exceeding by 4 - 12 weeks (29 - 84 days)	Number exceeding by 12 - 26 weeks (85 to 182 days)	Numbers exceeding 26+ weeks (183 days and over)
Croydon	10	3	2	3	2	0
Kingston	1	0	0	1	0	0
Merton	7	1	1	5	0	0
Richmond	0	0	0	0	0	0
Sutton	4	0	0	0	3	1
Wandsworth	12	0	1	1	6	4

Merton, Kingston and Richmond CCGs met the target for incomplete referrals exceeding 28 days in October 2018 at 12 and 26 weeks respectively. Croydon CCG achieved target for incomplete referrals at 26 weeks.

DST = Decision Support Tool

- SWL Quality Reporting is evolving.

- Focus on SWL Themes (including from CQRGs)

- Looking at Quality Exception Reports from key STP Programmes eg:
- Access (Maternity, Emergency & Urgent & Emergency Care, Primary Care)
- Cancer (Patient Experience, Survival Rates, Screening)
- LD & Autism (Transforming Care Partnership Plans, Readmission Rates)
- CYP, Mental Health Prevention (Admissions, Severity, Community MH, Emergency MH)

Provider	Quality Concern / highlight	Impact (safety, effectiveness, experience)	Mitigations / Actions
Croydon Health Services NHST Croydon	Type 1 Performance ED	Demands impacting on patient safety and patient experiences	Staffing has been streamed to ensure there is a regular review of all patients in ED in respect of comfort and safety. Croydon Trust are undertaking a deep dive into Type 1 performance as directed by the Trust's quality committee as part of on-going assurance. CCG fully included in this work to ensure assurance oversight. ED Performance and the impact on patient care is a quality theme being discussed by CCGs across London.
Epsom & St Helier University Hospitals NHS Trust Sutton	Quality concerns at ESH	Patients not receiving optimal care due to leadership and clinical management issues.	CQC undertook another unannounced visit to the Trust in October 2018. Overall the initial feedback has been positive with reported improvements. The NHSE Quality Risk Profiling Tool has been completed by commissioners and the Trust and the risks identified have now been discussed at a joint meeting in December 2018. All risks have ongoing action plans and these will continue to be monitored through the quality contract assurance process (CQRG) The CCG visited the Trust in December 2018 to see a number of wards including an escalation area, the surgical assessment unity and the Emergency department. Overall the visit demonstrated strong clinical leadership and many improvements in both the environment and the delivery of care to improve patient experience.

Provider	Quality Concern / highlight	Impact (safety, effectiveness, experience)	Mitigations / Actions
Integrated Urgent Care (IUC) (Vocare)	Quality concerns with IUC contract. Results from July 2018 inspection released end of September 2018 as "requires improvement" overall.	Patient safety and patient experience concerns. National provider – impact on other sectors, escalating to ensure local improvement plans are in place across other areas.	Quality Improvement Plan in place and shared at CQRG along with progress reports. Enhanced monitoring was commenced in September 2018 covering: quality resource, management of SI and incidents, demonstrating learning from incidents, staff training and development, auditing of calls and staff awareness of quality priorities and support. Concerns being escalated via the QSAG network for consideration of QRPT. Improvement work underway by the provider and is being rolled out across all their contracts.
South West London & St George's Mental Health NHS Trust	Additional assurance requested by CCG in respect of number and quality of SI's and to review implementation of learning from Sis.	To ensure that learning from SI's improves patient care and experiences	A Deep Dive / Thematic Review of Serious Incidents – live cases October & November 2018 (8 cases) has been commissioned by the Trust's DON. This is to identify any issues with SI systems and processes, look at implementation of learning and to identify any themes arising. Report will be available early in 2019. Early indications suggest Focus on Home Treat Team (Wandsworth) and Drug and Alcohol services and strengthening links with public health.

Glossary

Commonly used NHS Acronyms

click here to find more > NHS Digital

Acronym	Definition	Acronym	Definition
ABT	Assessment and brief treatment teams	NELCSU	North & East London Commissioning Support Unit
AEDB	A&E Delivery Board	NHS ENGLAND	National Health Service England
ASIP	Accelerated service improvement	NHS IMPROVEMENT	National Health Service Improvement
AWOL	Absent without leave	OAP	Out of Area Placements
CAMHS	Child and Adolescent Mental Health Service	OPEL	Operational Pressures Escalation Levels Framework
CCG	Clinical Commissioning Group	OPI	Operational Performance Indicators
CHS	Croydon Healthcare Services	PALS	Patient Advice and Liaison Service
CMHTs	Community Mental Health Teams	PICU	Paediatric intensive care unit
CPA	Care Programme Approach	PMO	Programme Management Office
CPN	Contract Performance Notice	PTL	Patient Tracking List
CQUIN	Commissioning for Quality and Innovation	QIAs	Quality Impact Assessments
CRT	Community recovery teams	QMH	Queen Mary Hospital, Roehampton
CSU	Commissioning Support Unit	RMH	Royal Marsden Hospital
DoLS	Deprivation of liberty standards	RMP	Royal Marsden Partners
DTOC	Delayed Transfer of Care	RRR	Richmond Rapid Recovery
ECIST	Emergency Care Intensive Support Team	RRT	Rapid Response Teams
ECP	Emergency Care Programme	RTT	Referral to Treatment
EIP	Early intervention in psychosis	SGH	St George's University Hospitals NHS Foundation Trust
ESTH	Epsom & St Helier Hospital NHS Foundation Trust	SI	Serious incidents
HCH	Hillingdon Community Health	SLAM	South London and Maudsley NHS Foundation Trust
HRCH	Hounslow and Richmond Community Health	SLF	South London Forum (Cancer)
HTT	Home Treatment Team	SOF	Single Oversight Framework
IAPT	Improved access to psychological therapies	SPA	SPA - Single Point of Access
IST	Intensive Support Team	SSOC	Shifting settings of care
KHFT	Kingston Hospital Foundation NHST Trust	SWL	South West London
KPI	Key Performance Indicator	TCI	To Come in
LD	Learning Disabilities	UEC	Urgent and Emergency Care
MHA	Mental Health Act	WW	Week Wait

NHS Acronym Buster App

The NHS has produced a new jargon busting App. The free App, produced by the NHS Confederation spells out what things mean and gives definitions for more than 700 commonly used acronyms and abbreviations in the NHS. You can download it for free from iTunes to your iPhone/iPad or from Google Play Store to your Android phone/tablet so you have the definition of over 700 commonly used NHS acronyms and abbreviations at your fingertips.

Just search 'NHS Acronym' in the iTunes app or Google Play Store - http://nhsconfed.org/acronym-buster

FOR FURTHER INFORMATION:

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NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	Finance Report January 2019 (Month 10)		
Lead Director (Name and Role)	James Murray, Chief Finance Officer; Neil Ferrelly, Local Director of Finance		
Clinical Sponsor (Name and Role)	n/a		
Author(s) (Name and Role)	Finance Department		
Agenda Item No.	2.5	**Attachment No.**	H

Purpose (Tick as Required)	Approve	Discuss	Note
		✓	✓

Executive Summary

Kingston CCG expects to meet all financial targets, as at month 10, including the planned surplus of £1.06m.

The CCG plans to meet the Mental Health Investment Standard, increasing mental health by 3.5% in 2018/19.

In month 10 acute, mental health, children's and primary care overspends are offset by underspends in adult continuing care, prescribing, corporate and reserves.

Background:
This report presents the financial position at the end of January '19. Areas of concern and risk have been highlighted for the committee to consider.

Purpose:
To provide oversight of the CCG financial position at month 10.

Reason for Committee Review:
This finance report is for information and is to be noted by the committees.

Key Issues:
1. The CCG expects to meet its planned in year 0.4% surplus of £1.06m.

2. Reserves and non-recurrent benefits have been utilised to enable the delivery of the planned in year surplus.

3. Kingston CCG's underlying position at month 10 is £0.61m surplus (0.2%). This compares to the planned 0.4% surplus.

4. Kingston CCG is ahead of target for QIPP in January and expects to fully achieve planned annual savings of £9.8m.
Conflicts of Interest: None
Mitigations: N/A

Recommendation: The Committee is asked to note the financial position.

Corporate Objectives This document will impact on the following CCG Objectives:	Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation

Risks This document links to the following CCG risks:	Failure to meet statutory financial duties
Mitigations Actions taken to reduce any risks identified:	Use of reserves and non-recurrent measures to ensure delivery of the planned surplus.

Financial/Resource/ QIPP Implications	As detailed in report.

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A

Patient and Public Engagement and Communication	N/A

Previous Committees/ Groups :	Committee/Group Name:	Date Discussed:	Outcome:
	Finance Committee	Monday, 25 February 2019	The report was noted

Supporting Documents	Please see month 10 finance report.

NHS
Kingston
Clinical Commissioning Group

KCCG Finance Report

January 2019

Neil Ferrelly – Local Director of Finance

Contents

1 Finance Scorecard

January 2019

Financial Strategy

- Work continues on finance and activity planning for 2019/20, across the STP commissioners and providers. The 1st draft activity plan was submitted on 14th January with zero net growth and QIPP.
- CCG allocations have been received with an uplift of 5.19% for 2019/20. Draft financial plans were submitted on 12th February. The CCG plans to achieve its breakeven control total, with QIPP savings of £7.6m required.

Financial Performance

- The CCG plans to meet all business rules in 2018/19
- Reserves have been used to enable delivery of the forecasted surplus
- Cash targets were achieved at month 10. Better Payment Practice Code (BPPC) was not achieved within the month, but the CCG expects to meet the year end target.
- QIPP savings are forecast to be achieved in full, although some savings are non-recurrent.

Financial Governance

- Financial policies are due for review and will be aligned across SWL.
- Interim external audit is due to commence on 25th February. The initial risk based audit began in November.
- In preparation for the draft accounts in April 2019, work has begun to have consistent reporting across South West London in areas such as the remuneration report.
- Month 9 accounts have been submitted in January, including an interim governance statement.

Financial Risk

- The 2018/19 plan meets all business rules, however a degree of risk remains in the planned position. This can be mitigated in 18/19 by non-recurrent means.
- Transformational QIPP schemes have not delivered planned savings. The shortfall has been mitigated by non-recurrent measures in 18/19.
- Year end agreements have been reached with 2 Trusts, removing risk from the majority of acute expenditure.

2 Key Indicators

January 2019

	YTD variance £'000	YTD Variance %	YTD RAG RATING	Annual Variance £'000	Annual Variance %	Forecast RAG RATING
Expenditure						
Acute Contracts	(2,508)	-2.3%		(4,360)	-3.3%	
Continuing Care	323	2.8%		364	2.7%	
Prescribing	784	4.5%		901	4.3%	
In-Year Surplus	0	0.0%		0	0.0%	
Risk & Mitigations						
Worst Case Outturn	N/A	N/A	N/A	0	0.0%	
Best Case Outturn	N/A	N/A	N/A	1	0.1%	
Underlying position						
Closing 2018/19 underlying position	N/A	N/A	N/A	(450)	-42.4%	
Opening 2019/20 underlying position	N/A	N/A	N/A	(450)	-42.4%	
QIPP						
Plan vs Outturn	1,375	21.8%		0	0.0%	

YTD = Year To Date

Kingston CCG expects to deliver against key financial targets. If all identified potential risks and mitigations materialise, the CCG would achieve a surplus £1k above plan i.e. a surplus of £1,061k.

QIPP schemes are in place to deliver £9.8m savings. There is a degree of risk in delivery of the identified QIPP schemes, estimated at £0.181m.

3 Month 10 Summary

January 2019

- The CCG expects to meet its planned in year 0.4% surplus of £1,060k
- Some reserves and non-recurrent benefits have been utilised to enable the delivery of the planned in year surplus.
- The CCG at month 10 holds mitigations of £1.928m against risk of £1.929m.
- Kingston CCG's underlying position at month 10 is £0.61m surplus (0.2%). This compares to the planned 0.4% surplus.
- Kingston CCG are ahead of target for QIPP year to date due (YTD) to phasing of the plan, and expect to fully achieve the planned target savings of £9.8m, despite under-achievement on some transformational schemes.
- Kingston Hospital is forecast to overspend by £3,305k YTD and £4,840k forecast. The YTD run rate has improved by £56k from month 9 to 10. The largest overspends are in emergency, A&E, elective, outpatient 1st and direct access.
- The Continuing Care & YPD position has worsened in month 10, showing an underspend of £130k. This is due to 27 new cases in January 2019, of which 17 are fast track. These costs have been partly offset by ongoing work by the CHC team. Funded Nursing Care has experienced lower growth than budgeted with an underspend of £238k in month 10.
- The prescribing YTD and forecast position is based on M1-M8 prescribing data extrapolated to month 12 and includes £510k YTD and £642k forecast for NCSO and increased drug tariff impact and £181k net impact of CAT M margin recovery. This results in an underspend of £782k YTD and £898k forecast.
- Primary Care Delegated commissioning budget reports a forecast overspend of £566k an increase of £28k since month 9. The main increase was for Global Sum this is due to the continued increase in list sizes for Q4 resulting the increase in cost in several areas.

3 Summary Financial Position

January 2019

	Year To Date			Full Year Forecast Outturn		
	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's
In Year Revenue Resource Limit	224,214	224,214	0	269,187	269,187	0
EXPENDITURE						
Acute Commissioning	113,203	115,798	(2,595)	135,844	138,656	(2,812)
Non Acute Commissioning	52,633	52,549	84	63,170	63,396	(226)
Primary Care	44,188	44,159	29	53,157	53,089	68
Corporate Costs	4,381	4,078	303	5,256	4,916	340
Estate Costs	536	567	(31)	643	680	(37)
Reserves	8,387	6,177	2,210	10,056	7,389	2,666
Total Applications	**223,328**	**223,328**	**(0)**	**268,127**	**268,127**	**(0)**
In Year Surplus	**886**	**886**	**0**	**1,060**	**1,060**	**0**
Historic Surplus	4,075	4,075	0	4,890	4,890	0
Cumulative Surplus	**4,961**	**4,961**	**0**	**5,950**	**5,950**	**0**

This report shows the in-year position.

The resource limit of £269,187k does not include brought forward surplus of £4,890k

This is the surplus that will be reported in the annual accounts.

4 Acute Commissioning

January 2019

	Year To Date				Full Year Forecast Outturn			
	Budget	Actual	Variance	Variance	Budget	Actual	Variance	Variance
	£000's	£000's	£000's	%	£000's	£000's	£000's	%
Foundation Trust SLAs								
Ashford & St Peters NHS FT	292	383	(91)	(31%)	350	460	(109)	(31%)
Chelsea & Westminster Hospital NHS FT *(including West Middlesex University Hospital)*	897	904	(7)	(1%)	1,076	1,078	(2)	(0%)
GOSH NHS FT	73	107	(35)	(48%)	87	124	(37)	(43%)
Guys & St Thomas NHS FT	1,348	1,902	(553)	(41%)	1,618	2,255	(637)	(39%)
Kings College Hospital NHS FT	388	587	(199)	(51%)	466	696	(230)	(49%)
Kingston Hospital NHS FT	74,884	78,189	(3,305)	(4%)	89,860	94,700	(4,840)	(5%)
Moorfields Eye Hospital NHS FT	782	689	93	12%	939	827	112	12%
Royal Brompton & Harefield NHS FT	542	606	(64)	(12%)	650	719	(69)	(11%)
Royal Free Hampstead NHS FT	147	132	15	10%	176	159	18	10%
The Royal Marsden NHS FT	1,662	1,694	(32)	(2%)	1,994	2,088	(94)	(5%)
Royal Surrey County NHS FT	190	179	11	6%	228	215	13	6%
University College London Hospital NHS FT	597	586	11	2%	716	703	13	2%
St Georges Hospital NHS FT	13,256	12,479	777	6%	15,907	15,295	613	4%
Other Acute SLAs								
Barts & the London NHS T	229	259	(31)	(13%)	274	311	(37)	(13%)
Epsom & St Helier NHS T	7,152	6,228	923	13%	8,582	7,708	874	10%
Imperial College NHS T	786	896	(110)	(14%)	943	1,041	(98)	(10%)
NW London Hospital NHS T	284	268	15	5%	340	328	12	4%
Royal National Orthopaedic Hospital NHS T	261	242	19	7%	314	291	23	7%
Ashtead Hospital	184	129	55	30%	221	154	66	30%
London Ambulance NHS T	4,968	4,968	0	0%	5,961	5,913	48	1%
Total Acute SLAs	**108,920**	**111,428**	**(2,508)**	**(2%)**	**130,704**	**135,064**	**(4,360)**	**(3%)**
Other Acute	195	204	(10)		234	245	(12)	
NCA's	1,865	2,099	(234)		2,238	2,519	(281)	
Total Other Acute	**2,059**	**2,303**	**(244)**		**2,471**	**2,764**	**(293)**	
Total Non SLA Acute	**2,224**	**2,067**	**157**		**2,669**	**828**	**1,841**	
Total Acute Commissioning	**113,203**	**115,798**	**(2,595)**		**135,844**	**138,656**	**(2,812)**	

£1.6m of non-recurrent measures have been utilised to offset some of the overspend

4 Acute Commissioning

January 2019

ISSUE	ACTION
Month 9 raw data was available for month 10 reporting, initial figures are showing an overspend of £2,508k year to date (YTD), with a forecast overspend of £4,360k.	See appendices for more details on acute figures. At month 10 we have data for the first three quarters of the year.
Kingston Hospital is forecast to overspend by £3,305k YTD and £4,840k forecast. The YTD run rate has improved by £56k from month 9 to 10. The largest overspends are in emergency, A&E, elective, outpatient 1st and direct access.	The forecast position at month 10 reflects the agreed year end position with Kingston Hospital. NELCSU will continue to monitor performance against agreed position.
Epsom St Helier contract reports an underspend of £923k YTD and £874k forecast. Underspends in the acute contract are in A&E, elective, emergency and outpatient follow up activity, the SWL elective orthopaedic centre activity is also contributing to the underspend.	Kingston CCG has agreed a year end position with the trust and this is reflected in the forecast at month 10. NELCSU will continue to monitor performance against agreed position.
Kings College Hospital reports a forecast overspend of £230k (49%), this is a slight improvement from month 9 of £7k. The overspend is mainly driven by elective activity in various specialities and overperformance in critical care across all areas except adult critical care 3 organs supported.	NELCSU to continue to monitor the contract and notify CCG finance of any new pressures or developments.
Guys and St Thomas' Hospital is forecast to be overspent by £637k or 39%, driven by elective activity in orthopaedics and cardiology and critical care.	NELCSU to continue to monitor the contract and notify CCG finance of any new pressures or developments.

4 Acute Commissioning - Activity

January 2019

Kingston Clinical Commissioning Group	Latest Period			Year To Date			Period	Trend/ Direction	Year end forecast
	Actual	Plan	Growth/ Plan	Actual	Plan	Growth/ Plan			
Total Referrals (General and Acute)	3,834	4,502	-14.8%	42,014	42,768	-1.8%	Dec-18		56,167
Total GP Referrals (General and Acute)	2,560	3,134	-18.3%	29,420	29,772	-1.2%	Dec-18		39,330
Total Other Referrals (General and Acute)	1,274	1,368	-6.9%	12,594	12,996	-3.1%	Dec-18		16,837
Consultant Led First Outpatient Attendances	7,659	7,925	-3.4%	76,307	75,285	1.4%	Dec-18		102,009
Consultant Led Follow-Up Outpatient Attendances	7,159	7,712	-7.2%	73,424	73,262	0.2%	Dec-18		98,158
Total Elective Admissions	1,177	1,376	-14.5%	12,177	13,068	-6.8%	Dec-18		16,281
Total Elective Admissions - Day Cases	954	1,074	-11.2%	10,127	10,200	-0.7%	Dec-18		13,539
Total Elective Admissions - Ordinary	223	302	-26.2%	2,050	2,868	-28.5%	Dec-18		2,741
Total Non-Elective Admissions	1,688	1,604	5.2%	14,065	14,228	-1.1%	Dec-18		18,670
Total Non-Elective Admissions - 0 LoS	691	624	10.7%	5,440	5,536	-1.7%	Dec-18		7,223
Total Non-Elective Admissions - +1 LoS	997	980	1.7%	8,625	8,692	-0.8%	Dec-18		11,447
Total A&E Attendances excluding Planned Follow Ups	6,089	6,311	-3.5%	55,832	55,987	-0.3%	Dec-18		74,105

The table above shows the Operating Plan 2018-19 supporting activity metrics up to December 2018, with any variation above the 2% threshold marked as amber or red. 0-day Length of Stay (LOS) Non-elective admissions are 10.7% (67 admissions) above plan for the month of December 2018, relating to Kingston Hospital and St Georges University Hospital, related to adults of working age with musculoskeletal or digestive disorders.

5 Non Acute Commissioning

January 2019

	Year To Date			Full Year Forecast Outturn		
	Budget	Actual	Variance	Budget	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Mental Health Contracts	12,045	12,045	(0)	14,454	14,454	(1)
Dementia	182	150	33	219	180	39
IAPT	2,114	2,075	38	2,536	2,508	28
Mental Health Placements	3,183	3,486	(303)	3,819	4,210	(391)
Collaborative Commissioning	136	152	(16)	163	183	(20)
MH NCA's	152	269	(117)	182	311	(129)
Other Mental Health	1,479	1,479	(0)	1,774	1,806	(32)
Mental Health Investment Standard	347	17	330	417	61	355
Child and Adolescent Mental Health	183	186	(3)	220	224	(4)
Learning Difficulties	626	626	(0)	751	751	0
Total Mental Health	**20,446**	**20,485**	**(39)**	**24,536**	**24,689**	**(153)**
Continuing Care & YPD	7,986	7,860	126	9,583	9,452	130
CHC Assessment & Support	712	713	(1)	865	870	(4)
Funded Nursing Care	2,679	2,481	198	3,215	2,977	238
Total Continuing Care	**11,378**	**11,054**	**323**	**13,664**	**13,299**	**364**
Children with disabilities	2,287	2,504	(217)	2,745	3,198	(453)
Collaborative Commissioning (Moor Lane)	1,050	1,050	(0)	1,260	1,260	0
Total Children with Disabilities	**3,337**	**3,554**	**(217)**	**4,005**	**4,458**	**(453)**
Community Services (YHC & HRCH)	16,379	16,377	2	19,655	19,652	3
Property Services	536	567	(31)	643	680	(37)
Capital Charges	234	231	4	281	281	0
Hospices	533	531	2	640	635	5
Other Non-Acute	325	316	10	391	383	8
Total Community Services	**18,008**	**18,021**	**(14)**	**21,609**	**21,630**	**(21)**
Total Non Acute Commissioning	**53,169**	**53,116**	**53**	**63,814**	**64,076**	**(263)**

5 Non Acute Commissioning

January 2019

ISSUE	ACTION
Overall Continuing Healthcare (CHC) is forecast to underspend by £364k, with an adverse movement of £129k since month 9. The Continuing Care & YPD position has worsened in month 10, showing an underspend of £130k. This is due to 27 new cases in January 2019, of which 17 are fast track. The cost of these new patients has been partly offset by ongoing work by the CHC team who have made savings through changes in packages of care and during M10 have identified 8 deceased patients and 1 patient that is no longer eligible for CHC. Funded Nursing Care has experienced lower growth than budgeted with an underspend of £238k in month 10.	QIPP savings will be monitored and reported on a monthly basis. The CHC team will continue to review CHC clients to ensure they still meet the CHC criteria.
Mental Health placements are forecast to overspend by £391k, an increase of £18k since month 9. The overspend has been caused by two new placements expected to cost £153k by the end of the year and additional costs of £149k due to the placement block contract being renegotiated.	Mental Health Investment Standard (MHIS) to be monitored throughout the year to ensure the requirement of 3.5% investment increase is met. As at month 10 we are still meeting the MHIS target.
Mental Health non contracted activity (NCA) are forecast to overspend by £129k. NCAs have been above the long-term average over the last few months. This may be driven by a few large invoices for inpatient stays.	Continue to monitor NCA invoices.

6 Primary Care

January 2019

	Year To Date			Full Year Forecast Outturn		
	Budget	Actual	Variance	Budget	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Prescribing	16,538	15,757	782	19,846	18,949	898
Prescribing Incentives	333	333	0	400	400	0
Central Drugs	481	489	(8)	577	587	(10)
Home Oxygen	240	229	11	288	274	14
Total Prescribing Services	**17,592**	**16,808**	**784**	**21,111**	**20,210**	**901**
Local Commissioned Services	1,630	1,737	(107)	1,956	2,076	(119)
Churchill Drugs	127	127	0	152	152	0
Out of Hours	912	911	1	1,094	1,093	1
NHS 111	544	550	(6)	653	660	(7)
GP IT	309	412	(103)	371	495	(124)
Primary Care Developments	518	537	(19)	621	639	(18)
Primary Care Investments	94	94	(0)	113	113	0
GP Forward View	584	584	(0)	701	701	0
Total Other Primary Care	**4,718**	**4,952**	**(234)**	**5,662**	**5,929**	**(267)**
Primary Care Delegated Commissioning:						
PMS Essential and Additional Services	8,618	8,690	(71)	10,412	10,433	(21)
GMS Global Sum & MPIG	8,217	8,350	(133)	9,867	10,041	(174)
Enhanced Services	519	504	15	623	612	11
Quality and Outcomes Framework (QOF)	1,669	1,636	33	2,003	1,979	24
Premises Payment	2,348	2,365	(17)	2,872	2,922	(50)
Seniority	182	182	0	219	220	(1)
Other Administered Funds (Maternity etc)	196	524	(327)	236	573	(337)
Personally Administered Drugs	95	114	(18)	115	133	(18)
Other Medical Services	32	17	15	39	17	22
SWL Primary Care Team	0	18	(18)	0	22	(22)
Total Primary Care Delegated	**21,878**	**22,399**	**(522)**	**26,384**	**26,951**	**(566)**
Total Primary Care	**26,596**	**27,351**	**(755)**	**32,046**	**32,879**	**(833)**
Total Primary Care & Prescribing	**44,188**	**44,159**	**29**	**53,157**	**53,089**	**68**

6 Primary Care

January 2019

ISSUE	ACTION
The prescribing YTD and forecast position is based on M1-M8 prescribing data extrapolated to month 12 and includes £510k YTD and £642k forecast for NCSO and increased drug tariff impact. The month 10 forecast position also includes £181k net impact of CAT M margin recovery, this includes the recent announcement of margin recovery of £10m per month from November 2018 and the part year effect of the previous margin recovery of £15m per month that ended in August 2018. This results in an underspend of £782k YTD and £898k forecast.	The prescribing team will continue to monitor GP prescribing and notify finance of any cost pressures. Note that there is a two month time lag in prescribing data.
Primary Care Delegated commissioning budget reports a overspend of £522k year to date, an increase since month 9 of £60k and £566k forecast at Month 10, an increase of £28k since month 9. In month 10, the main increase was for Global Sum this is due to the continued increase in list sizes for Q4 resulting in increased costs in several areas.	Monitor actual spend against budgets to identify any future benefits. All KMS KPI's are to be reviewed in 18/19. Notice will be given on all KPI's and new contracts will start in 2019/20, aiming to ensure no recurrent cost pressure.
Locally Commissioned Services (LCS) is forecasting an overspend of £119k in month 10 based on the Q1 to Q3 payments. An improvement of £23k, the largest improvement was seen in Wound Care which improved by £11k.	The overspend in LCS' are being monitored and reviewed.

7 Running Costs

January 2019

	Year To Date			Full Year Forecast Outturn		
	Budget	Actual	Variance	Budget	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Administration & Business Support	243	243	(0)	292	302	(10)
Business Informatics	147	133	14	176	153	23
CEO/ Board Office	555	556	(0)	667	667	(1)
Chair And Non Execs	140	141	(1)	167	171	(3)
Commissioning	268	244	24	320	284	35
Contract Management	1,040	1,052	(12)	1,248	1,269	(21)
Corporate Costs & Services	175	143	32	210	176	34
Corporate Governance	66	27	39	79	27	52
Education And Training	21	6	15	25	10	15
Finance	340	332	7	408	409	(1)
Patient, Public Involvement	104	68	37	125	79	46
Performance	0	0	0	0	0	0
Quality Assurance	158	159	(1)	190	190	(1)
Strategy & Development	39	11	28	47	11	36
Admin Projects	159	158	1	191	193	(3)
Total Running Costs	**3,454**	**3,272**	**182**	**4,143**	**3,942**	**202**
Medicines Management	540	435	105	648	525	123
Clinical Leads	387	371	16	465	449	16

7 Running Costs

January 2019

ISSUE	ACTION
The running cost budget is underspent by £182k year to date and £202k forecast at month 10 a worsening of £71k since month 9. It is anticipated that this position may deteriorate further by year end.	Close budget monitoring to identify any future cost pressures. The CCG cannot breach its running cost allowance.
The favourable forecast variance of £23k in Business Informatics is due to a vacant post which is not likely to be recruited to in 2018/19.	Keep monitoring the budget closely.
The Patient and Public Involvement outturn position will remain favourable until the end of the financial year due to a member of staff currently on maternity leave.	Keep monitoring the budget closely.
The Contract Management forecast position has worsened since month 9 by £22k due to extra costs for two posts in the CSU contract, one of which relates to Information Governance compliance and the other is to cover Overseas Visitors.	Keep monitoring the budget closely.
Due to a restructure of Corporate Governance, this budget is likely to remain underspent in 2018/19 as costs have been transferred to other areas.	Keep monitoring the budget closely.

8 Risks and Mitigations

January 2019

Kingston CCG

TABLE 1 CURRENT REPORTED POSITION			POTENTIAL UNMITIGATED RISKS		
	£'000	£'000		£'000	£'000
RISKS			**FURTHER RISKS**		
Acute SLAs			Acute SLAs		
Acute Overperformance	(4,360)		Acute Overperformance	(500)	
Other Acute	(293)		Continuing Care & Childrens	(466)	
Childrens	(453)		Primary care	(90)	
Community	(21)		Mental Health & LD	(322)	
Primary Care	(833)		Prescribing	(269)	
Mental Health	(153)		Community Services	(100)	
			QIPP risk	(181)	
Total Risks		**(6,113)**	**Total Further Risks to Mitigate**		**(1,928)**
MITIGATIONS			**FURTHER MITIGATIONS**		
Continuing Care	364				
Contingency	0		Contingency Held	99	
Acute reserves	2,666		Contract Reserves	662	
Prior year benefits	1,841		Prior year benefits not released	0	
Prescribing	901		Non-Recurrent Measures	1,168	
Running costs	202				
Other programme costs	139				
Total Mitigations		**6,113**	**Total Further Mitigations**		**1,929**
Total Reported Position		**(0)**	**Potential Surplus/(Deficit) to Mitigate**		**1**

The CCG at month 10 holds mitigations of £1.928m against risk of £1.929m.

If all identified potential risks and mitigations materialise, the CCG would achieve a surplus £1k above plan i.e. a surplus of £1,061k.

9 Statement of Financial Position

January 2019

	2019		
STATEMENT OF FINANCIAL POSITION	**JAN-19**	**DEC-18**	**NOV-18**
Intangible Assets	£292,831	£310,043	£327,255
Property, Plant And Equipment	£205,931	£213,914	£221,896
Non-current Assets Total	**£498,762**	**£523,956**	**£549,151**
Cash And Cash Equivalents	-£434,851	-£351,285	-£422,368
Current Trade And Other Receivables	£3,171,119	£13,003,966	£3,025,196
Current Assets Total	**£2,736,268**	**£12,652,681**	**£2,602,827**
Current Other Liabilities	-£2,998,262	-£3,547,696	-£3,342,951
Current Trade And Other Payables	-£28,526,522	-£40,732,059	-£27,895,627
Provisions	-£269,800	-£269,800	-£269,800
Current Liabilities Total	**-£31,794,584**	**-£44,549,555**	**-£31,508,377**
NC Provisions	-£263,677	-£263,677	-£263,677
Non-Current Liabilities: Total	**-£263,677**	**-£263,677**	**-£263,677**
Grand Total	**-£28,823,232**	**-£31,636,596**	**-£28,620,076**
General Fund	£28,823,232	£31,636,596	£28,620,076
Financed by Taxpayers Equity: Total	**£28,823,232**	**£31,636,596**	**£28,620,076**
Grand Total	**£28,823,232**	**£31,636,596**	**£28,620,076**
STATEMENT OF CHANGES IN TAXPAYERS EQUITY	**JAN-19**	**DEC-18**	**NOV-18**
Opening Balance	£24,250,118	£24,250,118	£24,250,118
Net Operating Cost for the Year	£223,328,128	£201,020,591	£177,905,079
Net Parliamentary Funding	-£218,755,014	-£193,634,113	-£173,535,122
Grand Total	**£28,823,232**	**£31,636,596**	**£28,620,076**

The Statement of Financial Position as at Month 10 represents a snap shot of the CCG's finances as at 31st January 2019, compared to the closing position at 31st December 2018 and 30th November 2018.

The cash balance as at 31st January 2019 of -£435k is due to timing between the cashbooks and the ledger. The actual bank balance at the end of January 2019 was £151k.

The actual bank balance is within the required limit of 1.25% of monthly drawdown in month 10.

9 Cash Drawdown

January 2019

Cash Resource Limit	Cash Report
£000	Jan-19
MCD Cash limit	267,846
Less	
Capital & CHC Risk Pool	0
Other Central/BSA payments	19,206
Remaining Cash limit	**248,640**

The Maximum Cash Drawdown (MCD) is based on the Annual Cash Forecast (ACF) sent to NHS England in March with in year adjustments. The current MCD is £267.8m.

The cash draw down in January 2019 was £23.5m.

The target for cash remaining at end of January was achieved with a balance of £151k: 0.81% (inside the 1.25% required by NHS England).

Month	Forecast Monthly Drawdown	Main Drawdown	Additional Drawdown	Difference between Forecast and Actual	Cumulative Drawdown	Proportion of Annual Cash Resource Limit	KPI 1.25% of main Drawdown	Actual month end cash balance	KPI Achievement
	£000s					%	£000s	£000s	%
Apr-18	20,720	16,200	2,900	-1,620	19,100	7.7%	203	83	0.51%
May-18	20,720	17,000	5,400	1,680	41,500	16.7%	213	124	0.73%
Jun-18	20,720	18,000	500	-2,220	60,000	24.1%	225	51	0.28%
Jul-18	20,720	17,000	1,650	-2,070	78,650	31.6%	213	134	0.79%
Aug-18	20,720	18,700	3,500	1,480	100,850	40.6%	234	87	0.47%
Sep-18	20,720	18,000	1,200	-1,520	120,050	48.3%	225	190	1.05%
Oct-18	20,720	18,800	1,600	-320	140,450	56.5%	235	192	1.02%
Nov-18	20,720	19,200	1,200	-320	160,850	64.7%	240	157	0.82%
Dec-18	20,720	18,400	0	-2,320	179,250	72.1%	230	197	1.07%
Jan-19	20,720	18,600	4,900	2,780	202,750	81.5%	233	151	0.81%
Feb-19	20,720	18,800							
Mar-19	20,720								
Annual Total	**248,640**	**198,700**	**22,850**	**-4,450**					

9 Cash Flow Statement

January 2019

CASH FLOW STATEMENT	Jan-19	Dec-18	Nov-18
	MOVEMENT £		
(Increase) decrease in trade and other receivables	9,832,846	-9,978,770	-786,502
Depreciation and amortisation	25,195	25,195	25,195
Impairments and reversals	0	0	0
Increase (decrease) in provisions	0	0	0
Increase (decrease) in trade and other payables	-12,754,971	13,041,179	1,263,617
Net operating costs for the financial year	-22,307,537	-23,115,512	-22,404,660
Provisions utilised	0	0	0
1.Cash Flows from Operating Activities: Total	**-25,204,467**	**-20,027,908**	**-21,902,349**
(Payments) for intangible assets	0	0	-21,291
(Payments) for property, plant and equipment	0	0	0
Proceeds from disposal of assets held for sale: property, plant and equipment	0	0	0
2.Cash Flows from Investing Activities Total	**0**	**0**	**-21,291**
Net parliamentary funding received	25,120,901	20,098,992	21,936,499
3. Cash Flows from Financing Activities Total	**25,120,901**	**20,098,992**	**21,936,499**
Grand Total	**-83,567**	**71,083**	**12,859**

	Jan-19	Dec-18	Nov-18
Movement	-83,567	71,083	12,859
Opening Amount	-351,285	-422,368	-435,227
Closing Amount	-434,851	-351,285	-422,368

The CCG has no capital allocation and spend in 2018-19.

Provisions will be reassessed at year end.

9 Aged Debtors

January 2019

Customer name	Invoice number	Invoiced date	AR due 0-30 amount	AR overdue 31-60 amount	Total AR due and overdue amount
NHS ENGLAND	7024100776	24/11/2018	£0	£538,275	£538,275
MACMILLAN CANCER SUPPORT	7024100785	20/12/2018	£2,227	£0	£2,227
ROYAL BOROUGH OF KINGSTON UPON THAMES COUNCIL	7024100789	20/12/2018	£1,135	£0	£1,135
ROYAL BOROUGH OF KINGSTON UPON THAMES COUNCIL	7024100791	20/12/2018	£39,439	£0	£39,439
ROYAL BOROUGH OF KINGSTON UPON THAMES COUNCIL	7024100794	25/01/2019	£49,531	£0	£49,531
ROYAL BOROUGH OF KINGSTON UPON THAMES COUNCIL	7024100795	25/01/2019	£728,174	£0	£728,174
ROYAL BOROUGH OF KINGSTON UPON THAMES COUNCIL	7024100796	25/01/2019	£300,000	£0	£300,000
ACHIEVING FOR CHILDREN LIMITED	7024100797	25/01/2019	£21,551	£0	£21,551
X	7024100798	30/01/2019	£246	£0	£246
NHS WANDSWORTH CCG	7024100799	31/01/2019	£986	£0	£986
CENTRAL SURGERY SURBITON	7024100800	31/01/2019	£2,294	£0	£2,294
NHS RICHMOND CCG	7024100801	31/01/2019	£185	£0	£185
NHS RICHMOND CCG	7024100802	31/01/2019	£26,207	£0	£26,207
NHS RICHMOND CCG	7024100803	31/01/2019	£22,701	£0	£22,701
NHS RICHMOND CCG	7024100804	31/01/2019	£21,583	£0	£21,583
NHS RICHMOND CCG	7024100805	31/01/2019	£20,631	£0	£20,631
NHS RICHMOND CCG	7024100806	31/01/2019	£22,701	£0	£22,701
NHS WANDSWORTH CCG	7024100807	31/01/2019	£5,326	£0	£5,326
ROYAL BOROUGH OF KINGSTON UPON THAMES COUNCIL	7024100808	31/01/2019	£5,717	£0	£5,717
Total			**£1,270,635**	**£538,275**	**£1,808,910**

The Aged Debtor Report at 31st January 2019 shows total outstanding debt of £1.8m of which £538k is overdue.

As at 12th February 2019, £26k of the outstanding debt has been paid.

Note that the aged debt report has been redacted to remove any sensitive information.

9 Better Payment Practice Code (BPPC)

January 2019

BETTER PAYMENT PRACTICE CODE 2018-19	Jan-19		
	NHS	NON-NHS	TOTAL
NO. OF INVOICES			
Paid in the month	286	774	1,060
Paid within target	271	761	1,032
% Paid within target	**94.76%**	**98.32%**	**97.36%**
VALUE OF INVOICES (£000s)			
Value paid in the month	16,569	7,143	23,712
Paid within target	16,092	7,036	23,129
Value % for the month	**97.12%**	**98.51%**	**97.54%**
CUMULATIVE NO. OF INVOICES			
Invoices paid YTD	2,447	6,669	9,116
Paid within target	2,386	6,577	8,963
% Paid within target	**97.51%**	**98.62%**	**98.32%**
CUMULATIVE £'000			
Value paid YTD	138,342	71,613	209,955
Paid within target	137,712	70,762	208,474
Value % Cumulative	**99.54%**	**98.81%**	**99.29%**

The BPPC target is to pay 95% of invoices within the required payment terms. Most of these targets have been met in month 10 with the exception of the no of NHS invoices.

The finance team will continue to monitor the invoice workflows and send out reminders to budget holders on a regular basis.

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	Initial Budget 2019/20		
Lead Director **(Name and Role)**	Neil Ferrelly LDU Director of Finance		
Clinical Sponsor **(Name and Role)**			
Author(s) **(Name and Role)**	Liam Bayly / Jenny Sinnott Head of Finance		
Agenda Item No.	2.6	**Attachment No.**	I

Purpose **(Tick as Required)**	Approve ✓	Discuss	Note

Executive Summary

Background:

The CCG has submitted a draft plan to NHS E. This will be subject to further revision as contracts are agreed.

Purpose: The governing body is asked to approve the initial budget based on the draft planning submission. This will be updated at the May meeting following the conclusion of the contract agreements.

Key Issues:

1) The CCG plan has been prepared using a set of assumptions. These will be updated as the more detailed contract negotiations are finalised for each individual provider.
2) The CCG plan requires delivery of a significant QIPP programme to meet the required control total.

Conflicts of Interest:
None

Mitigations:
N/A

Recommendation:
The governing body is asked to approve the initial budget summarised in section 4.

Corporate Objectives This document will impact on the following CCG Objectives:	Sustainability

Risks This document links to the following CCG risks:	Failure to meet statutory financial targets
Mitigations Actions taken to reduce any risks identified:	Continue to review and monitor the financial position on a monthly basis.

Financial/Resource/ QIPP Implications	As detailed in summary

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A

Patient and Public Engagement and Communication	N/A

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	Finance Committee	Monday, 25 February 2019	
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	None

Finance Plan 2019/20 - Draft Budget

Introduction

The Governing Body is asked to approve the draft plan as an initial budget. An updated plan will be provided to the May meeting, reflecting the Final submission and contract agreements.

Contents

1) NHS Allocations

The NHS has set 5 year allocations from 2019/20 for CCG's with the last three years being indicative. In addition, it has set some key changes to the final regime with a full review being undertaken over 2019/20 but these include

a) A clear intention to move towards making all NHS organisations and systems financially sustainable by the end of 5 years;
b) Gradual reduction in the level of Provider and Commissioner Sustainability Funds with the resource being moved into normal funding routes
c) Creation of a new £1.05bn Financial Recovery Fund (FRF) to support essential services which can be accessed by trusts in deficit who sign up to CT (FRF includes £200m from PSF and this will increase in 2020/21). Three Trusts on SWL have been offered a contribution form this fund.
d) It is understood that over the 5-year planning process further transformation funds to support key elements of the 10-year plan are being held centrally further to future decision making process. These will be clarified over coming weeks and months.
e) There are expectations that the mental health investment standard is met at 0.7% above growth;
f) Changes to the Market Forces Factor which reduce the level of resource attributed to London in comparison to other parts of the country. The allocation formula takes account of proposed MFF changes (impacts all services except for prescribing and primary care) and has pace of change applied to avoid volatility in bringing CCG towards their target allocation;
g) The headline cash growth rate for SWL CCG core services is 5.68% in 2019/20. The national average is 5.65% and the London average is 5.78%;
h) Changes to the funding formula for CCGs including mental health and community services;
i) In 2019/20 CCGs are expected to pass on through Tariff the impact of PSF (1.3%) and national inflation funding (3.7%). This includes funding of the staff pay award for 2018/19 and 2019/20. Trusts efficiency reduction has been set at 1.1%. Trusts in deficit are required to increase this to 1.6%.
j) CCG running cost allowances are being reduced by 20% by 2020/21. No reduction has been set for 2019/20.
k) Due to the changes in the national formula the SWL CCGs capitation position from target moves from 2.68% in 2018/19 to above target to 4.09% above target by 2023/24. This deteriorates due to the implementation of the new market forces factor.

2) SW London - System Working

The net impact of this for CCGs in SWL in 2019/20 is that a headline growth of 5.68%. 3.9% of this is passed through to Trusts directly through inflation and tariff leaving a growth of circa 1.8% dependent on local uplifts.

For 2019/20 all CCGs and Trusts have been set individual control totals. These have then been aggregated to provide a SWL System Control. The Planning Guidance allows for flexibility to move control totals between organisations but the SWL control total must not be exceeded. This is supported by a clear national intention that local systems move to a more transparent and collaborative approach. The implications of this are being worked through as part of the planning process and will be discussed through the SWL CCG Finance Committee in Common and into local Governing Bodies

3) Planning Assumptions

	Richmond 19/20	Kingston 19/20	Comments
NHS ENGLAND (LONDON) ASSUMPTIONS			
Funding levels	5.76%	5.19%	As per published allocations
Tariff efficiency (Acute)	(1.10)%	(1.10)%	As per Annex A prices document in 19/20 planning documentation
Tariff inflation (Acute)	5.10%	5.10%	Includes base tariff increase of 3.8% plus estimated net impact of PSF, MFF, CNST and procurement adjustments to tariff. CQUIN cost neutra
Tariff inflator/deflator (Acute)	4.00%	4.00%	
Tariff efficiency (Non Acute)	(1.10)%	(1.10)%	As per Annex A prices document in 19/20 planning documentation
Tariff inflation (Non Acute)	3.75%	3.75%	As per Annex A prices document in 19/20 planning documentation. 3.8% less procurement adjustment
Tariff inflator/deflator (Non Acute)	2.65%	2.65%	
Contingency	0.50%	0.50%	As per planning rules
Non recurrent investment reserve	0.50%	0.50%	

	Richmond 19/20	Kingston 19/20	Comments
CCG Assumptions			
Prescribing inflation and growth	6.00%	6.00%	
Primary Care growth and inflation	1.50%	2.00%	
Continuing Care growth and inflation	8.00%	8.00%	
Demographic growth	0.81%	1.35%	Revised demographic growth based on assumed list size growth in CCG allocations.
Primary Care Co-Commissioning Inflation	5.39%	5.18%	Increase in delegated primary care allocation excludes demographic growth
Acute - non demographic growth	3.19%	2.65%	Net acute growth set at 4% based on estimated weighted costs of agreed activity modelling.
Non acute non demographic growth	1.69%	1.75%	High level planning figure. Assume will fund additional non-acute services.

- Acute growth and tariff have been set based on guidance and current analysis available. Costs are in line with the detailed cash envelopes, plus additional non-demographic growth
- Plan assumes MHIS will be met, with target of 0.7% above allocation growth.
- Expectation that community and primary care expenditure and investment may increase above allocation growth, awaiting clarity about implications.
- Assumption that increase in delegated primary care allocation will be fully committed to fund confirmed contract changes.
- £1.50 per head to develop and maintain primary care networks is funded and assumed to be fully committed.
- Mandatory 0.5% contingency has been established.
- 0.75% commissioning reserve established

4) Kingston CCG 2019/20 Draft Financial Plan- Initial Budgets

Submitted to NHSE 12th February 2019

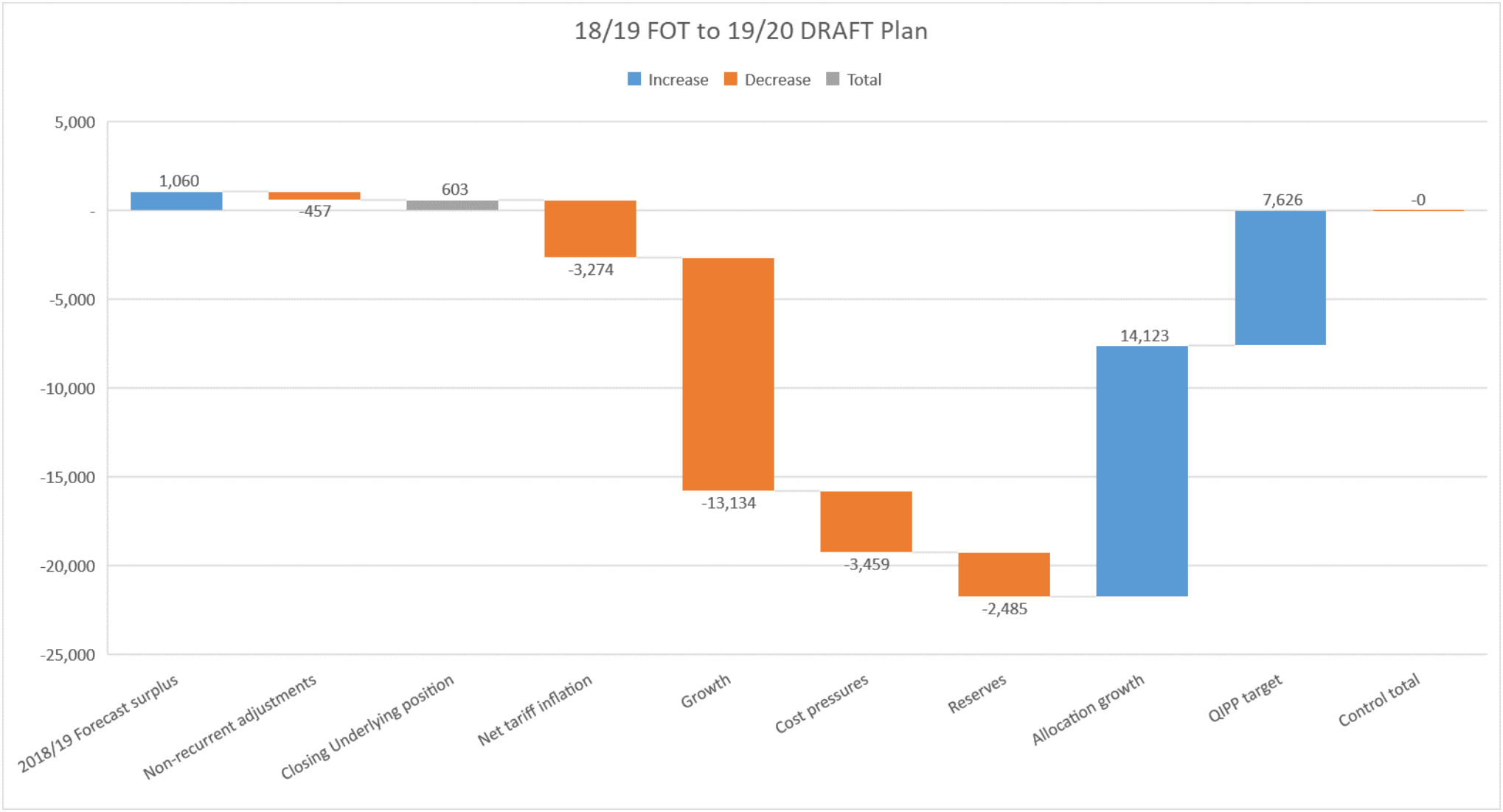
- Opening position is a 0.6M surplus.
- QIPP net requirement is £7.626m.
- The CGG control total is breakeven.

2018/19 Programme Baseline	234,274		234,274
Other Non-recurrent allocations	4,766		-
Recurrent adjustments	-188		44
Programme uplift			-
Running Costs	4,344		4,344
Delegated Primary Care (recurrent)	26,035		26,035
Total 18/19 Baseline	**269,231**		**264,697**

2018/19 Programme Baseline	234,274
Other Non-recurrent allocations	-
Recurrent adjustments	184
Programme uplift	12,377
Programme Baseline	**246,835**
Running Costs	4,316
Delegated Primary Care (recurrent)	27,669
Total 19/20 Baseline	**278,820**

Budget Area	2018/19 FOT	Remove non-recurrent allocations	Non-recurrent impact of pricing changes (-/+)	Non-recurrent adjustments	Opening 2019/20 plan	Gross Provider Efficiency (-)	Provider Inflation (+)	Activity Growth (Demog) (+)	Activity Growth (Non-Demog) (+)	Other Recurrent Cost Pressures	Investment Recurrent	Gross QIPP	QIPP Investment	Recurrent 2019/20	Non-recurrent items	Total 2019/20
Acute contracts - SLAs	135,444	-371	-1,316	235	133,992	-1,474	4,015	3,713	3,671	-120		-4,218	674	140,254		**140,254**
Acute contracts - Other providers	4,178	-320			3,858	-42	197	49	106					4,167	100	**4,267**
Acute - Other	-1,361			2,333	972	-11	50	12	27					1,050		**1,050**
Unidentified QIPP												-1,326		-1,326		**-1,326**
Mental Health	24,851	-1,516			23,335			294	555	303	324	-125	25	24,711		**24,711**
Community Services	21,055	-683			20,372	-224	764	257	407					21,576		**21,576**
Continuing Healthcare	17,628				17,628			222	1,216	1,400		-1,700	44	18,811		**18,811**
Prescribing	20,399				20,399			257	1,000	150		-1,000		20,805		**20,805**
Primary Care Other	5,143	-1,122		-309	3,712			47	182	1,224	818			5,982		**5,982**
GP IT	424				424			5	21	50				500		**500**
Other Programme Services	1,970				1,970			25	97					2,091		**2,091**
Social Care	3,187				3,187			40	61					3,288		**3,288**
Other CCG reserves	1,694	43		38	1,775			10		-87	225			1,923	418	**2,341**
Commissioning reserve 0.75%	1,302			-1,302						1,091				1,091		**1,091**
Contingency 0.5%	1,324				1,324					71				1,394		**1,394**
Running costs	4,011				4,011					305				4,316		**4,316**
Delegated Primary Care budgets	26,924	213			27,137			342	518	-328				27,669		**27,669**
Total CCG Expenditure	**268,171**	**-3,756**	**-1,316**	**995**	**264,094**	**-1,751**	**5,025**	**5,273**	**7,861**	**4,059**	**1,367**	**-8,369**	**743**	**278,302**	**518**	**278,820**
In year surplus/(deficit)	**1,060**				**603**							**-**	**-7,626**			**-**

5) Kingston CCG 2019/20 Draft Financial Plan Waterfall



6) Contract Negotiations

- Contract alignment return submitted on 19th Feb contained differences between commissioner and providers, in part due to QIPP
- Offers have been shared with community trusts, including tariff uplift, efficiency and adjustment for MFF and procurement changes, plus demographic growth. Non-demographic growth will be applied only for investments and agreed cost pressures.
- Other community providers have been offered an uplift for demographic growth
- Mental Health Trust has been offered tariff uplift, less efficiency, MFF and procurement changes. Further growth will be applied only for investments and agreed cost pressures. There is a large alignment gap between Trust and CCG's.
- For KCCG, negotiations with practices are ongoing to close the financial gap of c.£700k on the KMS contract

7) Next Steps

- Agree baseline and growth with providers
- Align plan with detailed growth and tariff from CSU work
- Understand position on primary care and community funding.
- Agree system priorities to lead transformation
- Continue to work up efficiencies and reach agreement between commissioners and providers.
- Reach contract alignment for agreement in March and final plan submission in April.

8) Timetable

Milestone	Date
Publication of: • Near final 2019/20 prices • 2019/20 standard contract consultation	21 December 2018
2019/20 deliverables, indicative CCG allocations, trust financial regime and control totals and associated guidance for 2019/20	Early January 2019
NHS Long Term Plan	January 2019
2019/20 CQUIN guidance published	January 2019
2019/20 Initial plan submission – activity focused	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
STP/ICS net neutral control total changes agreed by regional teams	By 1 February 2019
Draft 2019/20 organisation operational plans	12 February 2019
Aggregate system 2019/20 operating plan submissions, system operating plan overview and STP led contract / plan alignment submission	19 February 2019
2019/20 STP/ICS led contract / plan alignment submission	19 February 2019
Final 2019/20 NHS Standard Contract published	22 February 2019
Local decision whether to enter mediation and communication to NHSE/I and boards/governing bodies	1 March 2019
2019/20 STP/ICS led contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Parties entering arbitration to present themselves to the Chief Executives of NHS Improvement and England (or their representatives)	22-29 March 2019
STP/ICS net neutral control total changes agreed by regional teams	By 25 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Submission of appropriate arbitration documentation	1 April 2019
Arbitration panel and/or hearing (with written findings issued to both parties within two working days after panel)	2-19 April 2019
Final 2019/20 organisation operational plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions, system operating plan overview and STP/ICS led contract / plan alignment submission	11 April 2019
2019/20 STP/ICS led contract / plan alignment submission	11 April 2019
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 30 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Autumn 2019

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	Council of Members Report		
Lead Director (Name and Role)	Atin Goel, Council of Members Chair		
Clinical Sponsor (Name and Role)	Atin Goel, Council of Members Chair		
Author(s) (Name and Role)	Atin Goel, Council of Members Chair		
Agenda Item No.	2.7	**Attachment No.**	J

Purpose (Tick as Required)	Approve	Discuss	Note ✓

Since the last governing body report, the council of members has met on two occasions, 15 January 2019 and 12 February 2019, with good practice representation at each.

At the January 2019 meeting, members were provided with an update on Kingston Medical Services and also received a briefing on some of the detail published within the NHS Long Term Plan including financial challenges, the scale of ambition and the introduction of primary care locality networks.

Members also received a primary care update from Kathryn MacDermott which included details on the new outpatient transformation model, identified work streams to date, success so far and enablers for planned care transformation.

At the February 2018 meeting, members received a summary of the new GP contract, a further KMS update and a presentation on Dr Link by Keith Nurcombe.

Members also received a demonstration of 'C the Signs' decision support tool, available on iOS, android and as a website. The tool uses artificial intelligence mapped with the latest evidence to help GPs identify patients with cancer early. It gives GPs the ability to simultaneously check combinations of signs, symptoms and risk factors, in an easy to use format.

A presentation was also given by Elaine Lancaster on the physician associate expansion into primary care to achieve the DH target of 1000 physician associates in primary care by 2020. The target was set in response to the GP Forward View and Health Education England's Primary Care Commission which recognised the need for a wider clinical workforce in primary care to support service transformation.

Members were also updated by Doreen Redwood on the progress to produce a written statement of action to address the areas of significant weakness that had been identified in the Ofsted CQC inspection of Kingston's Special Educational and Disabilities Needs (SEND) action plan following the CQC report.

The next council of members meeting is being held on 12 March 2019.

Conflicts of Interest: N/A
Mitigations: N/A

Recommendation: The governing body is asked to note the council of members report.

Corporate Objectives This document will impact on the following CCG Objectives:	1. Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do 2. Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care 3. Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities 4. Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership, and effective membership & staff engagement 5. Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation.

Risks This document links to the following CCG risks:	N/A
Mitigations Actions taken to reduce any risks identified:	N/A

Financial/Resource/ QIPP Implications	N/A

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A

Patient and Public Engagement and Communication	N/A

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
		Click here to enter a date.	
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	NHS Long Term Plan – Key headlines		
Lead Director (Name and Role)	Tonia Michaelides, Managing Director		
Clinical Sponsor (Name and Role)	Dr Naz Jivani, Governing Body GP Chair		
Author(s) (Name and Role)	Tonia Michaelides, Managing Director		
Agenda Item No.	3.1	**Attachment No.**	K

Purpose (Tick as Required)	Approve	Discuss	Note
		✓	✓

Executive Summary

Background:

The NHS Long Term Plan was published in January 2019 and sets out a new service model for the 21st Century which includes more NHS action on prevention and health inequalities, further progress on care quality and outcomes, increased NHS workforce, training and recruitment, making better use of data and digital technology and a funding settlement to help put the NHS back into a sustainable financial path.

Reason for Committee Review:

It was agreed at the last governing body meeting in January 2019 to bring back some of the detail within the plan to members for further discussion.

Key Issues:

1. High level messages
2. Next steps in implementing the plan
3. Implications for local health and care plans

Conflicts of Interest:
N/A

Mitigations:
N/A

Recommendation:
The Committee is asked to: note the high level messages within the NHS Long Term Plan

Corporate Objectives This document will impact on the following CCG Objectives:	1. Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do 2. Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care 3. Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities 4. Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership, and effective membership & staff engagement 5. Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation

Risks This document links to the following CCG risks:	
Mitigations Actions taken to reduce any risks identified:	

Financial/Resource/ QIPP Implications	N/A

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for	N/A

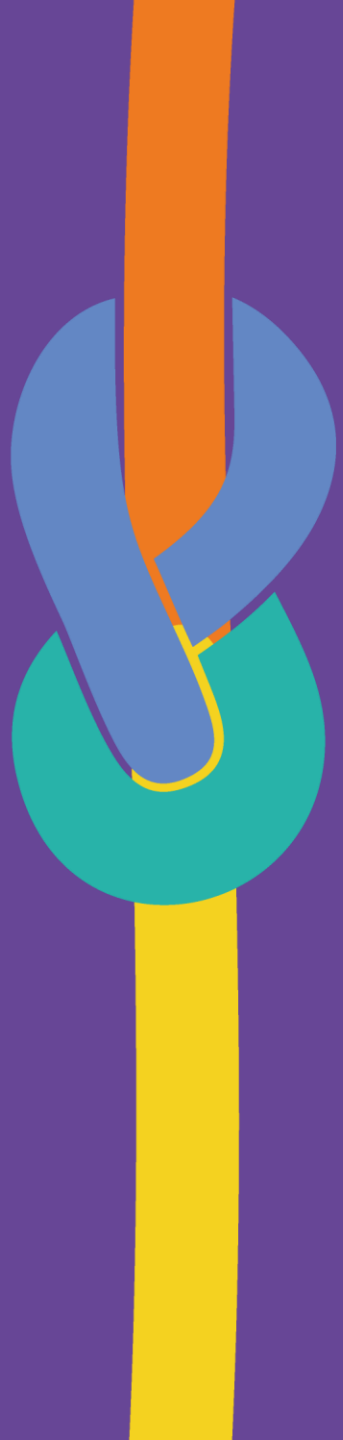
equalities? If so, what are the mitigations?	

Patient and Public Engagement and Communication	

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
		Click here to enter a date.	
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	Slide pack – NHS Long Term Plan key headlines

South West London
Health & Care
Partnership



NHS long term plan
Key headlines

High level messages

South West London Health & Care Partnership

- Focus on prevention and reducing health inequalities – specific new evidence-based NHS prevention programmes
- New clinical standards will be set to build on successes of stroke etc – Clinical standards review will be published in Spring 2019
- NHS priorities for care quality and outcomes improvement for the next 10 years, wider that then FYFW - cancer, mental health, diabetes, multimorbidity, healthy aging including dementia, children's health and wellbeing, maternity and neonatal, cardiovascular and respiratory conditions and learning disability and/or autism
- Reforms to hospital emergency care - every hospital with a type 1 A&E dept will move to a Same Day Emergency Care model; hospitals will establish acute frailty services
- Roll out of NHS Personalised Care model across the country
- The NHS and social care will continue to improve performance at getting people home without unnecessary delay
- Boost "out of hospital care" - Primary care and community care funding and requirements
  - Urgent community response and recovery support to deliver within two hours of referral
  - Reablement care within 2 days of referral
  - Primary care networks created with new "shared savings" scheme

High level messages

South West London Health & Care Partnership

- Renewed commitment that mental health services will grow faster than the overall NHS budget – new ringfenced investment fund created (£2.3 bn by 2023/24)
- Guaranteed NHS support to people living in care homes – vanguard model rolled out
- Greater recognition and support for carers – Quality Markers in primary care that highlight best practices in career support and identification
- Workforce is a significant focus - Expansion in nursing and other undergraduate places; new routes into nursing and other disciplines include apprenticeships; flexible rostering will become mandatory; doubling of volunteers
- Better use of data and digital technology
- Integrated Care Systems across the country by April 2021
- Funding
  - Major reforms to NHS financial architecture, payment systems and incentives
  - New financial recovery fund and "turnaround" process established
  - Expectation that over the next 5 years the NHS, trust sector, local systems and individual organisations will return to financial balance
- Legislative changes that would support more rapid progress outlined

South West London Health & Care Partnership

Looking a little closer at the detail …

Doing things differently: The NHS will move to a new service model in which patients will get more options, better support, and properly joined-up care at the right time in optimal settings

South West London Health & Care Partnership

- The right to have 'digital' GP consultations
- GP Networks to be funded to work together to deal with pressures
- Creating genuinely integrated teams of GPs, community health and social care staff
- Expanded community teams with new standards to provide fast support to people living in care homes
- 2.5m people will benefit from social prescribing, personal health budgets, and new support for managing their own health in partnership with patients groups and the voluntary sector
- Backed by investment in primary medical and community services – ringfenced local fund worth at least an extra £4.5bn a year in real terms by 2023/24
- New Clinical Standards to build on the success of major trauma, stoke etc
- "same day emergency care" model will be rolled out across all acute trusts
- Partnerships with local councils to build on improvements to cut delayed hospital discharges
- Outpatients will be fundamentally redesigned

Integrated care systems

South West London Health & Care Partnership

- Move to create ICSs everywhere by April 2021. Typically there will be a single CCG for each ICS.
- Bring together local organisations in a pragmatic, practical way to deliver "triple integration" – primary and specialist care; physical and mental health services; and with health and social care.
- Key role in working with Local Authorities at "place" level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and long term plan implementation. Support for blending health and social care budgets where councils and CCGs agree this makes sense.
- Funding flows and contract reform will support ICSs and there will be a new ICS accountability and Performance Framework
- Greater emphasis by the CQC on partnership working and system-wide quality in its regulatory activitiy
- Clear expectations that strong successful organisations not only provide high quality care and financial stewardship from an organisational perspective but also take on responsibility for wider objectives in relation to the use of resources and population health.
- Neither Trusts nor CCGs will pursue actions which, whilst potentially improving their institutional financial position, would result in a worse position for the system overall. New "duty to collaborate" for providers and CCGs.
- Creation of joint partnership board, drawn from commissioners, trusts and primary care networks with a Non-Executive Chair
- ICSs will be supported by a system oversight approach which reviews organisational and system objectives alongside the performance or individual organisations.
- Systems will need to produce and implement clear development plan and timetable to become an ICS

Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health

South West London Health & Care Partnership

Prevention: The plan funds specific new evidence-based NHS prevention programmes including to: cut smoking; reduce obesity partly by doubling the enrolment in successful Type 2 NHS diabetes prevention programme; limit alcohol-related A&E admissions; and to lower air pollution.

Tackling health inequalities: NHSE Funding will base funding on more accurate assessment of health inequalities and unmet need. Every local area will be required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years. These will need to be part of our local health and care plans. Plan also sets out specific action in some areas e.g. ensure people with learning disability and/or autism get better support; provide outreach services for people who are homeless; help people with severe mental illness for find and keep a job

Action by the NHS is to complement, but not substitute, the important role for local government

NHS priorities for care quality and outcomes improvement for the next 10 years

South West London Health & Care Partnership

- Cancer
- Mental health
- Diabetes
- Multimorbidity
- Healthy aging including dementia
- Children's health and wellbeing
- Maternity and neonatal services
- Cardiovascular and respiratory conditions
- Learning disability and/or autism

Workforce

South West London Health & Care Partnership

Increase the NHS workforce, training and recruiting more professionals Expansion in nursing and other undergraduate places:

- new routes into nursing and other disciplines include apprenticeships;
- new post-qualification employment guarantee;
- international recruitment expanded;
- new incentives for shortage specialties and hard-to-recruit geographies;
- doubling of volunteers

Make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

- flexible rostering will become mandatory;
- continuing professional development funding will increase each year;
- action to support diversity and a culture of respect and fair treatment;
- new inter-disciplinary credentialing programmes will enable more workforce flexibility across a person's NHS career and between staff groups;
- primary care networks to offer more flexible options for GPs and wider primary care team

Making better use of data and digital technology

South West London Health & Care Partnership

- More convenient access to services and health information for patients
  - digital access to be widespread
  - Patients and carers better able to manage their health and condition
- The new NHS App as a digital 'front door'
- Better access to digital tools and patient records for staff so that they can access and interact with patient records and care plans wherever they are – ready access to AI
- Digitally enabled primary and outpatients
- Improvements to the planning and delivery of services based on the analysis of patient and population data
- Automation and standardisation of generation and storage of NHS data to reduce duplication
- Predictive techniques to support ICS to optimise care for their populations

How the 3.4% funding settlement will help put the NHS back into a sustainable financial path

South West London Health & Care Partnership

- Current financial pressures first call on extra funds
- Realistic about inevitable continued growth, unmet need etc
- Provided for hospital funding as if trends over the past three years continue but expect the actions in the NHS plan to create a "dividend" (financially and capacity)
- No locked in assumption that funding for primary and community care will reduce the need for hospital beds
- Will continue to drive efficiencies – all of which will be then available for local investment in frontline care
- Reduced administration costs across providers and commissioners to release £700m
- Major reforms to NHS financial architecture, payment systems and incentives
- New financial recovery fund and "turnaround" process established
- Expectation that over the next 5 years the NHS, trust sector, local systems and individual organisations will return to financial balance

South West London Health & Care Partnership

Next steps …

Next steps in implementing the plan

South West London Health & Care Partnership

- NHS Assembly to be established **early in 2019**
- National implementation framework published in **Spring 2019**
- Clinical standards review will be published in **Spring 2019**
- National implementation programme **by autumn** to take into account government spending review recommendations on workforce education and training budgets, social care, council's public health services and NHS capital investment
- Sustainability and Transformation Partnerships and Integrated Care Systems (ICSs), need to develop and implement their own 5 year strategies to set out how the ambitions in the NHS Long Term Plan will be taken forward. These strategies will be published **in the autumn**. (see slide 17 for initial thinking on this)
- A workforce implementation plan will be **published later in 2019** and NHSE will establish a national workforce group
- Move to create ICSs everywhere **by April 2021**, systems will need to produce and implement clear development plan and timetable to become an ICS
- SWL to review existing transformation against the NHS Long Term Plan areas
- Local health and care plans to consider the implications of the Long NHS Long Term Plan (see slide 15 as a starter for ten)

South West London Health & Care Partnership

Appendices…

Implications for Local health and care plans of the NHS long term plan …

South West London Health & Care Partnership

- **Models of health and care will need to be consider the implications of fully integrated community-based health care**
  - new primary care networks
  - intermediate health care packages
  - urgent community response and recovery support services
  - pharmacy connection schemes
  - community hospital hubs
  - expanded neighbourhood teams will be implemented in their area
  - Guaranteed NHS support to people living in care homes
  - Dementia connect programme extension
  - Multidisciplinary clinical assessment service (CAS) within NHS 111, ambulance dispatch and GP out of hours services
  - Seven-day specialist multidisciplinary service and crisis care for people with LD and/or Autism
- **Prevention and reducing health inequality priorities – smoking, obesity etc**

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	Board Assurance Framework		
Lead Director **(Name and Role)**	Vicki Harvey-Piper Director of Corporate Affairs & Governance		
Clinical Sponsor **(Name and Role)**			
Author(s) **(Name and Role)**	Ranjit Plahe Governance, Risk & Office Manager		
Agenda Item No.	3.2	**Attachment No.**	L

Purpose **(Tick as Required)**	Approve	Discuss	Note
		✓	✓

Executive Summary

Background:
The Board Assurance Framework document forms the basis for the governing body to assess its position in respect of achieving its corporate objectives. It uses principal risks to the achievement of those objectives as the foundation for assessment and considers the current level of control alongside the level of assurance that can be placed against those controls as a means of determining whether corporate objectives are likely to be met.

Risks are scored using the standard NHS 5x5 matrix based on Impact and Likelihood. A copy of the matrix and description of impact detail is attached.

Purpose:
To present a summary of the Corporate Risk Register and Board Assurance Framework (BAF) to the governing body for information.

Reason for Committee Review:
Ownership of the BAF process lies with the governing body and as such twice a year, March and September, the governing body reviews the content of the BAF as a means of assessing the current level. The governing body receives summary BAF reports in the intervening months.

An internal audit review by RSM internal audit report (Jan 2019) highlighted that in comparison to other GBAFs reviewed within the South West London CCG Alliance, other CCGs use a minimum score of 15 for extraction of risks from the risk register into the GBAF. Kingston and Richmond CCGs have to date been reporting a minimum risk score of 9. To improve comparability, it has been recommended by RSM to change the minimum risk score considered in the GBAF to 15.

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Key Issues:

1. The BAF is formed from risks pulled through from the corporate risk register. There are several lower level risks in addition to the ones reported in the BAF currently on the register that are being mitigated and monitored through the committees of the governing body.

2. The executive management team is the designated committee responsible for oversight of the risk management process and at its monthly meetings has oversight of all residual risks (after mitigation). Each sub-committee of the governing body also reviews those risks specific to their corporate objective area and are made aware of significant changes to the risk register at each meeting.

3. There are currently 27 risks identified on the risk register

Conflicts of Interest:
Risk scores and their detailed content are reviewed monthly by the joint Kingston & Richmond Executive Management Team and presented to each sub-committee of the governing body at its respective meetings to ensure independent cross evaluation of risks is conducted and a consistent approach applied.

Mitigations:
N/A

Recommendation:
The governing body is asked to: Note the content of the full Board Assurance Framework and take assurance/raise any concerns over the current level of control in place to manage the key risks likely to impact on the achievement of the CCG corporate objectives.

The Governing Body is also asked to approve the internal auditor's recommendation to align with the rest of SWL CCGs and only extract risks with a minimum score of 15 and above from the risk register through to the BAF.

Corporate Objectives This document will impact on the following CCG Objectives:	The BAF considers principal risks identified for all five of the CCG corporate objectives.

Risks This document links to the following CCG risks:	The document details the principal risks likely to impact on the achievement of corporate objectives
Mitigations Actions taken to reduce any risks identified:	N/A

Financial/Resource/ QIPP Implications	Financial risks are included within the document

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A

Patient and Public Engagement and Communication	N/A

	Committee/Group Name:	Date Discussed:	Outcome:
Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Joint Kingston & Richmond Executive Management Team	25/02/2019	Risk Register and BAF reviewed
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	Att L1 Board Assurance Framework

1. Introduction

This report provides an overview of the risks, controls, assurances and actions currently identified on the Kingston Risk Register and Board Assurance Framework (BAF) as at 27 February 2019.

There is one very high risks identified for Kingston CCG:

- K7 - Failing to meet some of the national performance targets based on previous performance

The 2018/19 SWL internal audit took place in early December 2018 and its scope was to provide assurance on the maintenance of an effective risk management system and Board Assurance Framework for supporting the production of the Annual Governance Statement and to provide on-going assurance to the CCG governing body over the effectiveness of controls identified to mitigate principal risks that threaten the achievement of the CCG's strategic objectives.

An internal audit review by RSM internal audit report (Jan 2019) highlighted that in comparison to other GBAFs reviewed within the South West London CCG Alliance, other CCGs use a minimum score of 15 for extraction of risks from the risk register into the GBAF. Kingston and Richmond CCGs have to date been reporting a minimum risk score of 9. To improve comparability, it has been recommended by RSM to change the minimum risk score considered in the GBAF to 15.

2. Management and Scrutiny of Risk Registers

The current arrangement is that risk registers are reviewed by the following committees:

- Governing Body
- Audit Committee
- Joint Executive Management Team
- Primary Care Commissioning Committee
- Finance Committee
- Integrated Quality Governance Committee

3. Overview of risks

There are 27 risks identified on the risk register and of these, the residual risk is:

- 1 very high risks
- 16 high risks
- 8 moderate risks
- 2 low risk

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Kingston
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The table below provides a summary of all the risks.

Responsible Committee	Risk Ref	Risk Title	Executive Lead	Inherent Risk Priority	Residual Risk Priority	Direction since Sep 18	Target Risk Priority
1. Joint Executive Management Team	K15	Failure to deliver effective patient and public engagement	Vicki Harvey-Piper	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
	K14	Failure to deliver on the Equalities Duty	Vicki Harvey-Piper	I = 2 L = 2 Moderate (4)	I = 2 L = 2 Moderate (4)		I = 2 L = 2 Moderate (4)
	K8	Failure to develop leadership, capability and capacity could compromise the sustainability of the organisation	Tonia Michaelides	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
	K10	If the CCG fails to engage and develop staff this will impact on their motivation to deliver the business of the organisation	Vicki Harvey-Piper	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
	K18	Health and Safety: Failure to comply with Health and Safety legislation could lead to injury to individuals and substantial fines for the CCG	Vicki Harvey-Piper	I = 4 L = 3 High (12)	I = 3 L = 2 Moderate (6)		I = 3 L = 2 Moderate (6)
	K2	If information governance policies and procedures are not followed, then there is a risk that the CCG will lose its "trusted" status and business processes will be disrupted	Vicki Harvey-Piper	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
	K4	If the CCG is unable to demonstrate sufficient assurance of effectively embedded governance arrangements this may lead to a down grading in its assurance rating and possible loss of public confidence	Vicki Harvey-Piper	I = 3 L = 3 High (9)	I = 3 L = 2 Moderate (6)		I = 3 L = 2 Moderate (6)
	K24	Failure to deliver Health & Care Plan (HCP) to prioritise the local response to NHS Long Term Plan	Tonia Michaelides	I = 4 L = 3 High (12)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
2. Integrated Governance Committee	K11	Failure to deliver an effective Continuing Healthcare (CHC) service in line with national NHSE guidance.	Fergus Keegan	I = 3 L = 4 High (12)	I = 3 L = 2 Moderate (6)		I = 3 L = 2 Moderate (6)
	K9	Growth in demand for Continuing Care could jeopardise ability to meet statutory financial obligations	Fergus Keegan	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
	K31	Failure to agree the direction for the re-procurement of IAPT Services	Julia Travers	I = 4 L = 4 Very High (16)	I = 4 L = 3 12 - High (12)		I = 3 L = 3 09 - High (9)
	K20	Failure to deliver Winter plan	Fergus Keegan	I = 4 L = 3 12 - High (12)	I = 4 L = 3 12 - High (12)		I = 4 L = 3 12 - High (12)
	K19	Failure to produce and deliver the Kingston Local Health and Care Plan to deliver clinical and financial sustainability	Tonia Michaelides	I = 4 L = 4 Very High (16)	I = 3 L = 3 High (9)		I = 3 L = 3 High (9)
	K28	Failure to deliver the changes in primary care prescribing required to achieve financial balance	Fergus Keegan	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
	K39	If effective systems and procedures for Safeguarding Adults are not fully embedded then there is a risk that the safety of vulnerable adults is compromised	Fergus Keegan	I = 3 L = 2 Moderate (6)	I = 3 L = 2 Moderate (6)		I = 3 L = 1 Low (3)
	K3	If effective systems, procedures and adequate workforce for Safeguarding Children and Children Looked After are not fully embedded then there is a risk that the safety of vulnerable children and young people is compromised	Fergus Keegan	I = 3 L = 4 High (12)	I = 3 L = 2 Moderate (6)		I = 2 L = 1 Low (2)
	K5	If the CCG fails to recognise and act on early warning signs of failings in the quality and safety of its commissioned services it could result in special measures being imposed	Fergus Keegan	I = 3 L = 2 Moderate (6)	I = 3 L = 2 Moderate (6)		I = 3 L = 2 Moderate (6)
	K21	Inadequate oversight of Infection Prevention and Control	Fergus Keegan	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)

	K7	There is a risk of failing to meet some of the national performance targets, based on previous performance	Fergus Keegan	I = 4 L = 4 Very High (16)	I = 4 L = 4 Very High (16)		I = 4 L = 4 Very High (16)
Responsible Committee	**Risk Ref**	**Risk Title**	**Executive Lead**	**Inherent Risk Priority**	**Residual Risk Priority**	**Direction since Sep 18**	**Target Risk Priority**
3. Audit Committee	K6	If anti-fraud and anti-bribery policies are not embedded within the CCG there is a increased risk that fraud/bribery could occur leading to financial and reputational loss; financial penalties and possible criminal proceedings.	Neil Ferrelly	I = 3 L = 3 High (9)	I = 3 L = 1 Low (3)		I = 3 L = 1 Low (3)
4. Primary Care Commissioning Committee	K26	Delivery of the primary care transformation agenda as per the General Practice Five Year Forward View	Kathryn MacDermott	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 2 L = 2 Moderate (4)
	K27	IM&T strategy - GPIT; GP on line	Kathryn MacDermott	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 2 Moderate (6)
	K12	Ineffective commissioning of Primary Care Commissioning (medical services)	Kathryn MacDermott	I = 4 L = 2 High (8)	I = 2 L = 2 Moderate (4)		I = 2 L = 2 Low (4)
6. Finance Committee	K16	Potential overperformance in acute services could jeopardise ability to meet statutory financial obligations	Neil Ferrelly	I = 4 L = 4 Likely (16)	I = 1 L = 2 Unlikely (16)		I = 1 L = 1 Rare (4)
	K34	There is a risk of failure to meet statutory financial targets	Neil Ferrelly	I = 4 L = 3 High (12)	I = 4 L = 3 High (12)		I = 1 L = 2 Low (2)
	K23	Failure to deliver year on year QIPP targets	Tonia Michaelides	I = 5 L = 3 15 - Very High (15)	I = 5 L = 2 High (10)		I = 5 L = 2 High (10)
7. Delivery Group	K13	Kingston Co-ordinated Care: delays in the implementation of the new model of care (and misalignment of local Authority and CCG's Integration Objectives	Julia Travers	I = 3 L = 3 High (9)	I = 3 L = 3 High (9)		I = 3 L = 3 High (9)

4. New Risks

A new risk is in the process of being added based on the 15 risk factors in the risk assessment tool provided by the NHSE Regional EU Exit Team.

5. Deleted risks

No risks deleted.

6. Board Assurance Framework

The attached Board Assurance Framework (Att L1) report shows the controls in place for each risk with a residual priority rating of 8 or above (high) together with the assurance currently in place and outstanding actions to mitigate the risks.

The full risk register was presented to the Executive Management Team on 25 February 2019 and is available on request.

7. Summary

This report provides an overview of the assurances against the corporate risks.

Risk Matrix

Impact						
	5. Catastrophic	5	10	15	20	25
	4. Major	4	8	12	16	20
	3. Moderate	3	6	9	12	15
	2. Minor	2	4	6	8	10
	1. Negligible	1	2	3	4	5
		1. Rare	**2. Unlikely**	**3. Possible**	**4. Likely**	**5. Almost Certain**
		Likelihood				

Impact Details

Name	Description
1. Negligible	FINANCIAL Theft/loss up to £1000, Compliant unlikely Litigation risk remote, impact on service <£100 -- SERVICE DELIVERY/CORP OBJECTIVES Negligible Effects on service quality or corporate objectives -- SAFETY Negligible e.g. no obvious harm -- REPUTATION No Effects on reputation -- COMPLAINT/LITIGATION Negligible
2. Minor	FINANCIAL Litigation <£50k, Theft/loss between £1k-£5k, Financial impact on service £100-£5k -- SERVICE DELIVERY/CORP OBJECTIVES Service marginally impaired, Some impact on corporate objectives but recoverable -- SAFETY Minor injury or illness requiring minor intervention -- REPUTATION Temporary reputational damage-- COMPLAINT/LITIGATION Minor breach with no penalty
3. Moderate	FINANCIAL Litigation possible £50k-£500k Theft/loss between £5k-£25k, loss to service between £5k-£100k --SERVICE DELIVERY Service quality impaired, Achievement of corporate objectives delayed SAFETY Moderate injury requiring medical treatment and/or counselling REPUTATION Specific regional media coverage, Stakeholder expectations are not met. -- COMPLAINT/LITIGATION Legal action or regulatory penalty
4. Major	FINANCIAL Litigation £1M-£20M, Theft /loss £25k-£400k, impact to service £100k-£20M-- SERVICE DELIVERY/CORP OBJECTIVES Significant reduction in service quality, prioritisation of corporate objectives--SAFETY Major injuries / long term incapacity or disability (loss of limb) requiring treatment/counselling-- REPUTATION damage with Key Stakeholders, some national/widespread regional media coverage-- COMPLAINT/LITIGATION NHS London 'supervision' or legal case or overhaul of procedures, qualification of accounts
5. Catastrophic	FINANCIAL Litigation >£20 million, Theft loss over £500k, Financial impact to service>£25 million ----- SERVICE DELIVERY/CORP OBJECTIVES Complete failure of services. Unable to meet corporate objectives. ----- SAFETY Incident leading to death or major permanent incapacity An event which impacts on a large number of patients ----- REPUTATION Reputational Damage is irrecoverable, Extensive and sustained national media coverage ----- COMPLAINT/LITIGATION Termination of the PCT or criminal prosecution

Kingston CCG Board Assurance Framework

Report Date	27 Feb 2019

Kingston CCG Board Assurance Framework

18/19.1 Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do. / 3 High											
Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required

Kingston CCG Board Assurance Framework

18/19.1 Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 15	Failure to deliver effective patient and public engagement **Executive Lead:** Vicki Harvey-Piper **Delegated Risk Owner:** Caroline O'Neill **Last Updated:** 13 Jun 2018	Damage to organisational reputation due to failure to engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services. Inappropriate use of services due to lack of information and understanding about changes to services and buy in for public. Requirements for effective PPE overlooked within priority area programmes' project planning and delivery	I = 3 L = 3 9	Engagement and equality work plan in place to support priority programmes and respond to NHSE PPE assessment	Patient & Public Participation NHSE Assessment letter - July 2017. Patient & Public Participation - individual feedback - NHSE July 2017. Governing Body minutes Jan 2018				I = 3 L = 3 9	I = 3 L = 2 6	GB members understand their role in seeking assurance on evidence of engagement and impact on PPE in decision making. **Action Owner:** Caroline O'Neill **To be implemented by:** 29 Mar 2019
				Establish PPE forums	N/A						Develop Richmond primary care PPE framework into overarching PPE framework for the CCG **Action Owner:** Caroline O'Neill **To be implemented by:** 31 Mar 2019
				Local outreach engagement programme for seldom heard groups including SWL grassroots programme	N/A						Review PPE forums to ensure fit for purpose to reflect new ways of working. **Action Owner:** Caroline O'Neill **To be implemented by:** 31 Mar 2019
				PPE toolkit developed	N/A						Review compliance and ensure CCG able to positively respond to new patient participation indicator for IAF due in 2018/19. **Action Owner:** Caroline O'Neill **To be implemented by:** 31 Mar 2019
				Produce PPE framework for CCG	N/A						

Kingston CCG Board Assurance Framework

18/19.1 Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
											Develop process for regular review and triangulation of patient experience to inform PPE activities. **Action Owner:** Hannah Keates **To be implemented by:** 31 Mar 2019

Kingston CCG Board Assurance Framework

18/19.1 Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 13	Kingston Co-ordinated Care: delays in the implementation of the new model of care (and misalignment of local Authority and CCG's Integration Objectives **Executive Lead:** Julia Travers **Delegated Risk Owner:** **Last Updated:** 29 May 2018	CAUSE: 1) Misalignment of objectives and deliverables between partners - CCG and Local Authority (LA) and with providers 2) Lack of pace to deliver the model 3) Differential health and care financial drivers EFFECT: 1) Delays in the project delivery and delivery of savings targets 2) Unachievable integration objectives	I = 3 L = 3 9	Complex care LCS specification agreed and rolled out as part of KMS	N/A				I = 3 L = 3 9	I = 3 L = 3 9	KCC stocktake completed - set in context of wider strategic direction **Action Owner:** Julia Travers **To be implemented by:** 28 Feb 2019
				KCC (Kingston Co-ordinated Care) Programme Board to oversee delivery established in January 2019.	N/A			N/A			Reporting on delivery against QIPP requirement - monthly **Action Owner:** Julia Travers **To be implemented by:** 31 Mar 2019
				Kingston CCG Delivery Group (QIPP Delivery highlight report (bi-monthly))	N/A						Joint development between commissioners and providers to agree scope and breadth to move the " alliance contractual approach" for delivery of KCC for 2019 **Action Owner:** Julia Travers **To be implemented by:** 31 Mar 2019
				Kingston Commissioning Board to meet quarterly	N/A						
				Memorandum of Understanding (MOU), implementation plan and performance/outcomes framework between commissioners and providers	N/A						
				Programme Delivery Group - Commissioners and Providers monthly review of progress against Implementation Plan	N/A						

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 3 High

Kingston CCG Board Assurance Framework

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 3 High											
Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required

Kingston CCG Board Assurance Framework

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 21	Inadequate oversight of Infection Prevention and Control **Executive Lead:** Fergus Keegan **Delegated Risk Owner:** Laura Jackson **Last Updated:** 29 May 2018	Cause: Inadequate oversight of Infection Prevention and Control Effect: Failure to minimise risk of infections; failure to achieve quality premium for 2017/18	I = 3 L = 3 9	Care Homes: Any Qualified Provider (AQP) members are required to provide monthly data on a range of patient safety matters including HCAI Impact Team (YHC) provide support to some care homes.	Monthly data reports (sent and to and reviewed by KCCG Quality Manager)			Not all homes are AQP and reports are very high level.	I = 3 L = 3 9	I = 3 L = 2 6	SWL Alliance DOQs developing a business case to introduce an alliance level infection control team. **Action Owner:** Fergus Keegan **To be implemented by:** 31 Mar 2019
				CQC inspections of Care Homes include IPC. Joint Quality Review Group for Nursing Homes attended by Adult Safeguarding Lead.	CQC reports (monitored by Quality Manager) Minutes and reports to Joint Quality Review Group for Nursing Homes			Lack of contractual levers to affect improvements in care and IPC			Select AQP homes as default wherever feasible - provide information within IGC sub-group report (Residential and Nursing Homes) to identify proportion of CHC clients in AQP homes. **Action Owner:** Peter Warburton **To be implemented by:** 30 Sep 2019
				CSU contracted to provide infection control function.	Quarterly report provided by the CSU. Contract with the CSU			Lack of capacity as x1WTE Infection and Prevention Control Nurse covers 13 CCGs			
				CSU IPC Nurse attends Kingston Hospital's monthly IPC meeting.	Quality Manager in receipt of IPC meeting minutes.						

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
				Monthly Clinical Quality Review Group (attended by CCG's Director of Quality and Quality Manager) receives Kingston Hospital IPC report.	IPC report and minutes of CQRG meetings.			Kingston Hospital Foundation Trust currently has vacancy for Director of Nursing and Director of Infection Prevention and Control (DIPC)			
				Primary Care Quality and Development Group in place.	Minutes of PCQDG			Lack of assurance around priority of infection control on the PCQDG. Terms of Reference cover clinical quality but not IPC specifically.			
				Your Healthcare provides oversight of IPC through the Quarterly CQRG and employs a dedicated IPC Nurse.	Attendance at CQRG and minutes of meetings.			Lack of assurance around board level clinical leadership.			

Kingston CCG Board Assurance Framework

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 20	Failure to deliver Winter plan **Executive Lead:** Fergus Keegan **Delegated Risk Owner:** Fergus Keegan **Last Updated:** 10 Jan 2019	Failure to deliver system level change for unscheduled care with resulting unacceptable patient experience and waiting times. Lack of robust surge and escalation responses from all partners in the Kingston, Richmond and Surrey Downs system could result in patient safety concerns during periods of extreme pressure.	I = 4 L = 3 12	Demand and capacity modelled through to March 2019 to plan for surges in non-elective activity and maintenance of elective treatment programme.	N/A				I = 4 L = 3 12	I = 4 L = 3 12	Flu planning and communications strategy to be developed in line with national timeframes for winter 18/19. **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 31 Mar 2019
				Development of the UTC at Teddington Memorial Hospital to support emergency and urgent care. Plan to open July 2018.	N/A						Review effectiveness of Winter Plan **Action Owner:** Fergus Keegan **To be implemented by:** 31 Mar 2019
				Embedding the processes and procedures relating to the Urgent Treatment Centre at Kingston Hospital to support urgent and emergency care.	N/A						
				Flu planning and Communications Plans to be revisited and developed in line with national recommendations for winter 2019.	N/A						
				Links to Better Care Fund (BCF), Kingston Coordinated Care (KCC), and Richmond Outcomes Based Commissioning (OBC).	N/A						

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
				Monthly A&E Delivery Board oversight of Winter Plan and engagement of system level leaders.	N/A						
				System level Surge and Escalation Plan agreed with local partners and supported through the CSU Surge Hub on a daily basis.	N/A						
				Winter check list to be reviewed by all partners and RAG rated prior to submission to NHSE for further assurance. Identification of new areas of focus to be developed at A&E DB.	N/A						
				Workforce planning to cover key periods of Christmas and New Year undertaken by all Kingston and Richmond partners completed and reviewed by NHSE.	N/A						

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 16 - Very High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required

Kingston CCG Board Assurance Framework

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 16 - Very High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 7	There is a risk of failing to meet some of the national performance targets, based on previous performance **Executive Lead:** Fergus Keegan **Delegated Risk Owner:** Brian Roberts **Last Updated:** 29 May 2018	Performance against some provider indicators suggests that these may not be met in 2018/19 (Dementia prevalence/IAPT/ A&E, DTOCs)	I = 4 L = 4 16	CCG Monitoring framework	Performance reports to IGC (including Improvement & Assessment Framework IAF scorecard)				I = 4 L = 4 16	I = 4 L = 4 16	Board Assurance Framework will be prepared and presented quarterly to SMT **Action Owner:** Brian Roberts **To be implemented by:** 31 Mar 2019
				Clinical Quality Review Groups (CQRGs) and other contract meetings for all main providers where KPIs are reviewed and any actions agreed	CQRG ToR (KHFT, SWL&StGMHT, YHC) CQRG minutes Contract and performance meeting minutes Action plans for failing KPIs						Maintain monthly monitoring of Dementia prevalence rates and deep dive into dementia by Kingston Governing Body **Action Owner:** Brian Roberts **To be implemented by:** 31 Mar 2019
				Dementia Nurse in place, and regular meetings with dementia leads, the MAS and the clinical leads in place. Action plan reviewed at the IQGC regularly.	N/A						Regular CQRG for all main providers will monitor KPIs and take remedial action when required. **Action Owner:** Fergus Keegan **To be implemented by:** 31 Mar 2019
				IQGC performance reports to Governing Body	Integrated Governance reports						IGC/ QSP will monitor performance monthly and request recovery plans for performance targets when required. **Action Owner:** Brian Roberts **To be implemented by:** 31 Mar 2019
				Monthly meeting for Directors of Performance supporting SWL Alliance approach to managing performance	N/A						

18/19.2 Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care. / 16 - Very High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
				Monthly Performance monitoring by IQG Committee	Integrated Governance Exception Report; Action Plans for under-performing targets to IGC;						Key risks for achievement of national performance target are A&E and dementia. Recovery plans will be developed and monitored as particular areas of focus. **Action Owner:** Fergus Keegan **To be implemented by:** 31 Mar 2019
				Partnership working with Local Authority and Community partners to reduce DTOCs and to the required thresholds.	N/A						
				SWL Performance reporting and benchmarking data.	N/A						
				Urgent care performance monitored through A&E Delivery Board improvement plan is in place.	A&E Delivery Board reports A&E recovery plan						

Kingston CCG Board Assurance Framework

18/19.3 Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 27	IM&T strategy - GPIT; GP on line **Executive Lead:** Kathryn MacDermott **Delegated Risk Owner:** **Last Updated:** 02 Jan 2019	Cause: Primary Care digital currently held at SWL PMO Cause: SWL procurement on 111/OOH digital currently paused Cause: Practices are reluctant/don't have capability to engage with IT developments. Cause: Inconsistent approach to e-consultations across practices / SWL. Cause: Poor communications to practices and patients on IT developments. Effect: Poor engagement with local practices hampering roll out Effect: Delay in the offer of one digital solution for patient advice OOH Effect: Poor support will hamper roll out. Effect: Inconsistent approaches may be confusing to patients.	I = 3 L = 3 9	IM&T manager supports practices to address problems and manages contract with Your Healthcare Practice engagement programme	GPIT issues are reported to the primary care commissioning committee Progress monitored by IM&T steering group				I = 3 L = 3 9	I = 3 L = 2 6	Implementation plan for GPIT developments in place. **Action Owner:** Kathryn MacDermott **To be implemented by:** 29 Mar 2019
				Reports to I&IT Steering Group	N/A						

Kingston CCG Board Assurance Framework

18/19.3 Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 31	Failure to agree the direction for the reprocurement of IAPT Services **Executive Lead:** Julia Travers **Delegated Risk Owner:** Amanda McGlennon **Last Updated:** 29 May 2018	Cause: The existing IAPT contract expires in March 2018 and therefore will need to be extended to cover the procurement period to mitigate for gaps in the service. Effect: Delay in procuring a new contract. The existing provider may seek to re-negotiate current terms Lead to a reduction in performance/delivery of key targets.	I = 4 L = 4 16	Discussed and a way forward agreed at the November meeting of the Governing Body Part 2	N/A				I = 4 L = 3 12	I = 3 L = 3 9	Agree strategic intent and explore future options for delivery of service. **Action Owner:** Julia Travers **To be implemented by:** 29 Mar 2019
				Finance Committee approval to extension of existing IAPT contract for 2019/20 to support reprocurement							
				Regular performance review meetings with the provider	N/A						

Kingston CCG Board Assurance Framework

18/19.3 Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 19	Failure to produce and deliver the Kingston Local Health and Care Plan to deliver clinical and financial sustainability **Executive Lead:** Tonia Michaelides **Delegated Risk Owner:** Julia Travers **Last Updated:** 21 Feb 2019	1) Failure to address financial;, health and wellbeing; care and quality challenges identified in the Kingston system. 2) Failure to have a robust and credible LHCP in place. 3) Misalignment between health and local authority objectives 4) Insufficient capacity and resource to deliver 5) Incorrect governance arrangements in place	I = 4 L = 4 16	Development of LHCP overseen by GB and HWB					I = 3 L = 3 9	I = 3 L = 3 9	Phase 3 & 4: Agreeing the joint vision and model of care for Kingston and the actions to deliver these **Action Owner:** Julia Travers **To be implemented by:** 28 Feb 2019
				Health & Wellbeing Board in place. Will be the sign-off board for the LHCP	N/A						Produce Joint LHCP for Kingston **Action Owner:** Julia Travers **To be implemented by:** 29 Mar 2019
				Kingston Provider Alliance in place	N/A						To publish the Kingston LHCP (discussion document). **Action Owner:** Julia Travers **To be implemented by:** 29 Mar 2019
				Local Transformation Board in place	N/A						Phase 5: Stakeholder review of draft plan **Action Owner:** Julia Travers **To be implemented by:** 31 May 2019
				Reports to GB	N/A						
				SWL Alliance providing strategic oversight of development of Local Health & Care Plan	N/A						

18/19.4 Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership and effective membership and staff engagement. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required

Kingston CCG Board Assurance Framework

18/19.4 Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership and effective membership and staff engagement. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 2	If information governance policies and procedures are not followed then there is a risk that the CCG will lose its "trusted" status and business processes will be disrupted **Executive Lead:** Vicki Harvey-Piper **Delegated Risk Owner:** **Last Updated:** 06 Nov 2018	CAUSE: 1) Complexity of information governance legislation and guidance. New General Data Protection Regulation came into effect May 2018 2) Kingston CCG and Richmond CCG have separate IG arrangements although staff in LDU work across both organisations 3) Lack of clarity around working arrangements with Richmond (CSU) IG team 4) Loss of key staff in IG roles in Kingston EFFECT 1) Loss of "trusted" status 2) Increased risk of breaches and disrupted business processes 3) Failure to meet legal requirements of GDPR 4) Breach of confidentiality, Loss of public confidence and	I = 3 L = 3 9	Cyber Security Audit report (May 2018)	RSM Cyber Security Report			Whilst it appears that good IT functions with regard to firewall security are 'business as usual', it would be advantageous to make this a documented policy	I = 3 L = 3 9	I = 3 L = 2 6	Agree policy review work plan to cover both Richmond and Kingston CCG **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 29 Mar 2019
				IG Framework in place	IG Framework documentation - as reviewed & approved Sept 2017			Existing IG Framework needs to be refreshed to reflect joint working arrangements with Richmond CCG			Ensure Wandsworth CCG creates / adapts a corporate firewall policy **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 29 Mar 2019
				Independent Audit of Information Governance Toolkit self-assessment (RSM) February 2018	Audit report (Baker Tilly) March 2016						Submit Data Security and Protection Toolkit for 2018/19 **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 31 Mar 2019
				Joint Information Governance Steering Group (IGSG) with Richmond CCG	Minutes of Joint Information Governance Steering Group			No terms of reference for joint IGSG			
				KCCG is on the Stage 1 Accredited Safe Haven (ASH) register	HSCIC						
				Mandatory IG Training	-Papers & minutes of Information Governance Steering Group -Training analysis reports						
				Published Information Governance Toolkit (IGT) v.14.1 - March 2018	Published IGT (March 2018) on website						

18/19.4 Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership and effective membership and staff engagement. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
		fines 5) Joint working projects jeopardised		Records Management Policy and Strategy in place	Records management policy			Records Management Policy applies to Kingston CCG only - need new joint policy and strategy			

18/19.4 Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership and effective membership and staff engagement. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 8	Failure to develop leadership, capability and capacity could compromise the sustainability of the organisation **Executive Lead:** Tonia Michaelides **Delegated Risk Owner:** Vicki Harvey-Piper **Last Updated:** 22 Feb 2019	Lack of Organisational Development and succession planning means that the quality of future leadership and management of the CCG is compromised	I = 3 L = 3 9	Appraisal System	N/A				I = 3 L = 3 9	I = 3 L = 2 6	Review Clinical Leadership roles across LDU **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 29 Mar 2019
				Comprehensive training programme to enhance the skills and ability of the workforce to take on leadership roles	Comprehensive training programme to enhance the skills and ability of the workforce to take on leadership roles						L&D programme to be developed and shared across the LDU **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 31 Mar 2019
				Future Leaders - Clinical Learning Set	CCG Future Leaders programme for clinicians (launched in July 2015)			Future Generation Learning Set needs to be revitalised			Implement Organisational Development plan for LDU **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 31 Mar 2019
				Leadership review - recent appointments to bring new staff into the organisation either in leadership roles or who have the potential to take on these roles in the future	Leadership review - recent appointments to bring new staff into the organisation either in leadership roles or who have the potential to take to take on these roles in the future						Align HR Kingston CCG and Richmond CCG processes **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 31 Mar 2019
				Organisational Development Plan in place	Uptake of leadership training						

18/19.4 Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership and effective membership and staff engagement. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
				Quarterly development sessions for Senior Management Team (SMT)							
				Regular Joint Governing Body Seminars held. These include the Governing Body members of both Kingston and Richmond CCGs and the Senior Management Team.							
				SMT Weekly Meetings with MD to manage priorities Development sessions							
				Staff Survey & Action plan	Staff Survey results						
				Twice Yearly Kingston and Richmond Time out sessions.							

Kingston CCG Board Assurance Framework

18/19.4 Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership and effective membership and staff engagement. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 10	If the CCG fails to engage and develop staff this will impact on their motivation to deliver the business of the organisation **Executive Lead:** Vicki Harvey-Piper **Delegated Risk Owner:** Vicki Harvey-Piper **Last Updated:** 29 May 2018	Cause: Organisational change (recent & planned); Effect: Lack of/inconsistency in line management capability Effect: Instability caused by changes to the SWL system especially joining with RCCG as a local delivery unit Effect: Uncertainty surrounding re-location to new office space	I = 3 L = 3 9	Action on findings of Staff Surveys	Staff Survey results – feedback presentation to Staff Meeting				I = 3 L = 3 9	I = 3 L = 2 6	Maintain regular WOW meetings and implement the work plan. **Action Owner:** Vicki Harvey-Piper **To be implemented by:** 31 Mar 2019
				Appraisal system in place	Appraisal system documentation and training records Staff survey results						
				Governing Body and Team Away Days	Governing Body Away Day documentation						
				HR Policies in place	Policy documents			Some HR policies expired at the end of July 2017.			
				London Healthy Workplace Charter Commited Organisation	London Healthy Workplace Charter website						
				Mandatory and Developmental Training Programme	Training and development records; CSU Training Programme						
				Monthly Staff meetings chaired by Managing Director	Staff meeting agendas						
				Staff newsletter	Staff newsletters						

Kingston CCG Board Assurance Framework

18/19.4 Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership and effective membership and staff engagement. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
				Ways of Working (WOW) Group in place covering Richmond and Kingston CCGs with work plans in place.	WOW Action Plan 1 and 2 in place. ToR and meeting minutes - also reports to EMT						

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required

Kingston CCG Board Assurance Framework

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 24	Failure to deliver the borough Health & Care Plan (HCP) prioritise the local response to NHS Long Term Plan **Executive Lead:** Tonia Michaelides **Delegated Risk Owner:** Julia Travers **Last Updated:** 06 Feb 2019	Cause: 1) HCP not published within agreed timescales 2) Insufficient capacity to deliver HCP identified priorities 3) Insufficient system leadership in place to deliver HCP. Effect: Failure to address financial, health & wellbeing; care and quality challenges identified in the SWL Health & Care Partnership.	I = 4 L = 3 12	Borough based system leadership group in place.	N/A				I = 3 L = 3 9	I = 3 L = 2 6	Development of HCP implementation plan. **Action Owner:** Tonia Michaelides **To be implemented by:** 29 Mar 2019
				HCP discussion document published in March 2018.							Put Local Health and Care Plan in place with deliverables **Action Owner:** Tonia Michaelides **To be implemented by:** 31 Mar 2019
				Local and STP wide governance identified and implemented.	N/A						Local governance structures in place - to be reviewed again by to support local delivery of STP priorities. **Action Owner:** Tonia Michaelides **To be implemented by:** 31 Mar 2019
				Local delivery plan under development with local leads identified	N/A						Establishment of system within PMO **Action Owner:** Tonia Michaelides **To be implemented by:** 31 Mar 2019
				Local governance in place - CCG's Governing Body and the Health & Wellbeing Board	N/A						
				SWL STP programme management office (PMO) funded by 6 CCGs	N/A						

Kingston CCG Board Assurance Framework

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
											Put in place detailed implementation plan for all sustainability priorities **Action Owner:** Tonia Michaelides **To be implemented by:** 31 Mar 2019

Kingston CCG Board Assurance Framework

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 34	There is a risk of failure to meet statutory financial targets **Executive Lead:** Yarlini Roberts **Delegated Risk Owner:** Adrianna Wicinska **Last Updated:** 12 Feb 2019	Unplanned increase in acute activity, continuing healthcare and / or prescribing. Failure to achieve value for money in commissioning of services. Failure to achieve planned QIPP savings target.	I = 4 L = 3 12	Continue joint working with providers to deliver transformation and deliver savings across the SWL system.					I = 4 L = 3 12	I = 1 L = 2 2	Monthly activity, finance and detailed highlight reports for all QIPP schemes to be reviewed by the Delivery Group, Finance Committee and Governing Body. **Action Owner:** Yarlini Roberts **To be implemented by:** 31 Mar 2019
				Full QIPP for 18/19 identified	N/A						
				Robust monthly monitoring of acute activity performance against plans.	Day 5 Report from CSU which is followed up a day 5 meeting; This report forms the basis of the acute monthly position in the Finance Report which is then reported up to the Finance Committee & the Board						Monthly reporting of performance against acute, continuing care and prescribing budgets to relevant committees - ongoing throughout year **Action Owner:** Yarlini Roberts **To be implemented by:** 31 Mar 2019
				SWL SMT monthly review of acute activity	N/A						
				Use of reserves to mitigate over performance.	N/A						

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 28	Failure to deliver the changes in primary care prescribing required to achieve financial balance **Executive Lead:** Fergus Keegan **Delegated Risk Owner:** Lara Belling **Last Updated:** 30 May 2018	The allocated funding for primary care prescribing may not keep pace with the growth in costs and demand leading to a cost pressure.	I = 3 L = 3 9	Implementation of the Governing Body's recommendations for Choosing Wisely.	GB minutes etc; communication strategy with primary care regarding prescribing.			Individual prescribing practice can not be directed by the CCG and therefore the Governing Body recommendations may not be implemented. The DH has published the response to the Gluten Free foods consultation in January 18 with the preferred option being to retain a limited range of bread and mix products on prescription. The following GF foods will no longer be available for prescribing; biscuits, cereals, cooking aids, grains/flours and pasta. The local Governing Body do not recommend prescribing of all Gluten Free foods; this decision will remain in place until further discussions across SWL.	I = 3 L = 3 9	I = 3 L = 2 6	Work in partnership with SW London Pharmacy PMO to ensure consistency in practice across SW London. **Action Owner:** Lara Belling **To be implemented by:** 31 Mar 2019 Continue to monitor monthly financial performance and report through the Integrated Governance Committee & Delivery Group structure. **Action Owner:** Lara Belling **To be implemented by:** 31 Mar 2019

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
				Medicines Optimisation Team to support best practice and cost effective prescribing	Annual Practice Visit and follow up meetings between Prescribing Lead and Practice Pharmacist			Implementation of CCG recommendations may be influenced by Local Medicines Committee			
				Partnership work across SW London between CCG Medicines Optimisation teams to ensure consistency of approach between localities.	SW London Medicines Optimisation Collaborative Workstreams			Not all partners in SW London achieving consensus in Gluten Free and OTC work. Workload and prioritisation will impact on delivery and implementation of the different SWL workstreams. Compliance of CCG recommendations may be influenced by Local Medicines Committee			
				Regular monitoring of financial performance and reporting to the appropriate committee.	Monitoring impact and updates, participating in networks to get early warning of likely impact, prioritising practices forecasting overspend / not engaged in meds programmes / MOIS 2018-19			Lead time to financial reports is 2 - 3 months. Cat M prices increases from August 2018 & NCSO prices are not within local control and duration unknown.			

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
				The CCG has allocated growth in budget for primary care prescribing following a detailed review and forecasting exercise.	The detailed financial records supporting the budget setting.			Unexpected or unavoidable growth in costs over and above plan.			
K 26	Delivery of the primary care transformation agenda as per the General Practice Five Year Forward View **Executive Lead:** Kathryn MacDermott **Delegated Risk Owner:** Omid Gilanshah **Last Updated:** 29 May 2018	Cause: Insufficient investment to deliver the GPFV priorities. Cause: Delays in national guidance. Cause: Delays in London procurement for technology solutions. Cause: Difficulties in recruiting appropriate workforce. Cause: Engagement of practices with the 10 high impact actions. Effect: Poor patient experience, unsustainability and increasing demand, unmet needs, recruitment and retention and variation in service quality	I = 3 L = 3 9	Delivery of the GPFV priorities considered at the London wide GPFV Oversight Delivery Group	N/A				I = 3 L = 3 9	I = 2 L = 2 4	High level reports provided to Healthy London Partnership and NHSEL **Action Owner:** Kathryn MacDermott **To be implemented by:** 01 Mar 2019
				Delivery of the GPFV priorities reported to KCCG Primary Care Quality & Development Group, PCCC and SWL Transforming Primary Care Delivery Group.	Regular reporting to the Primary Care Co-Commissioning Committee						SWL led e-consultation strategy and pilot place. SWL procurement completed. Phase 1 of the e-consult pilot commenced. **Action Owner:** Kathryn MacDermott **To be implemented by:** 29 Mar 2019
				High level reports provided to Healthy London Partnership and NHSEL	N/A						

Kingston CCG Board Assurance Framework

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 3 High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 9	Growth in demand for Continuing Care could jeopardise ability to meet statutory financial obligations **Executive Lead:** Fergus Keegan **Delegated Risk Owner:** Laura Jackson **Last Updated:** 02 Jul 2018	Cause: - Growth in demand above the planned levels Effect: - Overperformance in continuing care leads to failure to meet statutory financial requirements	I = 3 L = 3 9	A reserve is held to allow for the potential increases of growth in demand.	Reserve is identified in finance report to finance committee and Governing Body				I = 3 L = 3 9	I = 3 L = 2 6	Financial monitoring of QIPP for CHC to include development of project initiation document and reporting to Delivery Group. **Action Owner:** Laura Jackson **To be implemented by:** 31 Mar 2019
				Continue to develop and work in partnership the adult social care relationship for CHC patients.	N/A						Weekly financial governance of CHC cases through clinical reviews and cost effective care packages **Action Owner:** Laura Jackson **To be implemented by:** 31 Mar 2019
				Escalation process is in place for CHC governance	email trail and excel spreadsheet held by finance officer (not uploaded as contains PID)						Work in partnership with SWL CHC teams to further develop arrangements for common ways of working in CHC (brokerage, policies and procedures). **Action Owner:** Laura Jackson **To be implemented by:** 31 Mar 2019
				Monthly monitoring of expenditure and modelling of growth trends by finance and information	Monthly reports to finance committee and minutes.						Personal Health Budgets monitoring to include offer of PHB to CHC clients where appropriate. **Action Owner:** Laura Jackson **To be implemented by:** 31 Mar 2019
				Monthly reporting to finance committee	Finance reports						

Kingston CCG Board Assurance Framework

18/19.5 Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation. / 10 - High

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Gaps in Contols or Assurance	Residual Risk Priority	Target Risk Priority	Action Required
K 23	Failure to deliver year on year QIPP targets **Executive Lead:** Tonia Michaelides **Delegated Risk Owner:** Yarlini Roberts **Last Updated:** 11 Jul 2018	Cause: 1) Lack of resource to implement programmes 2) Buy-in from key providers to implement schemes 3) Failure to meet financial plans Effect: 1) Reputational damage 2) Conditions may be placed on the CCG	I = 5 L = 3 15	QIPP progress reviewed at Finance Committee and Delivery Group. Status of Red and Amber schemes reviewed monthly.	A monthly QIPP report is available and minutes of the meetings.			Reported capacity issue requires investigation	I = 5 L = 2 10	I = 5 L = 2 10	Focus on End of Life Care (EoLC)/Musculoskeletal (MSK) pathways to deliver QIPP savings **Action Owner:** Sue Lear **To be implemented by:** 31 Mar 2019
				SWL joint QIPP schemes and Alliance system wide approach.	N/A						Joint programmes now being developed with RCCG **Action Owner:** Tonia Michaelides **To be implemented by:** 31 Mar 2019
											Outpatient redesign transformation projects **Action Owner:** Sue Lear **To be implemented by:** 31 Mar 2019
											One-off transactional savings to be identified to cover savings required for 18/19 control total **Action Owner:** Yarlini Roberts **To be implemented by:** 31 Mar 2019
											Maintain meetings with providers to agree QIPP to include in contracts **Action Owner:** Yarlini Roberts **To be implemented by:** 31 Mar 2019

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body meeting in public	
Date	Tuesday, 05 March 2019

Document Title	Minutes of the Finance Committee meeting held on 18 December 2019		
Lead Director (Name and Role)	Yarlini Roberts, Local Director of Finance		
Clinical Sponsor (Name and Role)	David Knowles, Finance Committee chair and Lay Member		
Author(s) (Name and Role)	Yarlini Roberts, Local Director of Finance		
Agenda Item No.	4.1	**Attachment No.**	M1

Purpose (Tick as Required)	Approve	Discuss	Note
			✓

MINUTES OF THE FINANCE COMMITTEE
HELD ON TUESDAY 18th DECEMBER 2018
CEDAR&WILLOW MEETING ROOMS, THAMES HOUSE, TEDDINGTON

PRESENT:	Bob Armitage	Lay Member & Chair (Chair)
	David Knowles	Lay Member & Chair (Chair)
	Naz Jivani	Governing Body Chair
	Phil Moore	Governing Body GP
	Annette Pautz	Governing Body GP
	Jim Smyllie	Lay Member
	Tonia Michaelides	Managing Director, K&R LDU
	James Murray	Chief Finance Officer, SWL Alliance
	Yarlini Roberts	Director of Finance, K&R LDU
	Fergus Keegan	Director of Quality
	Kathryn MacDermott	Director of Primary Care & Planning
	David Stout	Interim Director of Transformation
	Julia Travers	Director of Commissioning
IN ATTENDANCE:	Liam Bayly	Head of Finance
	Jenny Sinnott	Head of Finance
	Sarah McInnes	Head of PMO
	Brian Roberts	Performance and Information Lead
	Evelyne Schotte	PMO Manager
	Andy Wilson	NEL CSU
	Doreen Redwood	Lead Children's Health Commissioner

	Adrianna Wicinska	Finance Support Officer– Minutes
APOLOGIES:	Kate Moore	Governing Body GP
	Sue Lear	Deputy Director of Commissioning
	Branko Momic	Governing Body GP
	Graham Lewis	Governing Body Chair
	Paul Gallagher	Lay Member

18/112 WELCOME AND APOLOGIES

David Knowles welcomed those in attendance to the Finance Committee. The meeting remained quorate throughout only for Kingston CCG related issues, therefore Richmond related reports were for discussion and noting only.

18/113 DECLARATIONS OF INTEREST

There were no new declarations.

18/114 MINUTES OF THE LAST FINANCE COMMITTEE MEETING

Minutes of the last meeting held on Tuesday, 27th November 2018 were agreed as an accurate record.

18/115 ACTION LOGS AND MATTERS ARISING

Action Logs were reviewed and updated.

KINGSTON CCG AGENDA

18/116 KCCG FINANCE REPORT – MONTH 8

A copy of the Month 8 Finance Report was circulated prior to the meeting for information.
Jenny Sinnott presented the key messages from Month 8 Finance Report as follows:

- The CCG expects to meet its planned in year 0.4% surplus of £1,060k
- Some reserves and non-recurrent benefits have been utilised to enable the delivery of the planned in year surplus.
- Cash and Better Payment Practice Code (BPPC) targets were met in month 8.
- The CCG expects to fully achieve the planned target savings of £9.8m, despite under-achievement on some transformational schemes.
- NHS England are yet to release planning guidance, however a high-level overview had been received and copies were circulated prior to the meeting.

Contract Alignment
Members were advised the Contract alignment template was due later that week and the CCG have started negotiations to agree a year-end deal with Kingston Hospital. In addition, members noted a year end deal has been agreed for Epsom St Helier contract.

Acute Commissioning
Kingston Hospital is forecast to overspend by £2.5m YTD. This is predominantly driven by the overspends in Emergency, Elective and Outpatient Procedures.

Non-Acute Commissioning

Mental Health
Mental Health Placements are forecast to overspend by £251k. Members discussed further risks around Joint Funded placements with RBK and pressures at SW London St George's Mental Health Trust and associated risks.

Continuing HealthCare
Overall Continuing Healthcare position has improved in month 8 by £450k, forecast to underspend by £146k.

Primary Care
There have been continued improvements in the underspends in relation to Prescribing. The Prescribing position shows an underspend of £900k and includes savings from Category M.

The Month 8 Finance Report was NOTED.

18/117 DESIGNATED CLINICAL OFFICER – Business Case

A copy of the Business Case was circulated prior to the meeting and members noted that whilst Designated Clinical Officer (DCO) and Designated Medical Officer (DMO) posts are not statutory, there is an expectation that the CCGs have these roles in place to support delivery of the requirements as per SEND inspection recommendation.

Members noted there is a DMO post in Kingston and approval was sought to increase the number of weekly sessions provided to two which would cost Kingston CCG £10k.

The DCO post is needed to increase capacity as well as provide support to the DMO thus enabling both CCGs to have the capacity to do work required as specified by SEND inspection as well as provide support to the DMO to ensure quality services are provided to this group of children and young people. Members noted an investment of £65k across both CCGs is required.

Clarification was sought in relation to accountability for these two posts and Doreen Redwood confirmed the DMO is accountable within provider organisation and the DCO will likely sit within Fergus Keegan's team ensuring regular reports to IGC and QSP.

Based on the information available the business case was APPROVED, subject to Virtual approval from Richmond GPs.

18/118 KMS UPDATE

A copy of the pack was circulated prior to the meeting for information and members were reminded that following the PMS review Kingston CCG has committed to equalising up GMS practices and there was a recognition that this would lead to additional primary care investment of circa £2m. The CCG had identified both recurrent and non-recurrent funding streams to support 2018/19 but recognised that recurrent funding for future years needed to be identified thus signalling the cost pressure of circa £700k for 2019/20 and £870k for 2020/21.

There was also recognition that some specifications were not robust enough to support transformational schemes and there was a need to ensure they align to complex health and care needs schemes and are used as an investment to deliver the desired system change.

Paper outlined the proposal of the KMS Schemes & Prices for 2019/20 and next steps required, including the setting up the KMS Resurrection Group, implementing the Finance Committee recommendations and aligning all commissioning and primary care cohorts to avoid duplications and have appropriate target levels and monitor against them.

Members felt the whole system change cannot be achieved by Primary Care only and engagement is required with all providers to achieve the desired outcome. Further discussions will be held in the KMS Resurrection Group.

Based on the information available, the committee have NOTED the KMS Update, recognising the degree of urgency and susceptibility to change and external influences.

COMMON AGENDA

18/119 ACUTE UPDATE

West Middlesex

Members noted a verbal agreement for the first six months to be paid as per the agreed block and block agreement at plan value for outpatients only for the second part of the year was reached.

Kingston Hospital

Negotiations started to finalise a year-end deal with Kingston Hospital hoping to close before Christmas. Members noted that Ophthalmology is significantly over plan, which is mainly attributable to the wet Age-related Macular Degeneration (AMD).

18/120 QIPP REPORT

The QIPP report for Kingston and Richmond CCGs was presented to the committee and members noted that due to being unable to fully bridge the QIPP shortfall Richmond CCG has moved to a deficit financial forecast position of £3.9m. In addition, members noted that whilst Richmond CCG has failed to deliver against unidentified QIPP they have had strong performance on the identified plan, particularly in CHC and Medicines Management.

2019/20 QIPP

Members noted that work in underway to develop PODs for 2019/20 schemes. Concerns were raised around the level of the identified QIPP being insufficient to meet the requirement.

The QIPP Report was NOTED.

18/121 RISK REGISTER & BOARD ASSURANCE FRAMEWORK

Copies of Risk Registers and Board Assurance Framework for Richmond and Kingston CCGs were circulated prior to the meeting.

18/122 SYSTEM FINANCES

Yarlini Roberts gave a brief update on the progress of the Wider System Finance open approach for the management of financial risk across the system. Members noted the meeting took place in early December where principles have been agreed and committed to a joint CIP-QIPP forum. Opportunity within the Estates element was identified and it was agreed to set up Local Estates Finance Meeting including Local Authority thus aligning to the priorities of the Leadership Meeting.

18/123 2019/20 CAMHS TRANSFORMATION FUNDING PROGRAMMES

Paper outlined proposed budgets for 2019/20 CAMHS transformation funding programmes for Kingston and Richmond CCGs and members noted the funding increase is required for Richmond CCG across two financial years.

Yarlini Roberts felt a wider piece of work is required and Liam Bayly and Chris Varney were tasked to work with commissioning team to see what other investments Mental Health have or plan to commit and have a prioritisation conversation before making a decision.

Members ACCEPTED the recommendation and agreed to have further discussions outside of that meeting.

18/124 2019/20 PLANNING

Members discussed a recently published document in relation to the first planning submission in January covering activity. Full planning guidance including allocations is yet to be issued but is hoped to be released before Christmas.

RICHMOND CCG AGENDA

18/125 RCCG FINANCE REPORT – MONTH 8

A copy of the RCCG M8 Finance Report was circulated prior to the meeting for information and members noted that after discussions with NHS England and SW London, Richmond CCG is forecasting a year-end deficit of £3.9m against plan.

Due to the movement in the position the risks of unidentified QIPP have been removed from the position. The CCG expects to cover the remaining risks with the mitigations available. Discussions followed around the £1.25m in relation to Chelsea and Westminster transaction payment and the required mediation to resolve this matter resulting in the risk adjusted deficit position of £5.1m.

The Finance Committee NOTED the Month 8 Finance Report.

18/126 TENDER WAIVERS
None Received.

18/127 Any Other Business

LCS Overpayment

Paper tabled by Kathryn MacDermott outlined the outcome of the investigation of cost pressures in the respiratory LCS and members noted that several practices had made claims for level 1 beyond

October 2017, which was outside of LCS scope. The error was discovered upon reviewing the specification as requested by the LCS Steering Group following a significant increase in activity.

Members noted that practices were required to populate the relevant sections within the template prior to submission to the CCG and said template did not include a clear indication that level 1 payment was only applicable to October 2017.

Members AGREED for any overpayments to be claimed back from the practices. Members also agreed that repayment would be spread equally over Q3 and Q4 if the overclaimed amount exceeds £1k.

Date of the next meeting:

Monday, 28th January 2019, Cedar&Willow Meeting Rooms, Thames House (13.30-15.30).

Future Meeting Dates:

Monday, 25th February 2019	(15.00-17.00)
Monday, 25th March 2019	(13.30-15.30)
Tuesday, 23rd April 2019	(14.00-15.30)
Thursday, 23rd May 2019	(12.00-13.30)
Monday, 24th June 2019	(13.30-15.30)
Monday, 22nd July 2019	(13.30-15.30)
Monday, 23rd September 2019	(13.30-15.30)
Monday, 28th October 2019	(13.30-15.30)
Monday, 25th November 2019	(13.30-15.30)
Monday, 23rd December 2019	(13.30-15.30)

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body meeting in public	
Date	Tuesday, 05 March 2019

Document Title	Minutes of the Finance Committee meeting held on 28 January 2019		
Lead Director (Name and Role)	Yarlini Roberts, Local Director of Finance		
Clinical Sponsor (Name and Role)	David Knowles, Finance Committee chair and Lay Member		
Author(s) (Name and Role)	Yarlini Roberts, Local Director of Finance		
Agenda Item No.	4.1	**Attachment No.**	M1

Purpose (Tick as Required)	Approve		Discuss		Note	✓

MINUTES OF THE FINANCE COMMITTEE HELD ON MONDAY 28TH JANUARY 2019 CEDAR&WILLOW MEETING ROOMS, THAMES HOUSE, TEDDINGTON

PRESENT:

David Knowles	Lay Member & Chair (Chair)
Graham Lewis	Governing Body Chair
Phil Moore	Governing Body GP
Annette Pautz	Governing Body GP
Tonia Michaelides	Managing Director, K&R LDU
James Murray	Chief Finance Officer, SWL Alliance
Yarlini Roberts	Director of Finance, K&R LDU
Neil Ferrelly	Director of Finance, K&R LDU
Fergus Keegan	Director of Quality
Kathryn MacDermott	Director of Primary Care & Planning
David Stout	Interim Director of Transformation
Julia Travers	Director of Commissioning
Sue Lear	Deputy Director of Commissioning

IN ATTENDANCE:

Liam Bayly	Head of Finance
Jenny Sinnott	Head of Finance
Sarah McInnes	Head of PMO
Brian Roberts	Performance and Information Lead
Evelyne Schotte	PMO Manager
Andy Wilson	NEL CSU
Emma Walker	Corporate Support Officer– Minutes

APOLOGIES:	Bob Armitage	Lay Member & Chair (Chair)
	Kate Moore	Governing Body GP
	Jim Smyllie	Lay Member
	Naz Jivani	Governing Body Chair
	Paul Gallagher	Lay Member

18/128 WELCOME AND APOLOGIES

The Chair welcomed those in attendance to the Finance Committee. The meeting remained quorate throughout.

18/129 DECLARATIONS OF INTEREST

David Knowles declared a potential conflict of interest in relation to item 18/139.

18/130 MINUTES OF THE LAST FINANCE COMMITTEE MEETING

Minutes of the last meeting held on Tuesday, 18th December 2018 were agreed as an accurate record.

18/131 ACTION LOGS AND MATTERS ARISING

Action logs were reviewed and updated.

RICHMOND CCG AGENDA

18/132 RCCG FINANCE REPORT – MONTH 9

A copy of Richmond CCG Month 9 report had been circulated and members noted that the CCG is forecasting a year-end deficit of £3.9m against plan due to not being able to close the unidentified QIPP gap.

Acute Commissioning

An adverse variance of £552k YTD was reported by Chelsea and Westminster. This position is based on the block arrangement at the West Middlesex site for the first six months and the FOT PbR activity for the latter half of the year.

Members noted the CCG has agreed a year-end position with Kingston Hospital.

Non-Acute Commissioning

Members were informed the Adult CHC forecast outturn has worsened by £422k to a favourable variance of £850k. This was mainly caused by 16 new CHC cases and 4 new Care at Home packages. In addition, there were also increased costs from changes in packages of care and patients being moved to personal health budgets. These new costs have been partly offset by

significant work undertaken by the CHC team to identify deceased patients as well as those deemed no longer eligible for CHC.

Primary Care

The prescribing position shows and underspend of £1m YTD and £1.3m forecast and included the forecast for NCSO and increased drug tariff impact as well as net impact of Category M margin recovery.

Risks and Mitigations

The risk adjusted position showed a deficit of £4.6m and members were reminded that the resolution of the CWFT merger payment of £1.25m requires mediation, however it is likely that this cost will be incurred by the CCG.

Members also noted that the conversations around RHND bad debt were taking place across London.

Finance Committee NOTED the Month 9 Finance Report.

18/133 SLEEPING DISORDER CENTRE – OBSTRUCTIVE SLEEP APNOEA

A copy of the paper was circulated prior to the meeting and members noted the CET decided not to renew the contract with the Sleeping Disorder Centre (SDC) in 2017 due to the pricing not being favourably comparable to the local NHS trust who is now offering a similar service. Given significant patient pushback the CCG decided to reopen negotiations with the SDC who have now agreed to reduce their pricing in line with the local NHS Provider.

Presented options included continuation with SDC, awarding a new contract in line with local acute tariff and undertaking full procurement of the OSA service.

Given the information available, Finance Committee APPROVED the award of a new 3-year contract to Sleeping Disorder Centre and noted this recommendation was also supported by Executive Management Team.

18/134 CARE HOME PHARMACIST

The business case presented to the committee related to employment of a full-time Band 8a Care Home Pharmacist for Richmond CCG. Members noted the service is currently provided by HRCH, it was proposed to extend the medication review service and align with the Kingston CCG model.

The committee held a discussion regarding the financial benefits of the proposal. It was noted that the actual savings from the proposed recruitment would not be achieved during the first year of employment. However, the chief pharmacists believed that the benefits would not only be quantitative but also qualitative.

The care home pharmacist would also have easier access to guidelines available to CCG staff, thus prompting a further discussion about not having a two-tiered system where HRCH was involved in providing services.

The Finance Committee acknowledged that the proposal was in line with the wider model around support for care homes and that it could also result in hospitalisation avoidance. It was agreed that there was significant work to be carried out to ensure the plan was executed properly.

The Finance Committee APPROVED the Business Case.

COMMON AGENDA

18/135 2019/20 PLANNING

18.135.1 2019/20 Finance & Activity Plan

A copy of the 2019/20 Finance and Activity Plan was circulated prior to the meeting for information.

The Director of Finance outlined the CCGs' focus, which would be on waterfall and assurance.

- Waterfall > RCCG QIPP target of £14.5m plus £2m FYE of 18/19 QIPP; KCCG £9.7m QIPP target
- Assurance > both CCGs were asked to revise the activity submission, as NHSE did not agree with the deflating and inflating of growth.

Members were presented with the Activity summary as follows:

- Unaffordable contract values were submitted by some providers which may lead to misalignment with CCG's
- The plan would be submitted to NHSE at the beginning of February. The CSU was working on understanding the impact of tariffs.
- Kingston Hospital had shared the first draft of their proposal, which was comparable with CCG's pre-QIPP.
- Prior to the FRP draft submission to NHSE, more work would be undertaken in identifying further QIPP opportunities. Currently £10m unidentified QIPP existed for RCCG and £4m QIPP unidentified for KCCG. The draft submission would be presented to SMT on 6th February. The final submission deadline was in April.

The committee discussed the challenges ahead and whether de-commissioning or looking at "difficult choices", as per NHSE wording, would be the direction of travel. The Managing Director

believed that going down that route would not be beneficial and may pose more challenges for the CCGs.

Yarlini Roberts highlighted that:

- £10m worth of further savings still needed to be found for RCCG alone
- When the draft FRP is submitted to NHSE, the CCGs would have to evidence they were improving at tackling the underlying issues.
- RCCG been thorough in identifying transactional QIPP, resulting in £12m QIPP, which triggered a worsening underlying position of £6m.

The Director of Transformation reiterated how difficult decisions would need to be made at some point.

The Managing Director felt that if any decommissioning was undertaken it should be undertaken at a SWL level and once only. Additionally, the committee should note that the CCGs did not have the capacity to focus on decommissioning and transforming services at the same time.

Yarlini Roberts highlighted that as KCCG had delivered in 2018/19 there would be pressure to breakeven in 19/20. Concerns were raised around the required transformation, nevertheless the quantum identified and the timeframe were not sufficient to deliver.

The Chair felt the route forward laid in a different relationship with providers.

18.135.2 Control Total Letters

Copies of 2019/20 Control Total Letters for Kingston and Richmond CCGs were circulated prior to the meeting for reference.

18.135.3 2019/20 QIPP

The papers contained a draft 2019/20 QIPP plan, which was still in development. The plan had thus far been through robust process, a bottom up approach and check and challenge sessions.

Summaries for Kingston and Richmond CCG showed the identified £5.6m net savings (£3.9m risk-adjusted) for Kingston CCG and £6m net savings (£4.2m risk-adjusted) for Richmond CCG.

The Pipeline schemes figures were also included within the pack and were estimated at £2.5m and £3.1m for Kingston and Richmond respectively.

Members noted there is a need to identify more QIPP and continue to work with commissioning leads to complete project workbooks and quality impact assessments, which ought to be completed by the end of February.

It was noted that Acute QIPP schemes information had been shared with the CSU.

18/136 ACUTE UPDATE

Kingston Hospital

Members noted the Non-Elective activity continues to have a significant over-performance, the majority of which is in Paediatrics. Maternity Pathways continue to underperform against plan for the year.

In addition, members noted that A&E attendances were 3% above plan which has continued into M10. An increase in Day Cases was seen in M9 particularly in General Surgery, Ophthalmology and ENT.

It was noted that Elective overperformance was caused by diverted RTT work from St Georges, Ashford & St Peters and Epsom, & St Helier's.

18/137 2018/19 QIPP REPORT

The QIPP report for Kingston and Richmond CCGs was presented to the committee and members noted that capacity continues to be an issue due to the amount of work that needed to be delivered. Members noted that System-wide priorities had been agreed and would need to be aligned to enable delivery.

Richmond CCG

Due to phasing of the unidentified QIPP the YTD position was positive. Transformational QIPP, which had historically been challenging, had been delivered. The CCG is forecasting £12m, including £2m of non-recurrent benefits.

Kingston CCG

Members noted the position has worsened in month 9. Transformational QIPP continued to under-perform, which was partly set off by the strong performance of ECI and Referral Management Schemes. The CCG is forecasting £9.7m, including £800k of non-recurrent benefits.

18/138 RISK REGISTER & BOARD ASSURANCE FRAMEWORK

Copies of Risk Registers and Board Assurance Framework for Kingston and Richmond CCGs had been circulated prior to the meeting for information.

Risks related to Kingston CCG included the possibility of jeopardising the ability to meet statutory financial obligations by potential overperformance in Acute Services (K16) and Risk of Failure to meet statutory financial targets (K34). Members agreed the Target risks were correct, however the Residual Risks needed to be reviewed and updated.

Risks related to Richmond CCG were around the Failure to deliver Financial Recovery Plan implementation to achieve operating plan target for 2018/19 (PR4) and Failure to identify required

QIPP savings for 2018/19 (PR48). Members recognised the QIPP target was significant as shown within the Finance Report.

18/139 SWL PROSTATE CANCER

Due to possible conflict of interest, the Chair abstained from this item and the item was chaired by Dr Graham Lewis.

The paper presented to members outlined an initiative to provide follow-up appointments for prostate cancer patients in primary care rather than in an acute setting.

Members noted that currently this cohort of patients is seen in primary care for comorbidities and secondary care for follow-up appointments. The plan was to integrate the pathways into one, which would see patients attending primary care only, thus linking in with the Outpatient Transformation Programme.

It was noted that this proposal had initially been introduced in 2017; the funds were attached to certain cancer waiting times targets which were only met last month, allowing SWL to release the funds to make a non-recurrent payment. The CCGs were asked to make a recurrent payment of £12,150 and £14,400 for Kingston and Richmond CCG respectively.

It was highlighted that the KCCG practices details seemed out of date, which lead to questions around the validity of the costings. It was agreed that this would be reviewed before the initiative was implemented.

The committee also noted that following the Transforming Cancer Programme, there was an expectation from SWL that the CCGs would proceed with the proposal. If the proposal was implemented a plan on how to support the practices, possibly via and educational day, would need to be drafted.

It was deemed important to involve the GPs at an early stage to ensure effective recruitment could take place. Additionally, quality control measures and appropriate governance would need to be applied.

The budget allocation was APPROVED.

18/140 NAMED NURSE FOR CHILDREN LOOKED AFTER (CLA)

Copy of the proposal related to the appointment of the Named Nurse for Children Looked After was circulated and members noted that both CCGs had a statutory responsibility to commission services supporting the health and wellbeing of children care and currently neither Kingston nor Richmond CCG funds a Named Nurse to meet the responsibilities for CLA.

This matter was previously discussed by the EMT and subsequently supported.

The proposal sought funding for a full-time Band 8a nurse to work across Kingston and Richmond to support children looked after and work with the CCG lead and specialist nurses based within the providers. The cost of recruiting is circa £57k and the post would most likely be hosted by HRCH.

The committee APPROVED the funding.

KINGSTON CCG AGENDA

18/141 KCCG FINANCE REPORT – MONTH 9

A copy of the Month 9 Finance Report was circulated prior to the meeting for information and members noted the Month 9 accounts including an interim governance statement were submitted to NHS England.

Jenny Sinnott presented the key messages from Month 9 Finance Report as follows:

- The CCG expects to meet its planned in year 0.4% surplus of £1,060k
- Some reserves and non-recurrent benefits have been utilised to enable the delivery of the planned in year surplus.
- Cash and Better Payment Practice Code (BPPC) targets were met in month 9.
- The CCG is ahead of target for QIPP year to date due to phasing of the plan, and expect to fully achieve the planned target savings of £9.8m, despite under-achievement on some transformational schemes.
- Year-end agreement was reached with two Trusts thus removing the risk from the majority of acute expenditure

Members noted the underlying position has worsened slightly due to an increased use of non-recurrent measures to meet the control total.

Non-Acute Commissioning

Mental Health
Members noted Mental Health placements were forecast to overspend by £373k. The increase of £122k since month 8 is predominantly due two new placements expected to cost £173k by the end of the year.

Primary Care
Prescribing position has marginally worsened in Month 9, however is still reporting a large underspend.

Primary Care Delegated commissioning budget reports an overspend of circa £500k year to date due to increased locum reimbursements. In month 9 the main increase was reported in Premises cost due to an underbudgeting of a practice local authority rates by £50k.

The Finance Committee NOTED the Month 9 Finance Report.

18/142 MENTAL HEALTH PLACEMENTS QIPP

Paper disseminated among members highlighted the proposed Mental Health QIPP for 2019/20 and outlined the investment required to support the delivery of the QIPP efficiencies in Mental Health.

Members noted the resource was indicated within the Resettlement Teams for Richmond CCG, who carry out the sourcing and clinical review of placements and support the case management of Section 117 patients living in supported housing or in solely CCG funded accommodation as part of their recovery.

An investment of £25k to fund a part time Band 7 position in the Kingston CCG Recovery and Support Team at SWL St Georges is required, thus linking with the community and Local Authority. The Managing Director suggested the team should liaise with SLP to see if some of the existing resource could be utilised. Tonia Michaelides also highlighted that ultimately the decision around where complex placements sat within SW London would need to be made.

The investment was APPROVED.

18/143 KCCG and RBK LA SUPPORTED ACCOMODATION

A copy of the paper had been presented to the committee for consideration and discussion and members noted the Kingston CCG and Royal Borough of Kingston Local Authority had agreed to review the block funding arrangements to consider whether they adequately reflected the support and funding responsibilities of the two organisations while sufficiently meeting the care needs to clients and subsequently agreed to jointly fund the block contracts from 2018/19.

Paper outlined the financial implications of this agreement to Kingston CCG for this financial year and from 201920 as well as the principles agreed by both organisations to ensure smooth running of the placement process and mitigate any impact on clients.

Discussion followed around the funding of contracts and contributions to Health and Care, where patients were under section 117 but there was a shared responsibility of funding. Suggested split of 50:50 or 25:75 or 90:10 would be exercised where appropriate.

In terms of rebasing contributions, the proposal now represented a cost pressure for the CCG; the impact in 18/19 would be £148K. In 19/20 this would decrease, and the cost, moving forward will be offset by closure of Mill Place.

The Committee was in support of these arrangements.

18/144 PROVISION OF INTERIM SPECIALIST PERSONALITY DISORDER (PD) SERVICE

Paper outlined the identified service gap in respect of lack of specialist Personality Disorder service provision for people in Kingston.

The CCG has committed to work with the Trust to implement an interim specialist Personality Disorder Service and intends to commission a full specialist PD service in collaboration with RCCG in the future. Members noted £180k of Mental Health Investment Standard resources was committed by Kingston CCG to fund this service.

The Director of Transformation suggested that mapping the impact of the service would be a useful exercise.

Based on the information available, members APPROVED the funding.

18/145 PRIMARY CARE DIETICIAN

The proposal related to the recruitment of a Primary Care Dietician for Kingston CCG to undertake reviews of domiciliary patients registered with practices. Members were reminded this proposal was approved at a previous Finance Committee for Richmond CCG and noted the Kingston CCG aims to mirror the same model thus helping with the delivery of the 2019/20 QIPP.

The model was based upon a previous KCCG pilot from 2011 where a dietician was employed to work across all practices, resulting in savings of approximately £74k. A piece of work carried out a SWL level based on a dietician, who had undertaken similar intervention work, showed that the project had resulted in savings of 35%, which, if applied to 17/18, would achieve savings of circa £71k.

Question around the sustainability of the model arose, would should be addressed by making the post substantive.

Based on the information available, members APPROVED the Business Case and noted the assurance would be given via the Programme Delivery Group.

18/146 TENDER WAIVERS

There were no tender waivers.

18/147 ANY OTHER BUSINESS

Members noted that Yarlini Roberts, Local Director of Finance at Kingston & Richmond CCGs, is joining the South West London Alliance finance team on a nine-month secondment, taking the lead on financial sustainability, CCG organisational development and financial architecture. Whilst Yarlini is undertaking her secondment, Neil Ferrelly will be the Interim Local Director of Finance.

Chair has extended their appreciation to Yarlini Roberts for her contribution to the LDU and welcomed Neil Ferrelly to the organisation.

Date of the next meeting:

Monday, 25th February 2019, The Wade Room, The Lensbury, Broom Rd, Teddington (15.00-17.00)

Future Meeting Dates:

Monday, 25th March 2019	(13.30-15.30)
Tuesday, 23rd April 2019	(14.00-15.30)
Thursday, 23rd May 2019	(12.00-13.30)
Monday, 24th June 2019	(13.30-15.30)
Monday, 22nd July 2019	(13.30-15.30)
Monday, 23rd September 2019	(13.30-15.30)
Monday, 28th October 2019	(13.30-15.30)
Monday, 25th November 2019	(13.30-15.30)
Monday, 23rd December 2019	(13.30-15.30)

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body meeting in public	
Date	Tuesday, 05 March 2019

Document Title	Minutes of the Integrated Governance Committee meeting held on 17 July 2018		
Lead Director (Name and Role)	Fergus Keegan, Local Director of Quality		
Clinical Sponsor (Name and Role)	Phil Moore, IQGC chair and GB deputy chair (clinical)		
Author(s) (Name and Role)	Fergus Keegan, Local Director of Quality		
Agenda Item No.	4.1	**Attachment No.**	M2

Purpose (Tick as Required)	Approve	Discuss	Note
			✓

NHS Kingston CCG Integrated Governance Committee (IGC)
Tuesday 17th July 2018
Cedar/Willow Rooms, Thames House @ 15:30 – 17:30hrs
MINUTES

IGC Members	17.4	15.5	19.6	17.7	21.8	18.9	16.10	13.11	18.12	2019	15.1	19.2	19.3
Phil Moore (Chair) *PM*	SA	SA	A	A									
Fergus Keegan (Deputy Chair) *FK*	A	A	A	SA									
Nazim Jivani *NJ*	SA	SA	A	A									
Tonia Michaelides *TM*	SA	SA	SA	SA									
David Knowles *DK*	A	A	SA	A									
Naeem Iqbal *NI*	SA	DNA	DNA	SA									
Pete Smith *PS*	A	SA	SA	A									
Nadeem Nayeem *NN*	A	A	DNA	SA									
Jim Smyllie *JSm*	SA	DNA	DNA	A									
Paul Gallagher *PG*	DNA	DNA	DNA	DNA									
Brian Roberts *BR*	A	A	A	A									
Julia Travers *JT*	A	SA	SA	A									
Laura Jackson *LJ*	SA	A	SA	A									

Kathryn Yates *KY*	SA	A	SA	SA									
Iona Lidington *IL*	SA	SA	SA	SD									
Ellie O'Reilly (minutes) EO	A	A	A	SA									
Clare Woollett (minutes) CW	A			A									

KEY: A = Attended, DNA = Did Not Attend, SA = Sent Apology, SD = Sent Deputy, NR = Not Required

Item		Action
Standing Items		
1.	**Welcome, apologies for absence and confirmation of quoracy** Phil Moore, the Chair, welcomed the Integrated Governance Committee (IGC) members and other attendees and apologies were given as indicated above. It was noted that the meeting was quorate. Helen Raison (HR) was in attendance as a deputy for Iona Lidington.	
2.	**Declaration of Interest in matters covered on the agenda** None.	
3.	**Minutes of IGC held on the 19th June 2018 and matters arising** The minutes were agreed as an accurate record. **Action Log** Please refer to the action log for updates and changes. **Matters Arising:** PVL and Aspergillis Fumigatis: NJ confirmed that the issues raised at the previous meeting has been fed back to the Kingston Hospital CQRG.	

4.	**Integrated Governance Exception Report**
	BR presented an overview of the report. Key issues to note:
	
	• In the 2017/18 CCG IAF ratings, Kingston CCG has received an overall rating of 'good' – with 'amber' for finance and 'green' for leadership. The rating for finance is due to unidentified QIPP. This is the same rating as has been given to Richmond CCG.
	• The constitutional standards that are not currently being achieved by Kingston CCG are:
	  ○ Dementia diagnosis rate
	  ○ Incidence of healthcare associated infection: C Difficile
	  ○ A&E 4 hour standard for Kingston Hospital
	
	Dementia:- currently the rate stands at 61.6% (as at 31st May 2018) against a target of 66.7%, despite the action plan that has been implemented to address the shortfall. Guidance has been sought from NHSE on any additional actions that could be taken and a forthcoming governing body seminar has been arranged to focus on the issue. Members discussed whether a particular demographic or other factors in Kingston could be influencing the low rate of diagnosis and if this is the case, how it could be demonstrated to NHSE. HR agreed to	

Item		Action
	consider whether the Public Health team could develop a research project to find whether there is any evidence for this. **Action: HR to consider whether/how a research project could be undertaken to look at factors influencing low diagnosis rates in Kingston** **Healthcare acquired infections**:- there have been 11 C-Difficile infections for April and May 2018 against a year to date plan of 5 (the ceiling target for 2018/19 is 29). The NELCSU Infection Control Team are currently carrying out a review and their report is awaited. **A&E 4 hour standard**:- As per previous reports/minutes Kingston Hospital has not met the standard of 95% in each month to date during 2018/19. However, the position has improved compared to the winter months though there has been some deterioration during the current heatwave. • All 9 cancer standards were achieved for April and May 2018 • Total GP referrals:- The variance against plan for GP referrals has fallen to 4.4% in May (YTD) compared to 7.4% in April. The variation is within surgical specialties and not linked to particular practices. The CCG expects the activity to be within planned levels by July 2018. • Quality Premium (QP):- Members agreed to the proposed performance management approach to improving achievement of QP measures but acknowledged that delivery would remain a challenge.	**HR**
5.	**Reporting from Clinical Quality Review Groups** LJ provided an overview of the reports as follows, noting that a joint report is produced covering both Kingston and Richmond CCGs and that IGC meetings do not align with the CQRG reporting cycle: <u>Kingston Hospital Foundation Trust</u> • A more robust response system is now in place to deal with complaints. This is being monitored at associate director level. The subject of complaints is dealt with in detail at the CQRG and it is confirmed that there are currently no specific trends. • A new, early warning system for sepsis management will come into effect in March 2019 but steady progress is already being made with focussed and proactive management evident in A&E. Anecdotally, GPs report that patients referred into A&E have been well managed. <u>SW London & St Georges Mental Health Trust</u> • Kingston CCG is now the lead commissioner for the Trust • A huge amount of work has been done to improve quality which is now being reflected in performance • Deep dives taking place to give a focussed examination and analysis of particular issues <u>SW London Integrated Urgent Care</u> The report was noted.	
Annual Reporting		
6.	**2017/18 Annual Report Complaints, PALS and MP letters** The report was noted as received. The number of complaints and MP letters remains very low.	

Item		Action
Standing and Additional Items		
7.	**The Public Health Core Offer to Kingston CCG** HR presented the Public Health Core Offer which is intended to support the CCG in its commissioning function. A Memorandum of Understanding (MOU) and a draft workplan for 2018/19 are also included. • Core offers are being developed to align local authorities and CCGs across SW London • Offer is not overly prescriptive and seeks to reinforce the existing positive working relationship between the team and the CCG. • Support the relationship by CGG providing workspace in Thames House for team members on an ad hoc basis • Presenting a workplan that is sustainable and deliverable but recognises the reduced workforce and resource within the team • Training registrar posts have been retained – 3 new starters on 1st August 2018 • Would seek to work with the CCG to support local priorities e.g. locality profiling or dementia • MOU very similar to previous ones Members discussed the papers and approved the approach while emphasising that preserving the established, strong relationship between the public health team and the CCG should remain the focus.	
8.	**Policies for discussion/approval** None.	
9.	**Any other business** None.	
10.	**Date of Next Meeting** Tuesday 21st August 2018 from 15:30 – 17:30, Please note change of venue: Kent Room, The Groves Medical Centre, 171 Clarence Avenue, New Malden, KT3 3TX	

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body meeting in public	
Date	Tuesday, 05 March 2019

Document Title	Minutes of the Integrated Governance Committee meeting held on 21 August 2018		
Lead Director (Name and Role)	Fergus Keegan, Local Director of Quality		
Clinical Sponsor (Name and Role)	Phil Moore, IQGC chair and GB deputy chair (clinical)		
Author(s) (Name and Role)	Fergus Keegan, Local Director of Quality		
Agenda Item No.	4.1	**Attachment No.**	M2

Purpose (Tick as Required)	Approve	Discuss	Note
			✓

NHS Kingston CCG Integrated Governance Committee (IGC)
Tuesday 21st August 2018
The Groves Medical Centre, 171 Clarence Avenue, New Malden, KT3 3TX
15:30 – 17:30hrs
MINUTES

IGC Members	17.4	15.5	19.6	17.7	21.8	18.9	16.10	13.11	18.12	2019	15.1	19.2	19.3
Phil Moore (Chair) *PM*	SA	SA	A	A	A								
Fergus Keegan (Deputy Chair) *FK*	A	A	A	SA	A								
Nazim Jivani *NJ*	SA	SA	A	A	A								
Tonia Michaelides *TM*	SA	SA	SA	SA	SA								
David Knowles *DK*	A	A	SA	A	SA								
Naeem Iqbal *NI*	SA	DNA	DNA	SA	DNA								
Pete Smith *PS*	A	SA	SA	A	SA								
Nadeem Nayeem *NN*	A	A	DNA	SA	SA								
Jim Smyllie *JSm*	SA	DNA	DNA	A	DNA								
Paul Gallagher *PG*	DNA	DNA	DNA	DNA	DNA								
Brian Roberts *BR*	A	A	A	A	SA								
Julia Travers *JT*	A	SA	SA	A	A								
Laura Jackson *LJ*	SA	A	SA	A	SA								
Kathryn Yates *KY*	SA	A	SA	SA	A								

Iona Lidington *IL*	**SA**	**SA**	**SA**	**SD**	**SA**								
Helen Raison HR				**A**	**SA**								
Ellie O'Reilly (minutes) EO	**A**	**A**	**A**	**SA**	**A**								
Clare Woollett (minutes) CW	**A**			**A**									

KEY: A = Attended, DNA = Did Not Attend, SA = Sent Apology, SD = Sent Deputy, NR = Not Required

Item		Action
Standing Items		
1.	**Welcome, apologies for absence and confirmation of quoracy** Phil Moore, the Chair, welcomed the Integrated Governance Committee (IGC) members and other attendees and apologies were given as indicated above. It was noted that the meeting was not quorate but would go ahead. Any approval recommendations will be recorded and actions noted. Ruth Harkness (RH), Pete Warburton (PW) Anne-Marie Brosnan (AMB) and Emma Richmond (ER) were in attendance to present items 5, 7, (RH), 8 (PW), 9 (AMB) & 13 (ER).	
2.	**Declaration of Interest in matters covered on the agenda** There were no new declarations of interest. For the minutes, FK noted AMB was on secondment from HRCH.	
3.	**Minutes of IGC held on the 17th July 2018 and matters arising** The minutes were agreed as an accurate record. **Action Log** Refer to the action log for updates and changes. **Matters Arising:** FK advised the September meeting would be cancelled due to a clash with Governing Body and the Workplan will be adjusted to defer the September papers to the October meeting. It was acknowledged this would be a busy agenda due to the additional papers and the committee agreed to extend the October meeting by 30 minutes to accommodate this. After further discussion, it was also agreed to have this at The Grove Medical Centre as this could then follow on from the LMC and take place from 3pm – 5:30pm. **Action** 1. **EOR to action meeting changes as discussed.**	EOR
4.	**Integrated Governance Exception Report** FK presented an overview of the report and highlighted: • Overall Position against constitutional standards – currently showing at 85% and it was noted that it would be useful to see last year data for comparison. • Dementia Diagnosis Rates – currently amber and improvement plan prepared • 1 x Mixed Sex Breach @ KHFT • C.diff – is currently above trajectory. It was noted that SLo is due to report at the October meeting and will highlight hospital acquired cases and the RCA's. RH advised the criteria has changed and it is now more robust in terms of reporting and counting.	

Item		Action
	• A&E – still not achieving waiting times. FK stated the first draft of the winter plan is going to the next A&E Delivery Board and TM will then present this to the SW London Urgent and Emergency Care Board. FK expects this winter to be very challenging and noted the winter plan will come to the IGC October meeting. • Operating Plan – there has been an increased number of GP referrals above plan. This has been attributed to a growth in cancer referrals, specifically Urology. It is believed that a few contributing factors have influenced this including a National advertising campaign and a raised awareness. • 2WW – have had some duplications following the introduction of E-Referrals. It was noted that it is limited year to date data (Q2) and this may improve over the year. It was agreed that a breakdown of referrals would be useful and JT to discuss options with BR. • Quality Premiums – There are currently 5 rated red as detailed on the report and these include GP appointments and Local Right Care – CHC has improved and is expected to continue to do so. It is currently green YTD (12.8%) FK stated we will have a clearer overview of our position at the October meeting and if there has been no change it will highlight challenging concerns. PM noted a cautious optimism, with no apparent themes. . **Action:** **1. BR to provide details of the GP referral increases**	
5.	**Reporting from Clinical Quality Review Groups (CQRG)** RH provided an overview of the reports and advised these are now joint covering both Kingston and Richmond CCGs. It was noted that no report had been received from London Ambulance service for this meeting and agreed that Chelsea & Westminster and HRCH are acknowledged for information. The following was highlighted: <u>Kingston Hospital Foundation Trust</u> • C.diff – 1x breach; RCA completed and reviewed at SIRG with no lapses in care concluded • Never Event – Insulin Syringes where patient got a very high dose. Actions are being monitored and in progress, the report will come back once signed off by NHS England. <u>St Georges Healthcare NHS Trust</u> • SI – A Never Event investigation indicated that CAS/NICE alert guidance had been issued but not implemented at the time of the incident. • Cardiac Services Review - it was advised this service had come under scrutiny and an external review had been carried out and reported several issues including staffing, training and Clinical Leadership. A discussion followed first noting it was important to state that St George's are still providing care of a high standard and as a Trust are open in addressing their issues. Internal and external scrutiny including from NHSI, NHS England and the relevant CCG's are in place.	

Item		Action
	The CCG's actions are to include a Board to Board meeting with Sarah Blow in attendance. It was concluded that to ensure vigilance and assurance this should remain on the agenda as although St Georges are not main providers for Kingston, this committee should have sight of any further issues or progress. **Actions** **1. To report this on St Georges CQRG feedback form until assurance agreed by the committee** <u>SW London Integrated Urgent Care</u> • Vacancy rate for 111 remains an issue • Sickness has improved due to the implementation of a new process • Call rates answered has improved to 88% against a 90% target. • CQC - awaiting report and no immediate actions imposed. <u>SW London St Georges Mental Health</u> • A shortage of PICU adult beds was advised, with a plan to review. A discussion suggested early intervention in the community before crisis. It was noted the assured column had not been completed but PM felt assured that things were improving and reporting has improved. Going forwards a deep-dive will be held bi-monthly. FK advised on the bed issues, there is a Multi-Agency Discharge Event planned and this will be fed back in a future meeting. <u>Your Healthcare</u> It was noted these meetings are now quarterly. • IT access to community care plans are available with tablet devices • Amy Woodgate given notice and awaiting feedback JT advised RBK have a joint responsibility to care for residence and they are working on communication with partners. NJ noted issue on communication from hospitals to community and he has spoken to the Medical Director and the Director of Nursing in relation to this. Following discussion, it was stated that FK and JT to review communication processes with KHFT, YHC, HRCH and GP's to ensure there is a process in place to enhance communication and provide further assurance. **Actions** **2. FK & JT to get further assurance on the communication as discussed.** It was noted the same template would be preferred that includes the columns detailing assurance and responsibility. RH advised this has been recommended as the template for all the CQRG's to adopt and RH will remind the leads and re-send the correct template.	RH
6.	**Risk Register Report** FK advised this is a new standing item for this group and stated this is to strengthen the oversight of the specific Quality and Safety Risks and their progress to provide assurance to the Governing Body that we are monitoring the risks and the actions to mitigate.	

Item		Action
	The following was noted: • K7 - Risk of Failing to meet some national performance targets 2018/19 for Dementia, IAPT, A&E and DTOC is rated red currently and actions are detailed on the report. • K21 – Oversight of IPC. KY advised there is a measles risk and MMR uptake issues in a specific co-hort and asked how we were going to pick this up. FK advised this would be reported through the quarterly IPC reports. Also in previous discussions in Richmond QS&P, ER had an action to communicate to GP's regarding vaccinations and this could also be done to the Kingston GP's. NJ asked for this to include the financial impact. A campaign for awareness could be looked at and this would be for the Public Health team. FK to discuss with ER.	
Quarterly Reporting		
7.	**Q1 2018/19 Serious Incidents** RH advised this is a joint report for the Kingston and Richmond CCG providers and it was agreed that Chelsea & Westminster and HRCH are acknowledged for information. The following was noted: <u>Kingston Hospital Foundation Trust</u> As previously noted KHFT have a robust reviewing process and there are no exceptions from this report <u>SW London St Georges Mental Health</u> The LDU are currently reviewing the SI's, however this is under review and a meeting is scheduled to take place shortly to discuss future review arrangements. <u>St Georges Healthcare NHS Trust</u> 1 x Never Event – misplaced nasogastric tube. Monitoring is done by the Wandsworth and Merton LDU and Kingston & Richmond CCG are informed if a resident of Kingston or Richmond is involved. <u>Your Healthcare</u> There have been 2x SI's both involving Kingston patients and we are assured appropriate actions are being taken. There have been no notifications of SI's outside the SWL providers for Kingston or Richmond patients.	
8.	**Q1 2018/19 Safeguarding Adults** PW introduced the report and noted: • The Safeguarding Adults Board Communication Sub-Group – has been very successful in engaging local community groups and is continuing to grow and reach lots of people through these community groups. • Safeguarding Adults Reviews – there have been 2x reviews and both reports are in draft awaiting final review • LD Mortality review – 2x notifications from March are completed. There were 2x notifications in July from KHFT and this has raised some concerns around us not being notified of the deaths in good time as one of these patients had passed away in May. • LeDer – short film produced for GP's to raise awareness and this has been very well received. • MCA/DoLS - training programme in place is being well attended. • Data Collection - The SWL safeguarding teams are working together to collate data to format and implement a reporting framework.	

Item		Action
	• Community DoLS – new procedures are in place that includes making an application to the Court of Protection. CHC teams and the CCG will be responsible for presenting these cases to court and this raises the following issues: – Capacity, as the process will take time to complete the documentation and have representation attending court – Complexity of the completing the process – Financial implications as each case will be £400 - £1000 depending on the level of required legal input. PW updated the committee on two Nursing home issues. One remains suspended with issues around patient care, specifically privacy & dignity, skin and respect. The second is under a voluntary suspension that we want to extended as the actions to date have not been sufficient. The report was noted as received	
9.	**Q1 2018/19 Safeguarding Children's** AMB introduced her report and noted: • CP-IS has been implemented in KHFT, however Achieving for Children (AFC) have not met the timeframe and we are awaiting an update. • K&R CCG staff were 87.5% complaint with Safeguarding Training for Q1 • Staffing issues were noted: – the Designated Nurse for Safeguarding RCCG is currently on secondment to Oxfam and is due to return in 3 months – the Designated Nurse for Safeguarding Children & Children Looked After for K&RCCG is on long term sick – Named GP resigned and although there has been an expression of interest, it was felt that without the support of experienced designated Nurses it would be difficult to offer the post to the candidate now. – Designated Nurse for Children Looked After K&R CCGs (Vicky Fraser - VF) is now full time – Deputy Designated Nurse for Safeguarding Children (AMB) part time secondment from HRCH It was also noted that PW and SL would be providing cover. PM ask if we had adequate assurance that the arrangement mitigated risk and for how long before this may need to go onto the Risk Register. FK stated this is an interim arrangement with the recruitment process underway and ST returning within the next 10 weeks. The Safeguarding Board are aware we have a gap and have been supportive of our arrangements. FK wanted to note the team have worked well as a LDU and thanked them for their hard work. • Some data is still unavailable, AMB advised she had received none from KHFT and limited data from SWL St Georges and felt the next report will be more concise as she becomes more established in her role. KY advised she is currently looking at Safeguarding documentation in practices and how we can do supervision. PM felt this was a good report and thanked AMB. The report was noted as received	

Item		Action
Integrated Performance Reporting		
10.	**Q1 2018/19 Continuing Healthcare Reports** • **Adult Continuing Care** FK noted this very much on the NHS England agenda. KCCG have a well-established stable team and are doing well with some work needed on personal health budgets. FK referred the committee to the report for further detail and the report was noted as received. • **Children's Continuing Care** JT advised this is Doreen Redwoods (DR) - Children's Senior Health Commissioning Manager's first Kingston report having now taken this on as well as Richmond and the following was noted: – Expecting to deliver QIPP savings, if no new high cost patients – Staffing issue are noted as effecting the delivery of quality KPI requirements as detailed in 3.2 The report was noted as received.	
11.	**Q1 2018/19 Mental Health Report** JT introduced the report and noted**:** • Ongoing achievement of the Increasing Access to Psychological Therapies (IAPT) access and recovery targets and work to develop IAPT / Long Term Conditions pathways • Provision of specialist Personality Disorder (PD) services for Kingston • Actions to address on-going under performance against dementia diagnosis in Kingston. • Financial challenges of the Transforming Care Programme (TCP) as detailed in the report • Exception reports from SWL StG gives overview on key constitutional standards. KY stated her concerns on the use of temporary staffing and the potential quality issues on whether the right staff are in the right roles. It was acknowledged there has been a lot of work to reduce temporary staffing but this is challenging due to a shortage of mental health staff. It was noted that although there is still work to be done, to address workforce issues a lot has been done and this has included deep dives, focusing on issues e.g. bullying and harassment, also shifting from agency to bank staff. The report was noted as received	
Annual Reporting		
12.	**2017/18 Safeguarding Children's Annual Report** FK advised he will be discussing this with TM withdrawing this report due to its availability considering the unpredicted staffing difficulties as detailed in item 9	FK
Standing and Additional Items		
13.	**Policies for discussion/approval** • **Primary Care Rebate Scheme (PCRS) Policy and Process** ER introduced her paper advising this is a proposed rebate scheme that is currently in place in Richmond CCG. Concerns were raised that GP's would be instructed to prescribe a particular branded medication, perception of data in FOI requests, transparency and motives of the pharmaceutical companies.	

Item		Action
	ER stated legal advice was in place and a level of Governance needs to be agreed to ensure we are not influencing the rebate scheme and we would continue with generic prescribing. The pharmaceutical company will receive transaction data, volume usage and provide cashback. JT noted the SWL SMT are looking to adapt this across the SW London sector and KCCG are currently the only CCG not signed up to this scheme. It was noted that waiting for the SWL agreed process may be the preferred option for Kingston CCG once agreed for the sector. FK acknowledge the SWL approach and the Kingston CCG concerns raised. As the committee, could not agree and were not quorate FK noted the need for input from clinical support members that were not available today and asked for the concerns to be addressed and bought back to this committee in the future.	
14.	**Any other business** • RH advised she would be attending a South London Patient Safety Forum to discuss roles in incident management in General Practice. It was noted that this is not currently monitored by the CCG but is managed by NHS England. PM advised GP's are obligated to report any significant incidents in their appraisals, however PM was not sure if this is onward reported. It was felt a process within GP was needed further discussion and implementation.	
15.	**Date of Next Meeting** 18th September 2018 – please be advised this meeting has been cancelled. 16th October to be held at The Groves Medical Centre, 171 Clarence Avenue, New Malden, KT3 3TX 15:00 – 17:30hrs **2018** 20th November 18th December @ 15:30hrs – 17:30hrs in the Cedar/Willow Room - 2nd floor, Thames House, 180 High Street, Teddington TW11 8HU. **2019** 15th January 19th February 19th March @ 15:30hrs – 17:30hrs in the Cedar/Willow Room - 2nd floor, Thames House, 180 High Street, Teddington TW11 8HU.	

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body meeting in public	
Date	Tuesday, 05 March 2019

Document Title	Minutes of the Integrated Governance Committee meeting held on 16 October 2018		
Lead Director (Name and Role)	Fergus Keegan, Local Director of Quality		
Clinical Sponsor (Name and Role)	Phil Moore, IQGC chair and GB deputy chair (clinical)		
Author(s) (Name and Role)	Fergus Keegan, Local Director of Quality		
Agenda Item No.	4.1	**Attachment No.**	M2

Purpose (Tick as Required)	Approve ☐	Discuss ☐	Note ✓

NHS Kingston CCG Integrated Governance Committee (IGC)
Tuesday 16th October 2018
The Groves Medical Centre, 171 Clarence Avenue, New Malden, KT3 3TX
15:00 – 17:30hrs
MINUTES

IGC Members	17.4	15.5	19.6	17.7	21.8	18.9 CNX	16.10	13.11	18.12	2019	15.1	19.2	19.3
Phil Moore (Chair) *PM*	SA	SA	A	A	A		A						
Fergus Keegan (Deputy Chair) *FK*	A	A	A	SA	A		A						
Nazim Jivani *NJ*	SA	SA	A	A	A		SA						
Tonia Michaelides *TM*	SA	SA	SA	SA	SA		SA						
David Knowles *DK*	A	A	SA	A	SA		SA						
Naeem Iqbal *NI*	SA	DNA	DNA	SA	DNA		A						
Pete Smith *PS*	A	SA	SA	A	SA		SA						
Nadeem Nayeem *NN*	A	A	DNA	SA	SA		SA						
Jim Smyllie *JSm*	SA	DNA	DNA	A	DNA		SA						
Paul Gallagher *PG*	DNA	DNA	DNA	DNA	DNA		SA						
Brian Roberts *BR*	A	A	A	A	SA		SA						
Julia Travers *JT*	A	SA	SA	A	A		SA						
Laura Jackson *LJ*	SA	A	SA	A	SA		A						

Kathryn Yates *KY*	**SA**	**A**	**SA**	**SA**	**A**		**SA**						
Iona Lidington *IL* **Helen Raison HR**	**SA**	**SA**	**SA**	**SD** **A**	**SA** **SA**		**SA** **SA**						
Ellie O'Reilly (minutes) EO	**A**	**A**	**A**	**SA**	**A**								
Clare Woollett (minutes) CW	**A**			**A**									
Emma Walker (minutes) EW							**A**						

KEY: A = Attended, DNA = Did Not Attend, SA = Sent Apology, SD = Sent Deputy, NR = Not Required

Item		Action
Standing Items		
1.	**Welcome, apologies for absence and confirmation of quoracy** Phil Moore, the Chair, welcomed the Integrated Governance Committee (IGC) members and other attendees and apologies were given as indicated above. The meeting was not quorate but would go ahead. Any approvals or recommendations will be recorded and actions noted. It was advised the RCCG equivalent committee to the IGC, the Quality Safety & Performance Committee, had taken place earlier and approval had been given to the papers by this committee that are also on this IGC agenda. Rachel Rowen (RR), Kathy Capus (KC), Nerida Burnie (NB) and Jackie Walters (JW) were in attendance to present items 3 (Aiii) & 12.	
2.	**Declaration of Interest in matters covered on the agenda** There were no new declarations of interest.	
3.	**Minutes of IGC held on the 17th July 2018 and matters arising** The minutes were agreed as an accurate record. **Action Log** The action log was updated as attached. It was advised that "closed" actions in the pack should be taken out for future committees. **Matters Arising:** A broader discussion around QSP took place. If the combined committee arrangements went ahead, it was agreed the committee would need to be truly integrated as it was initially set out to be. The KCCG IGC and RCCG equivalent committee new ToRs would be completed by November. The preference would be for the meetings to take place at Thames House and its effectiveness would be reviewed after a period of three months.	
4.	**Integrated Governance Exception Report** **Integrated Annual Workplan 2018/19** The workplan was on track. Exceptions were represented by: • LAS - latest figures had not been received. • Safeguarding children - as no annual report had been completed due to permanent post holder being on long term leave and the interim nurse having only just joined the organisation, for a period of six months. It	

Item		Action
	was noted that the original post holder had offered to assist with the report when possible from home. • St Georges - no figures had been sent. Assurances, however, had been received. **Update - Dementia Diagnosis Performance in Kingston** KCCG had not achieved the national target of 66.7% dementia diagnosis to date against the expected national prevalence and was an outlier in SWL. In August 61.2% diagnosis rate against a target of 66.7%. had been achieved with1,063 people being diagnosed. (Chart 1) In April 2017, the prevalence criteria had changed from residence to registration of population, which had a further impact on KCCG's performance. (Chart 2) However, it was noted KCCG was not an outliner nationally (Chart 3). The committee acknowledge the difficulties in pinpointing the reasons for KCCG's performance. Care home attachments to practices and possibly demographics were factors. Sarah Wells had been reviewing coding at practices while Kathy Capus alongside Nerida Burnie had visited 12 practices, 9 are pending. **Appendix 1** set out the workflow and outcomes, demonstrating the difficulties in achieving a dementia diagnosis. The action plan, contained in the report, outlined the steps that had been taken to date and further actions, developed in conjunction with NHSE, which were still to be undertaken. Examples being: Pre-assessment counselling, retendering dementia services and improving pathways for Parkinson' patients which did not involve multidisciplinary approach and failed in identifying cognitive impairment. In addition, the committee suggested that a communications campaign, aimed at the elderly and their families, would be considered, as well as targeting the Practice Educational Days. It was also suggested Public Health play a role in tackling the stigma element around a diagnosis. The committee acknowledge the hard work that had been undertaken so far, *noted* the report and *gave support* to the actions outlined. **Performance Exception Report** As at 10th October 2018, Kingston CCG had achieved 85% of the performance indicators. <u>Scorecard</u> Challenging areas were: • Rate of diagnosis - was 61.2% in August 2018 compared to the national target of 66.7%. • RTT - waiting list in August was higher than in March due to Kingston Hospital, whose waiting list had increased, partly down to the impact of the prostate awareness campaign. The patients with longer waiting list (52 week waits) were transfers from St Georges. A letter from Kingston Hospital to James Eaton (NHS Improvement) and Kadir Meer (NHS England) detailing actions was included.	

Item		Action
	• Accident and Emergency - waiting times still a challenge for Kingston Hospital had not met the standard of 95% of patients spending less than 4 hours in A&E. The issues would be reported to the GB in November. • London Ambulance Service (LAS) - clinical performance of the service had improved significantly in 2017-18. • Delayed Transfers of Care - the performance had been consistent. <u>Operating plan</u> The CCG was off plan, by over 2%. Total number of GP referrals had decreased in August, dermatology and urology were the main areas of referrals. The referral rates were comparable to other CCGS. <u>Improvement and Assessment Framework (IAF) Dashboard</u> Primary care facilitators were supporting general practice to ensure that the LD population were on the LD register. <u>Quality Premium Position for 2018-19</u> Reds and Ambers included: • Experience of making a GP appointment (position had not been updated). • CHC performance fluctuating since the beginning of the year but now moving in the right direction. The same red and amber KPIs had been reported for a long time. The report was *noted.*	
5.	**Reporting from Clinical Quality Review Groups (CQRG)** It was noted that: • Chelsea and Westminster Hospital Trust - no report due to scheduling • LAS - no report received. • Kingston Hospital - actions from the audit reports were being implemented. • Your Healthcare - reporting from YH not due until the following week and nothing reporting by exception. • South West London St Georges Mental Health - bed occupancy would be discussed at the following CQRG. The report was *noted* by the committee.	
6.	**Risk Register Report** The winter plan had now been received and would be reflected in the risk register moving forward. The team had updated their actions.	
Quarterly Reporting		
7.	**Infection Prevention and Control Report** Concerns had been raised at the last committee around the numbers in the report matching the graphs and the narrative. The CCG was subsequently informed a new QA process would be in place before the issuing of the next report. The report was presented by the Director of Quality on behalf of Sheila Loveridge.	

Item		Action
	Main areas of focus were: *C. diff* - the CCG was asked to note the increase in community acquired C.diff cases at mid quarter. Small proportion at Kingston hospital, issues at St George's relating to patient isolation. *E.Coli* – not set as a constitutional target, however the CCG's ambition was to reduce cases by 10% from last year. Both Kingston Hospital and St Georges were performing above target and most cases were not hospital acquired. In June 2018, the trust reported a crude rate of 76.4 cases per 100,000 bed days of community-onset E. Coli cases compared to a national average of 97.7 cases per 100,000 bed days. *MRSA* – the CCG has a zero target for MRSA. One case had been reported through the SI route. Challenges around line management, isolation and after care. *MSSA* – greater vigilance and awareness were required but no particular issues to report. No trust apportioned cases. Chickenpox and measles – more work with public health needed undertaking - this had not yet progressed. The GP representative highlighted that he was not aware of Primary Care issues around chickenpox. The committee received report and *noted* the recommendations.	
8.	**Q1 2018/19 Emergency Preparedness Response and Resilience and Business Continuity** A meeting with NHSE had taken place and the informal feedback was that KCCG was assured. Formal assurance would be brought back to a future meeting.	
9.	**Q1 2018/19 Complaints, PALS and MP Letters** Key updates: • 134 contacts had been made with KCCG in first quarter, the PALS function resulted in a patient not being admitted to A&E. • Several issues related to metal health and access to services. • Two complaints had been made against the CHC team: who had to abide by the national framework.	
Integrated Performance Reporting		
10.	**Q1 2018/19 Learning Disability mortality** • Issues identified around care in hospital for patients with learning disabilities. • Two notifications of death had been received in Q1, the second one was for a person with learning difficulties. • Four reviews had been undertaken by KCCG, the target was 70% of notifications completed by December.	
11.	**Q1 2018/19 Medicines Optimisation Report** This was a quarterly report for which the formatting had changed slightly due to the joint reporting. The key focus was self-care and excluded drugs (not prescribing budget but acute commissioning). Points to be noted were: • June had seen an underspend. • The CSU Support Services had been employed to work on IFRs. • Incentive schemes for 16/17 had been closed off and KCCG had been rated green for antimicrobials.	

Item		Action
	• SWL collaborative work streams; KCCG underperformed against these projects due to issues with leadership • Care home tackling medicines' waste – lack of infrastructure to support them. GB GPs had been asked to consider mobilising their workforce into care homes. A business case had been brought to the committee previously and, subsequently, the CCG had employed a new pharmacist from Kingston Hospital and would be recruiting a dietician. • Drop list – mainly self-care initiative. NHSE work streams on deprescribing. The LMC were waiting for the NHSE position and discouraged practices to take up the recommendations, thus impacting the financial outturn. Communications had now been activated after the embargo. ➢ **Action - A question around Astro PU arose – Emma Richmond would study the figures and seek to determine the reason for the anomaly.** <u>Medicine Optimisation priorities documents</u> The paper was designed to set out the scope of practice for medicines team and showed how the team fitted in with the corporate objectives. The new priorities for the team for the following three years were: a. Medicines Optimisation Team (workforce and management; strategy and governance) b. Primary care prescribing c. Secondary care medicines d. Commissioning support to CCG Medicines-related aspects should be considered at every step of the commissioning cycle. This paper would be presented to SMT the following week. Pulling together the different ways of working had been a significant task. Moving forward, the team would be accountable to a GB committee. IGC, QSP or PCCC. The latter providing better scrutiny, with all the GPs in the room. A couple of questions arose: • Scriptswitch - how often was the menu updated? Each organisation had a different profile and as the KGGG team was diminished this had not been updated. • Workshop on deprescribing – did the workshop have an impact? ➢ **Action – ER to investigate impact of deprescribing workshop.**	
Standing and Additional Items		
12.	**Policies for discussion/approval** **End of Life Strategy** This strategy had been developed in conjunction with Richmond CCG. The common areas the organisation wanted to improve were: • Information sharing • Coordination of working better together • Improving processes: discharges, fast tracking of patients, training and education support for carers and access to EOL for all.	

Item		Action
	Main areas of focus for this year were: • Train staff on pathways in primary care, offering advance care planning in secondary care. • Embed EOL care in community settings • Getting more people to focus on deliverables. The key deliverable was to embed EOL care. McMillan had been approached for funding to support the community. Volunteers had been identified to be matched with people who were lonely. The CMC scheme had also been implemented, meaning that chances of dying home were 80/20 vs 50/50 without a record. Another work stream would be around patient satisfaction. The report was *endorsed* and should be taken to GB for info and ratification. **Winter Plan** The report provided the details of the Winter Plan. There would be some minor changes ahead of the GB in November (additional description of flu vaccination and staff availability). An extra session was planned in the surge plan. Mental Health also needed updating aby SWL St Georges (as new Chief Operating Officer in post). Challenged with flu delays for vaccinations of over 65s. **Quality Impact Assessment** Two QIPP projects did not receive clinical support: R038 – Mental health no uplift R039 – Learning disability no uplift Two QIPP projects did not have a QEIA • R011 – TOPs, this was a 17/18 project run by the council on behalf of Richmond CCG • R035 – POLCE IVF FYE, this is a 17/18 projects that has impact in 18/19 and closed at the end of August	
13.	**Any other business** None	
14.	**Date of Next Meeting** 20th November **2018** 18th December @ 15:30hrs – 17:30hrs in the Cedar/Willow Room - 2nd floor, Thames House, 180 High Street, Teddington TW11 8HU. **2019** 15th January 19th February 19th March @ 15:30hrs – 17:30hrs in the Cedar/Willow Room - 2nd floor, Thames House, 180 High Street, Teddington TW11 8HU.	

Kingston Clinical Commissioning Group Governing Body meeting in public	
Date	Tuesday, 05 March 2019

Document Title	Primary Care Commissioning Committee minutes of meeting on 4 December 2018		
Lead Director (Name and Role)	Kathryn MacDermott, Director of Primary Care & Planning		
Clinical Sponsor (Name and Role)			
Author(s) (Name and Role)	Kathryn MacDermott, Director of Primary Care & Planning		
Agenda Item No.	4.1	**Attachment No.**	M3

Purpose (Tick as Required)	Approve	Discuss	Note
			✓

Minutes of the Kingston CCG Primary Care Commissioning Committee meeting in public

Date: **4 December 2018**
Time: **3pm to 5pm**
Location: **King's Centre, Chessington**

PRESENT:
Members:

Jim Smyllie	Lay Member, PPE and Chair
David Knowles	Lay Member & Vice Chair
Tonia Michaelides	Managing Director, Kingston & Richmond CCGs
Yarlini Roberts	Director of Finance, Kingston & Richmond CCGs
Kathryn Yates	Governing Body Nurse Member
Nadeem Nayeem	Secondary Care Specialist
Dr Graham Lewis	Independent GP Advisor

In Attendance

Kathryn MacDermott	Director of Primary Care & Planning, Kingston & Richmond CCGs
Liz Meerabeau	Healthwatch Kingston
Dr Julius Parker	Chief Exec, Surrey & Sussex Local Medical Committee (LMC)
Dr Phil Moore	Governing Body Deputy Chair, Clinical
Dr Naz Jivani	Governing Body Chair & GP
Dr Gareth Hull	Governing Body GP
Dr Naeem Iqbal	Governing Body GP
Dr Annette Pautz	Governing Body GP
Joe Reed	SWL Alliance Primary Care Contracting Team
Terry Silverstone	Kingston & Richmond Local Pharmaceutical Committee (LPC)
Omid Gilanshah	Head of Primary Care
Jack Edge	Primary Care Transformation, SW London HCP
Penny Williams	Kingston GP Chambers
Lindsay Marshall	Corporate Business Manager, Richmond CCG (minute-taker)

APOLOGIES FOR ABSENCE:

Paul Gallagher	Lay Member and Audit Chair
Cllr Margaret Thompson	Health & Wellbeing Board representative
Iona Liddington	RBK Public Health

Dr Atin Goel	Chair, Council of Members
Dr James Benton	Practising GP
Dr Pete Smith	Governing Body GP
W Cunningham-Davies	SWL Alliance Primary Care Contracting Team

Item No	Agenda Item	Attachment/ Action
	STANDING ITEMS	
1.1	**CHAIR'S WELCOME AND CONFIRMATION OF MEETING QUORACY** The Chair welcomed members to the fifteenth meeting of the Kingston CCG Primary Care Commissioning Committee. The chair declared that the meeting was quorate. The chair informed the meeting that there would be a seminar following the meeting in public, followed by part 2 meeting for voting members only.	
	DECLARATIONS OF INTEREST The chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Kingston CCG. Interests declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests. The Register is available either via the Governance & Business Lead or the CCG website at the following link: http://www.kingstonccg.nhs.uk/about-us/primary-care-commissioning-committee.htm **Declarations of interest from Sub-Committees** None declared. **Declaration of interest from today's meeting** There was an interest declared relating to item 2.2, Minor Surgery Services, by the following GPs who currently provide these services: Dr Phil Moore, Dr Naz Jivani, Dr Gareth Hull, Dr Naeem Iqbal, Dr Annette Pautz, and Dr Graham Lewis.	
1.2	**MINUTES OF THE LAST MEETING HELD ON 2 OCTOBER 2018** The minutes of the last meeting held on 2 October 2018 were approved as an accurate record of the meeting.	A
1.3	**MATTERS ARISING AND ROLLING ACTION LOG** **1) KPCC01, Item 14 Public Questions from 7.8.18**: In answer to a query form member of public IK, Omid Gilanshah (OG) had undertaken to report back on progress on exploring options around Warfarin testing, including the use of safe patient testing including INR, home testing and handheld machines. *OG reported that there was a programme underway to look at options. He would put the member of public IK in touch with the programme lead.* **2) KPCC02, Item 13 Delegated primary care commissioning finance report from 7.8.18:** Jenny Sinnott (JSi) had undertaken to review how the allocation of funding was reported in relation to the KMS budget, and bring this information back to the December PCCC. *Yarlini Roberts (YR) undertook to cover this point in the finance report*. All other outstanding actions/matters arising were being taken forward on the agenda.	B OG

Item No	Agenda Item	Attachment/ Action
1.4	**ITEMS TAKEN IN PRIVATE ON 2 OCTOBER 2018:** • *SWL IUC Procurement* • *Chessington Park CQC breach notice*	
2	**STRATEGY AND COMMISSIONING**	
2.1	**PRIMARY CARE AT SCALE** The PCCC received a report that provided an update on the progress of the five Kingston primary care at scale (PCAS) bids which the PCCC had approved for further development at the August PCCC. Penny Williams (PW) from Kingston GP Chambers took the committee through the report and commented that Chambers had used the feedback from the PCCC to make the projects more innovative. She noted that the aim was to help practices work together to implement projects which provide a direct benefit to the practice and would help manage the GP recruitment problem. One of the expected benefits of the PCAS projects is releasing GP time from back office functions so they can focus on more complex patient problems and release time for more effective consultations. It was noted that the projects were pilots and work in progress, and the aim was to ensure sustainability by identifying workforce skills and requirements going forward. The projects consisted of two network bids and three back-office projects. The network bids were on time and working to the project plan, whereas the three back-office projects were delayed through IT issues or lack of project management time. Progress on the projects was being reviewed regularly. It was intended the back-office projects would be rolled out to other practices. Member of public RR raised that at the PCAS seminar on 26th June some practices had suggested developing their own IT solutions as some hospital letters could not be read by some GP surgeries and he felt that this might not be the best use of money. In response PW explained that Docman had a history of incompatibility with most other systems. However, work was underway to improve interoperability and the hospital was looking to commission a new version of Docman which would be more compliant. Member of public RR felt that Chessington Surgery should be asked to get involved in a pilot. PW explained that there were areas with strong representation that had been ideal for developing the pilot but the learning would then roll out to other areas including Chessington. *The PCCC supported the direction of travel.*	C
2.2	**SUMMARY OF MINOR SURGERY SERVICES IN SOUTH WEST LONDON AND RECOMMENDATIONS FOR 2019/20** *Interests were declared relating to being providers of minor surgery services by: Dr Phil Moore, Dr Naz Jivani, Dr Gareth Hull, Dr Naeem Iqbal, Dr Annette Pautz, and Dr Graham Lewis. The Chairman considered that the GPs could remain in the room for the discussion. They would not be involved in any decision as they were non-voting members.* The committee received a paper providing an overview of the various minor surgery services provided in primary care and making a recommendation to commission the complex minor surgery services via the existing London Minor Surgery direct enhanced service (DES) for one further year from April 2019. Joe Read (JR) took the PCCC through the paper. He explained that the additional year would give the CCG an opportunity to consider how to commission the service going forward. It was noted that the London Wide Minor Surgery DES was introduced in January 2014 and all except for three CCGs in London had signed	D

Item No	Agenda Item	Attachment/ Action
	up to the DES. A decision was now required on commissioning these services from April 2019. During the discussion it was suggested that the list of practices signed up to the minor surgery service may have some inaccuracies and should be checked. Dr Julius Parker (JP) reported that the LMC was supportive of the recommendation as it would avoid CCGs having to commission the service themselves. The report also drew attention to the decommissioning of the inter-referral scheme portal from 31st March 2019, which had been discussed in the PCQDG and which Kingston was looking at taking forward via GPTeamNet. *The PCCC approved the recommendation to commission the London DES for another year from 1st April 2019.*	
2.3	**MINUTES OF THE LAST LOCALLY COMMISSIONED SERVICES STEERING GROUP OF 24TH JULY** (*standing item*) The committee received and noted the minutes of the last locally commissioned services steering group of 24th July. Amongst the points noted were that the group was doing work on cost pressures within LCSs. Some work had been started on shared care drugs and diabetes in partnership with Richmond.	E
2.4	**SWL TRANSFORMING PRIMARY CARE UPDATE** The PCCC received an update on the SWL Primary Care Transformation Programme, which supports and drives delivery of primary care transformation and the ambitions in the General Practice Forward View across SWL. Jack Edge (JE) from the Primary Care Transformation team at the SW London HCP, took the PCCC through the report. Amongst the key issues raised were: • The roll out of online consultations in primary care has begun, and is now live in 17 practices across SWL (one in Kingston). • The next wave of clinical pharmacist bids closes on 23rd November, with another wave closing on 22nd February 2019. • The Primary Care at Scale assurance pack has been submitted to NHSE to secure the second tranche of transformation funding. • One practice in Kingston was working on the international GP recruitment programme. • Several practices in Kingston were being offered support under the resilience programme, the majority through Kingston GP Chambers. • Three surgeries had signed up to on-line consultations and practices were encouraged to join. Naeem Iqbal (NI) was interested in receiving feedback on how the on-line consultations were being used on a day to day basis, for example how many consultations were taking place and feedback from patients. JE reported that the project was in its early stages and the team was working on producing more information that could be shared. • KY requested more information on workforce projects and JE agreed to invite her to the SWL Workforce Delivery group. • Liz Meerabeau (LM) commented that the workforce theme was not well developed in the STP, particularly around skill mix in primary care. She also felt that the on-line consultations scheme should be discussed at the primary care forum in Kingston in order to widen the scope of patient engagement. JE would arrange for the project lead to contact LM. Member of public RR was keen to provide his feedback on the project and JE reported that the team was working on developing public and patient engagement.	F JE JE

Item No	Agenda Item	Attachment/ Action
3	**FINANCE AND PERFORMANCE**	
3.1	**SWL PRIMARY CARE CONTRACTUAL SUMMARY** The Committee received and noted the Contract Summary Report 2018/19 Q3 which showed contract variations, infection control and CQC visits. Joe Reed (JR) took the PCCC through the report.	G
3.2	**EXTENDED PRIMARY CARE ACCESS UPDATE** **3.2.1 Extended access highlight report** The committee received an update on the progress of the extended access service, together with the monthly access highlight report. It was noted that utilisation had increased to 86%. KM noted that the Chessington hub was less busy at the weekends and was proposing further engagement work with Chessington residents to encourage them to use the hubs. It was noted that instead of the GP access highlight report CCGs would be submitting data using an on-line portal, and there would be a review of how information was presented to the PCCC. KM asked for feedback from the committee about what sort of format they would prefer. PM queried the figure of 88% booked appointments and OG agreed to check these figures with Chambers. KY questioned whether the format of the friends and family feedback could be changed to be presented in a more meaningful way to aid understanding. She suggested making questions more detailed and including more commentary around self-care, and improving feedback to members of the public. It was agreed that KM and KY would meet outside to discuss. NI drew attention to the fact that the PCCC had still not received any feedback on when the equality impact assessment (EIA) would be implemented. KM reported that she had raised the subject at the SWL transforming primary care delivery group and was awaiting a response. She suggested that it may be best to wait until the new services were commissioned before carrying out the assessment. Confirmation was awaited from the HLP whether EIAs should be done by individual CCGS or across SWL. Nadeem Nayeem (NN) queried whether the hubs had led to a reduction in A&E attendances. TM felt that there had been an impact on A&E attendances, if only to hold them static. NI raised that there had been concerns raised at the Health and Wellbeing Board around lack of hub provision in the Coombe and New Malden area. TM felt that there was a need to examine whether further services were needed by looking at demographics and whether there is a shortage of services, as Kingston generally was not under provided with primary care capacity. NJ agreed and suggested a review of services required by the borough and the rationale behind them. Member of public RR commented that there was a need for improved communication around weekend hub availability in Chessington. He felt that a better model would be to have GPs operating during the week and hubs operating at the weekend to give GPs a break. **3.2.2 Extended access audit** The committee received a report showing the results of the audit of the utilisation of Kingston's three extended access hubs located in Surbiton Health Centre, Kingston Health Centre and Merritt Health Centre. The audit had been carried out by Kingston GP Chambers at the request of the CCG and had covered A&E and NHS 111 bookings, patient feedback, appointment information and DNAs (non-	H KM/KY

Item No	Agenda Item	Attachment/ Action
	attendance). A number of actions had been identified which GP Chambers was taking forward. Key issues had been: 1. Practices under-utilising the hubs – as a next step, the CCG has asked GP Chambers to contact these practices to understand the reason. 2. No hub in New Malden – the CCG has asked GP Chambers to review the locations of the service to see if a 'spoke' could be trialled in New Malden. 3. Weekend v Week day capacity – The CCG has asked GP Chambers to consider in more detail the number of weekday and weekend appointments available as patients in different locations have favoured one over the other. KM was planning a deep dive into provision and utilisation in Coombe and New Malden as practices in those areas only recorded 14% utilisation. Action will also be taken to attempt to address inequity in access to hub appointments. In relation to DNAs, the CCG had worked with Chambers to put in place a system where patients could cancel an appointment however it was not yet operational. Attention was drawn to the need to improve communication, accessibility of information and promotion of the service. Some practices' websites could be improved to make the information clearer. DK expressed disappointment at the absence of communications in surgeries about hubs which meant that awareness of the hubs amongst Kingston patients was still relatively poor. KY suggested a "you said we did" approach to demonstrate that action was being taken. A member of public RR suggested putting more information about the hubs on residents' association websites. GL pointed out that hubs had been running longer in Richmond and were at 98% capacity and he would be concerned about raising expectations that there was more capacity than was the case.	I
3.3	**E-REFERRAL SYSTEM UPDATE** (*monthly standing item*) The committee received a progress report on the national NHS e-referral (e-RS) paper switch off (PSO) project. It was noted that utilisation continued to improve. 2WW referrals at KHFT were now live and were being monitored by NHSE and NHS digital. Kingston Hospital and Kingston and Richmond CCGs continue to work in partnership to resolve implementation issues. There was still considerable variation across Kingston practices and some practices' utilisation between September to November had fallen. It was requested that any practices that felt they need training or support should contact the PC facilitator or team who can log the issue and provide support. Leaflets were available to be circulated to practices and patients to explain e-RS. PM asked for the layout of the chart to be revisited as he felt that it was not easy to interpret. It was noted that the last column should say "Nov 2017- Sept 2018 change" as it showed the increase over the previous year. TM emphasised that the utilisation performance was very positive as it had increased month on month. There would be a focus on practices that need support. NJ drew attention several instances where patients had been given access to cancel clinics and rebook into other clinics but had booked themselves into the wrong clinic subsequently, and felt that this needed monitoring.	J

Item No	Agenda Item	Attachment/ Action
3.4	**SWL INTEGRATED URGENT CARE PERFORMANCE REPORT** *(standing item)* The committee received a report showing performance data for August 2018 for the SW London IUC contract. The service consists of NHS 111 (advice, promotion of self-care, and treatment for patients with an urgent health need 24/7) and Out of Hours (OOH). It was noted that performance and activity levels had declined and SW London was working with the provider to identify the reason behind the drop and to improve the service. A deep dive had been requested.	K
3.5	**PRIMARY CARE FINANCE UPDATE** Members received the primary care budget report for month 7 (October 2018). Yarlini Roberts took the committee through the report. Amongst the main points noted were: • At month 7, an overspend of £601k is forecast, mainly due to delegated commissioning and locally commissioned services (LCS). • Under delegated primary care budgets, there had been a rise in pay awards which had increased costs on PMS and GMS services. In relation to the KMS budget, YR went through funding streams that had led to the delegated commissioning overspend. • Attention was drawn to slide 5 which showed LCS budgets. There was an increase in the number of diabetic patients and there was a need to look at the pathway in both Kingston and Richmond. • With regard to shared care drugs, it was noted that the primary care and medicines optimisation teams were working together to resolve the issues that had led to the large overspend. KM reported that the practices had been claiming for drugs that were considered transfers of care rather than shared care. It was being monitored at the LCS steering group. The CCG had made a commitment to honour the payments for this year but would need to clarify shared care and transfers of care going forward. • AP questioned why on page 6 the complex needs service specification was not included on the list. YR agreed that she would check why it was not included. • It was noted that the overspend for delegated primary care was considerable and there was a need to examine how to make the service more sustainable in terms of budgets. Member of public RR drew attention to the fact that the NHS was now offering Freestyle Libre for diabetes patients and he asked whether there was extra money given to CCGs to fund it. YR reported that CCGs would have to fund it from their current prescribing baseline.	L
4	**QUALITY AND GOVERNANCE**	
4.1	**PRIMARY CARE RISK LOG** The committee received and noted the primary care risk log. It was noted that there were no changes to the risk log since the October meeting. The risk pertaining to DXS had been downgraded as it had been fully implemented. In relation to the risk around the IT strategy, it was noted that notification had been received that the GP IT capital bid had been approved. It was raised that the Richmond PCCC had discussed whether it was appropriate to include a risk around primary care workforce in the local risk registers. The PCCC agreed that this risk should be added to both logs. The scope of workforce would include all primary care staff, including admin and clerical and nursing.	M KMac

Item No	Agenda Item	Attachment/ Action
5	**FOR INFORMATION**	
5.1	**MINUTES OF THE LAST PRIMARY CARE QUALITY & DEVELOPMENT GROUP MEETING ON 2 OCTOBER 2018** The committee received and noted the minutes of the last primary care quality & development group (PCQDG) meeting on 2 October 2018. PM raised that there was a need to review the terms of reference of the PCQDG and reschedule dates to enable the PCQDG to feed into the PCCC. JP queried point 59 on the action log on page 2 concerning locum reimbursement. It was noted that it related to one-off claims in the interim period before the FAQs and the new locum reimbursement policy were issued.	
5.2	**ANY OTHER BUSINESS** There was no other business.	
5.3	**DATES OF NEXT MEETINGS *(all Tuesdays at 15:00 to 17:00 at the* King's Centre, Coppard Gardens, Chessington, KT9 2GZ** • 5 February 2019 • 2 April 2019	
6	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	
	The following questions were raised: 1) A member of public (RR) asked the following question: Is there any timeline for responding to the Ofsted/CQC report on SEND (Special Educational Needs or Disabilities) services in Royal Borough of Kingston? Response: TM reported that the Royal Borough of Kingston was leading on it and an action plan was being developed. It would be an agenda item for the Kingston CCG governing body in public in January. 2) A member of public (KB) asked the following question: Can the CCG confirm that the glucose monitoring system Freestyle Libre would be available for suitable type 1 diabetes patients. Response: It was confirmed that there was a Kingston CCG policy that would allow this treatment to be available for type 1 diabetic patients who met the applicable criteria.	

Amended by KMac 27.1.19, JS 28.1.19
Amended and approved by PCCC on 5.2.19

ROYAL BOROUGH OF KINGSTON UPON THAMES

HEALTH AND WELLBEING BOARD

15 NOVEMBER 2018

(7:30 pm – 9:50 pm)

Members of the Board

Councillors:
Councillor Liz Green (Co-Chair), Councillor Rowena Bass*, Councillor Ed Fram, Councillor Dave Ryder-Mills, Councillor Margaret Thompson*, Councillor Diane White

Representatives from Kingston CCG, Healthwatch and the Voluntary Sector:
Dr Nazim Jivani (Co-Chair), Dr Phil Moore, Dr Peter Smith*, Dr Liz Meerabeau, Patricia Turner

Council Officers (non voting):
Robert Henderson*, Iona Lidington, Stephen Taylor

Advisory Members (non voting):

Siobhan Clarke – Your Healthcare*, Tonia Michaelides – Kingston CCG, Dr Mark Potter – South West London and St George's Mental Health Trust*, Jane Wilson – Kingston Hospital NHS Trust*, Gwen Kennedy – NHS England*, Dr Anthony Hughes - GP Chambers*

*Absent

29. QUESTIONS AND PUBLIC PARTICIPATION

There were no questions from the Gallery.

30. DECLARATIONS OF INTEREST

There were no declarations of interest.

31. APOLOGIES FOR ABSENCE AND ATTENDANCE OF SUBSTITUTE MEMBERS

Apologies were received from Councillors Margaret Thompson and Rowena Bass. Councillors Alison Holt and David Cunningham attended as alternates respectively.

Apologies were also received from Jane Wilson and Siobhan Clarke and Sally Brittain and Grant Henderson attended as alternates respectively. Apologies were received from Dr Anthony Hughes, Dr Pete Smith and Stephen Taylor.

32. MINUTES

Dr Liz Meerabeau sought clarification of the MESCH approach referred to in Minute 25 of the last meeting. The Director of Public Health provided the following information:

The Maternal Early Childhood Sustained Home-visiting (MECSH) approach is to reduce inequalities by improving the health and social wellbeing of vulnerable families with new babies, while also strengthening child and community health service provision through the integration and coordination of services, particularly via health visitors.

RESOLVED that:

1. the above paragraph be added to Minute 25; and

2. the minutes as amended were confirmed as a correct record and signed by the Co-Chair, Councillor Liz Green (in the Chair).

33. PARTNERS' UPDATES AND THE WORK PROGRAMME Appendix A

The following information was presented in the Partners' Update report:

Public Health:

- Mental Health Time to Change Hub – this is a forum for local people and local public, private and voluntary organisations to come together to end the stigma and discrimination experienced by people with mental health problems.
- Mental Health Champion (MHC) lead Councillors - following approval at Council on 18 October, MHCs are being appointed for each strategic committee. The Health and Wellbeing Board will receive updates regarding the work of MHCs as part of the implementation of the Thrive Kingston Mental Health Strategy.
- Preventing and reducing the impact of drug and alcohol misuse – an update on the work of the Kingston Wellbeing Service which works in partnership with Moving on Together to support recovery. An event took place at Surbiton Health Centre on 27 September to celebrate recovery month. A clip from a video was shown.
- Health protection – winter preparedness – Local health partners have developed winter plans to deal with increases in respiratory and cardiovascular illness and promotion of stay warm in winter and flu vaccinations campaigns are underway with vaccination being delivered in a staged way. There were initially some vaccine supply problems. The "Haven" winter night shelter will be open from 8pm to 7.30am nightly until March 2019 operated by the Kingston Churches Action on Homelessness. There are some concerns about the number of people accessing this service.
- Health Protection Committee – the setting up has been deferred due to senior staff losses.

- Public Health Workforce – recent organisational change has led to the public health function being brought under the new Communities directorate along with a number of other functions. The introduction of a new organisational structure has led to the loss of three senior colleagues and thanks were noted for their professionalism and commitment.
- Connected Kingston – this will become publicly available in January 2019 and an application to the Local Digital Fund will be made to enable further developments.

Kingston Hospital NHS Foundation Trust:

- Performance Targets - the Hospital is continuing to perform well on cancer targets, the 18 week referral to treatment time and A&E performance is around 90% seen in 4 hours.
- Delayed transfers of care – the numbers of patients who have been delayed in in hospital for more than 6 days and more than 231 days have been falling.
- Winter plans have been approved by the A&E Board and submitted to NHSE
- Transformational projects on theatre productivity and outpatients are progressing
- Workforce Developments – the Trust received a national award from the Skills for Health, Health Heroes for Health and Wellbeing and staff retention
- A new Mental Health Assessment Unit adjacent to the emergency department is being progressed with phase 1 opening on Christmas Eve and phase 2 during 2019.

Kingston Clinical Commissioning Group:

- Health and Care Plan engagement – an engagement event is taking place on 21 November
- Over the counter medicines publicity has been developed and will be made widely available for patients along with winter messages promoting the use of Pharmacies for advice
- Outpatient transformation project – NHS organisations in Kingston are collaborating to transform outpatient services so patients and GPs can access the advice and services of specialist clinicians in the most efficient and effective way.
- South West London Health and Care Partnership update – work has been progressing on the following areas Children and Young People, End of Life Care, connecting Care, Local Health and Care Plan and Joint workforce priorities
- Finance update – the CCG expects to meet its planned 0.4% surplus of £1.06m and the QIPP savings of £9.8M.

Adult Social Care:

- Maximising independence – the new model has been in place for 4 months. All clients who need some support to become independent receive a 5 day service including a full assessment. Where needed, extra reablement support is provided for 3 weeks. After this time an ongoing package of care may be required by some.

- Home to Decide – is a programme for people being discharged but have been assessed as needing residential placement. It provides 24hour support and assessment for 3 days and a further 11 days enablement support to maximise independence.
- Safe and Connected Royal Mail pilot in Kingston to tackle loneliness in older people
- ASC Organisational Change – Assistant Director posts have been recruited (Jane Bearman – Operations, Martin Sanford Hayles – Commissioning and Transformation). Corporate Heads of Service are being recruited.
- ASC now includes community housing

Healthwatch Kingston:

- Has planned the Health Care partnership engagement event on 21 November
- Work around the Youth Out Loud! Initiative to engage with young people on health and social care services.
- HWK chairs and administers the Thrive Kingston Mental Health Strategy Planning and Implementation Group.
- Bidding for the Time to Change Kingston Hub
- Co-chairing with a person with LD the Kingston All-Age Learning disability Partnership Board
- Enter and View report of Kingston Adult Community Services at Safe and Connected Royal Mail pilot in Kingston to tackle loneliness in older people
- The Enter and View report of Kingston Adult Community Services at Tolworth Hospital will be published imminently
- A discharge form Kingston Hospital survey will be run for a month from 5 November, with a second month in March 2019.
- Service User Survey for ICope (IAPT service) is due to go live in November and end in March.

Kingston Voluntary Action:

- Food Poverty – the action plan is awaiting sign off before it is shared with the Board. A number of insights have been reflected in the final draft.
- Connected Kingston – Social Prescribing Programme which has been co-produced with KVA to train Connected Champions who will provide help and support to access information about opportunities which will have a positive impact on people's health and wellbeing.
- Mental Health – KVA has participated in the mental health strategy Planning and Implementation group and will now participate in the Time to Change Steering Group. It is also working with the LSCB on mental health and risky behaviours to help prevent problems and hospital admissions.

During discussion a question was raised by Mary Clark, in the gallery about the absence of a winter hub in the Maldens and Coombe area. Dr Jivani replied that there are three hubs in Kington, Surbiton and Chessington which serve the whole of Kingston and people can attend any of these. They are open from 7am to 8.30pm and provide extended access, not just services over the winter period. Dr Jivani stated that feedback suggested that people in the New Malden area are happy to

attend these hubs. He added that the hubs are not used to capacity and especially on Sundays and usage is reviewed on and on-going basis. Tonia Michaelides added that there is now an urgent treatment centre at front of A&E at KHT which is staffed by GPs. Mrs Clark pursued her question and suggested that only 5% of elderly people access the other hubs as two bus journeys are needed. The Co-Chair asked the CCG to provide a fuller response to Mrs Clark.

The Board considered the work programme for the forthcoming meetings.

RESOLVED that:

1. The Partners' Updates are noted; and

2. The work programme is agreed as follows:

   31 January 2019
   Update on Communicating with people to encourage seeking of dementia diagnosis to enable provision of support for living well
   Food Poverty Action Plan
   "Prevention is better than Cure" DHSC White paper (published 5 November)

   28 March 2019
   Health Protection Committee Terms of Reference

3. Discussions are held by respective Communications Teams to ensure efficiency with health communications aimed at the public.

Voting: unanimously in favour

34. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TRANSFORMATION PLAN 2018 REFRESH — Appendix B

The report, introduced by Doreen Redwood, Lead Children's Health Commissioner, K&R CCGs, provided information to the Board about the Child and Adolescent Mental Health (CAMHS) Transformation Plan 2018 Refresh.

The NHS Five Year Forward View 2015 included the aim to ensure sustainable improvements are made in children and young people's (CYP) mental health outcomes by 2020 and the Transformation Plan provides the local vision, the priorities, service improvements and actions to address the mental health needs of children and young people and parents/carers of the local populations.

The Plan is refreshed annually and is submitted to NHSE and the CCG receives an allocation of £377K to support the programme. This year's assurance process is lighter touch and focusses on addressing new areas introduced in the key lines of enquiry: Transparency and governance, understanding local need, workforce, collaborative and place based commissioning, health and justice, improving access to psychological therapies for children and young people, eating disorders, data, crisis care. The Plan is developed using participation methods including engagement with children, young people, parents and carers.

During the three years that the Transformation Planning process has been in place there have been achievements in the following areas:

- Training in school
- Introduction of on-line counselling, support and advice
- Increase in support for eating disorders
- Increase in support in A&E
- Recruitment of more people
- Increasing the uptake of support

Challenges to delivering the plan are:

- Waiting times which have not reduced as planned
- Difficulties recruiting
- Increasing demand for services
- Increasing admissions to hospital
- Developing the right help for CYP with learning disabilities and challenging behaviour

2018/19 ambitions, priorities and delivery have been developed using the five outcomes identified in “Future in Mind” guidance issued in 2015 i.e.

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without Tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce.

The report identified priorities under each of these and Board’s views were sought.

During her introduction Doreen Redwood stated the strategic approach in South West London is to reduce in-patient admissions for CYP and locally we have a community based service. Tonia Michaelides added that there is a greater emphasis on preventing the development of mental health problems.

The Board heard that there were challenges. Pre- and post diagnostic support for Children with Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity disorder (ADHD) is a challenge and an improved pathway is being developed to make access easier. Waiting list pressures are not unique to Kingston and an increasing demand for services can often follow successful service provision. The national target of increasing access to treatments to 32% may not be achieved but progress has been good so far.

A question was asked by James Moore in the Gallery. He suggested there is a shortage of in-borough places for children with SEND and asked for details of the numbers who do not have in borough service. Ian Dodds responded that there was a reliance on out of borough provision and currently about 6 are provided for in this way but the intention is to build more local capacity. Charis Penfold added that Kingston is a small borough and does not have the ability to provide a wide variety of care and it can therefore be appropriate to have an out of borough placement. Mr Moore asked a further question about whether children are appropriately placed out

of borough. Ian Dodds agreed to look at the details and provide an answer outside of the meeting.

The following points were made by members:

In response to a question about the capacity to meet the Plan's aspirations, Doreen Redwood replied that there is a need to increase the capacity for the Single Point of Access to meet the growing demand in schools and need to provide fast access to someone to talk to.

Attention was drawn to the pressures on mental health arising from unmet housing needs; the consequences of eviction on children can be enormous especially where families are relocated at some distance.

Doreen Redwood pointed to a new service in schools offered by child wellbeing practitioners who deliver low level interventions for parents and young people. Whilst this cannot meet all needs progress is being made and any national investment for mental health teams in schools will enable further progress.

Dr Phil Moore drew attention to ensuring the needs of home educated children are met.

Further information was requested about the detail about how progress is made and monitored and it was agreed that the draft Transformation Plan would be circulated to members.

RESOLVED that:

1. The information in the report and provided verbally is noted;

2. A six-months' progress monitoring report is presented for consideration at a future meeting of the Board;

3. Comments made about the ambitions, and the need for further details about how they will be achieved are noted by the CCG; and

4. The full draft plan would be circulated to members of the Board.

Voting: unanimously in favour

35. ALL AGE LEARNING DISABILITY STRATEGY Appendix C

The report, introduced by Elizabeth Brandill-Pepper, Corporate Head of Service, Specialist Commissioning, set out Kingston's five year Joint Health and Social Care Strategy for Children, Young People and Adults with Learning Disabilities (LD). Approval of the strategy (attached at Annex 1) is being sought by the Children's, Adults' and Education Committee on 22 November and the Board was requested to endorse it and was asked to ensure that the strategy is reflected within members' own organisation's strategic plans.

The Strategy has been produced in three versions – a full technical version, a summary and communication document and an easy read version.

The All Age Learning Disability Strategy replaces the earlier Learning Disability Strategy which expired in 2017. It has been co-produced on the basis of local needs outlined in the Learning Disability Joint Strategic Needs Assessment (JSNA), the Special Educational Needs and Disability JSNA and extensive engagement work with families and carers. The strategy aims to "increase independence, improve access to mainstream services and community assets thereby leading to increase cost efficiency and value for money". It is aligned with the three LD outcome measures in the joint NHS, Adult Social Care and Public Health outcome Framework, other national drivers and the Marmot Review (which considers inequalities in health outcomes which for people with learning disabilities can mean that their lives are up to 20 years shorter than average). The Strategy identifies key interventions for early years, transition and adulthood and these are framed around themes of maximising independence, strengthening the pathway from education to employment, being part of Kingston and having good health. The Strategy also focusses on improving choice about where people live i.e. away from institutional care and within the community.

Healthwatch Kingston has been commissioned to provide chairmanship to the All Age Learning Disability Partnership Board which oversees the actions associated with the plan and the Partnership Board includes representation of people with learning disabilities and their families.

The following points were raised in discussion:

Members complimented officers on the three version approach and some expressed a preference for the easy read document and the version for people with leaning disability was particularly welcomed. The Board was informed that the Council has a resource to enable easy read versions to be produced and this approach will be taken forward for other strategies, including the joint Autism Strategy.

Grant Henderson, Your Healthcare, drew attention to some specific comments on an earlier version of the document which had not been reflected and he would welcome opportunities for further discussion.

Comment was made about the specialist support and assistance which people with LD may require when in touch with the Contact Centre and the general on-line approach to finding out about services may present a real barrier for them. In response Elizabeth Brandill-Pepper accepted that the Contact Centre could be an overwhelming place to visit and Peer Advocates (people with LD employed by Council to improve accessibility) are currently undertaking an audit of the Contact Centre and Job Centre Plus to identify any improvements would could be made.

A question was asked about whether the housing department had been involved in the formation of the strategy and in response it was confirmed that community housing now sits within adult social care which will lead to efficient working and breakdown silos. Housing stock will be used differently and be more appropriate for people with LD and will promote their independence with the use of assistive

technology. Further work with developers is taking place in the housing market to enable more in-borough provision rather than sending people out of borough.

In response to a question about Education, Health and Care Plans (EHCPs), Ian Dodds confirmed that 1200 people in Kingston have EHCPs and the demanding for these is increasing annually by 9%, but this is slightly less than 11% annual increase in demand nationally. The focus is on those with most complex needs and also to provide interventions early for children so they can be helped to develop resilience and independence to reduce need ahead of transferring to adult services.

RESOLVED that:

1. This Board endorses the All Age Strategy for People with Learning disabilities;

2. This Board notes that the Strategy will be delivered via the All Age Learning Disability Partnership Board chaired by Healthwatch Kingston;

3. Members of the Board ensure that the Strategy is reflected within their own organisations' strategic plans and the Strategy is shared using a joint communications approach for alerting organisations; and

4. The suggestions and comments made above are taken forward by officers as appropriate.

Voting: unanimously in favour

36. SEND INSPECTION BRIEFING Appendix D

The report, introduced by Ian Dodds, Interim Chief Executive, Achieving for Children (AfC) and Charis Penfold, Director for Education Services, AfC, briefed the Board on the recent Office for Standards in Education, Children's Services and Skills (Ofsted) and Care Quality Commission (CQC) inspection of services for Special Educational Needs in Kingston for people age 0 to 25. The inspection took place between 17 and 21 September 2018. The full letter dated 23 October 2018 was attached at Annex 1.

The purpose of the review was to judge the effectiveness in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014. As well as visiting a range of providers, meetings were held with leaders for health, social care and education. A letter setting out the findings of significant areas of weakness was sent to the Director of Children's Services. The letter identified areas for further improvement and also highlighted areas of strength.

Areas of significant weakness were identified as:

- The overall poor quality and monitoring of Education, Health and Care (EHC) plans, including contributions from health professionals

- The timeliness of leaders ensuring that the annual review process and any subsequent amendments to EHC plans are consistently made in line with the SEN code of practice
- The strategic leadership and monitoring of the CCG's work in implementing the 2014 reforms
- To ensure that there is a productive and positive relationship between parents and parent representatives, including a parent carer forum.

Areas of strength and good practice include:

- The single point of access (SPA) and the added value of the SPA supporting earlier identification of SEND needs and faster access to specialist support services
- Co-location of services
- Early years provision, including Portage for pre-school children and information sharing between professionals eg health visitors and nursery
- Parents value the support and input of professionals

Senior officers will be meeting the Department for Education on 20 November to discuss how the four areas of weakness will be addressed and actions being undertaken by Achieving for Children, Kingston Clinical Commissioning Group and Public Health were set out.

Kingston is required to submit a Written Statement of Action within 70 days of the receipt of the letter ie by 8 January 2019. The Statement of Action will be evaluated by Ofsted and the CQC within 10 days of receipt and Ofsted and the CQC will formally sign off the Statement of Action for the Local area. The intention is that the Written Sign off Statement will be brought to the next meeting of the Health and Wellbeing Board on 31 January 2019. The Board heard that Written Statements of Action can be lifted within 12 to 18 months by the Inspection Team and inspectors will return to see the progress made.

The Co-Chair and other members expressed disappointment at the letter. The Co-Chair drew attention to the fact that families had been raising issues for some time and these views should have been heeded earlier. She welcomed the development of the new Parent Carer Forum and looked forward to the time when the Forum provides feedback that services are improving. The suggestion was made that the Forum to hold meetings in the evenings and at weekends to enable the participation of working parents. Ian Dodds added that it was important to obtain feedback from the wider parent/carer community, not just the Forum.

A comment was made that the report did not discuss schools or families in a strong enough way and these perspectives need to be captured.

In response to a question about assurance that actions would be followed through, Ian Dodds explained that the proposed Governance arrangements would provide the required assurances. He added that the Statement of Action had not yet been completed.

In response to a question about the quality of EHC plans, Charis Penfold confirmed that quality assurance processes are being introduced and all the statutory elements, including educational psychology, are now in place. Doreen Redwood confirmed that the CCG will increase the capacity of the dedicated Medical Officer to examines the plans and ensure there is a health contribution to these plans. Dr Pete Smith, Children's Champion is leading work with the Governing Body, including a strategic review of therapies which are very important to this group and this will provide opportunity to consider how best to joint commission services for the future. Tonia Michaelides confirmed that the CCG has taken this very seriously and recognised that oversight was not sufficiently strong. This has been reviewed. She added that the CCG would look to commission additional services within the finance resources but these may need to be considered against other demands.

A question was asked about how parents will be reassured about the steps being taken to make the required improvements and whether meetings for parents should be held? Tonia Michaelides advised that the CCG is not a provider of services but has oversight in the same way as the Council. The Chair stated that an item on the CCG Board agenda will be picking up on these areas in January. The newly-appointed interim Director of Children Services for Kingston will be focussing on this.

The Co-Chair pointed to the imminent report from the Kingston Education Commission and the need to address over spend including on the dedicated schools grant. Central Government funding is now insufficient and a deficit budget may not be set. If reserves are insufficient, then significant cuts would need to be made. There are opportunities within a partnership collective approach to do things differently and deliver better outcomes and it was important that schools are more involved in this.

RESOLVED that:

1. the report and verbal information provided is noted; and

2. the Ofsted/CQC Written Sign off Statement will be brought to the next meeting of the Health and Wellbeing Board on 31 January 2019

Voting: unanimously in favour

37. GOVERNANCE ARRANGEMENTS FOR THE SEND TRANSFORMATION PLAN — Appendix E

The report, introduced by Ian Dodds, Interim Chief Executive, Achieving for Children (AfC), sought the Board's endorsement for the governance arrangements for the Kingston Special Educational Needs and Disabilities (SEND) Transformation Plan 2018/19 - 2021/22, subject to approval at the Children's and Adults' Care and Education Committee at its meeting on 22 November 2018.

A three year SEND Transformation Plan has been developed to respond to the significant financial pressures facing the service as well as addressing the service quality issues identified in the local area SEND inspection in September 2018 (see

minute 36) and will be considered by the Children and Adults Care and Education committee on 22 November 2018.

The forecast cumulative overspend on the Dedicated Schools Grant for Kingston will reach £13M by the end of 2018/19. The funding of high needs education provision is a national issue and Kingston is not unique in experiencing these pressures. However, in Kingston the rate of increase in costs for SEND is of the order of 9% pa ie £2M pa and at this rate of increase the cost in 2022 will amount to £46M which is an unsustainable position, exceeding the Council's General Fund and earmarked reserves. The objective is to ensure that the schools budget, including high needs, stays within the existing DSG funding allocation.

Whilst the SEND Partnership Board will drive the delivery of the plan, strong governance arrangements will be required which will also secure full engagement from partner organisations to promote constructive debate, scrutiny and challenge. The proposal is for the Health and Wellbeing Board to have accountability for the SEND Transformation plan and for the Children's and Adults' Care and Education Committee (CACE) to have formal constitutional responsibility for the Transformation Plan.

Following a request from Tonia Michaelides, Managing Director Kingston Clinical Commissioning Group for lines of responsibility for partner organisations it was agreed that KCCG would need to be represented within the governance arrangements in addition to the Council enabling decisions appropriate to the two organisations to be taken by those organisations. The overall direction and accountability would be held by Health and Wellbeing Board.

In response to a question about the separation of Kingston and Richmond children's services under the leadership of two Directors of Children's Services, Ian Dodds confirmed that there would be separate transformation plans submitted to the DfE and that the more local focus would enable the plan to be more effectively implemented by the local SEND Partnership, including involvement of the parent and carer community.

A comment was made that it would be helpful for proposed Partnership Board membership to be submitted as late material to CACE committee.

RESOLVED that:

1. The Kingston Clinical Commissioning Group is included within the governance arrangements and captured in late material for CACE committee; and

2. The governance arrangements as amended are endorsed by the Board.

Voting: unanimously in favour

38. HEALTH & WELLBEING BOARD WORKING ARRANGEMENTS PROPOSALS Appendix F

The report on proposals for Working Arrangements for the Health and Wellbeing Board was introduced by Iona Lidington Director of Public Health.

A Health and Wellbeing Board workshop was held on 5 March 2018, a summary of proposals was considered by the Board later that month but progress was paused due to the change in Administration in May.

Themes identified during these discussions were:

- The Board should set the strategic direction of local preventative work and priorities in health and social care
- Relevant outcomes for the Board's work are prevention of ill-health, improvement of wellbeing and reduction in health inequalities.
- The Board should not be limited to its statutory functions eg Joint Strategic Needs Assessment.

Other suggestions put forward were:

- Direct oversight of the commissioning of local public health, NHS and/or social care services
- Responsibility for local implementation of national and regional health and social care policies and initiatives
- Oversight and formal decision making responsibility for a small number of specific joint priority projects eg Kingston Co-ordinated care.

The proposal was that the Director of Public Health reviews the suggestions made in the workshop and develop a full set of proposals for the future of the Board in informal consultation with existing members and other partners. This will include identifying options and associated costs for new models of governance and reviewing evidence from the JSNA to support a priority setting process for the reconfigured Board in 2019.

It was also proposed that the Board be chaired by a lay chair but following discussion this suggestion was not taken forward by the Board.

RESOLVED that:

1. The Board should hold formal meetings in public in the evening and informal daytime workshops on priority topics as closed sessions; and

2. The Director of Public Health be delegated to develop a formal set or proposals for changes to the Board's Terms of Reference to be agreed at a future meeting and in line with the Constitutional Review.

Voting: unanimously in favour

39. URGENT ITEMS AUTHORISED BY THE CHAIR

There were no urgent items.

Signed…….Date…….
Chair

NHS
Kingston
Clinical Commissioning Group

Kingston Clinical Commissioning Group Governing Body Meeting Part 1 in Public	
Date	Tuesday, 05 March 2019

Document Title	PRIMARY CARE REBATE SCHEME (PCRS) POLICY		
Lead Director **(Name and Role)**	Fergus Keegan, Director of Quality		
Clinical Sponsor **(Name and Role)**	N/A		
Author(s) **(Name and Role)**	Shaistah Qureshi, Deputy Chief Pharmacist Lara Belling, Medicines Optimisation Manager		
Agenda Item No.	4.2.1	**Attachment No.**	N1

Purpose **(Tick as Required)**	Approve ☐	Discuss ☐	Note ✓

Executive Summary

Background:

Primary care rebate schemes (PCRS) are contractual arrangements offered by pharmaceutical companies which offer financial rebates directly to CCGs on GP prescribing expenditure for certain branded medicine(s).

Legal advice sought by the London Procurement Partnership (LPP) concluded that primary care rebate schemes are not unlawful and are within the powers of CCGs to agree to, provided they meet certain requirements. Following this the LPP in consultation with stakeholders, developed a set of principles of good practice for primary care organisations to use to facilitate robust scrutiny and identification, adoption and implementation of primary care rebate schemes.

Primary care rebate schemes provide a mechanism for the manufacturer to enable CCGs to benefit from discounted prices for branded medicines that are otherwise only available, for example, to hospitals.

Purpose:

Historically Kingston CCG has not taken part in PCRS for medicines. To ensure that robust local governance process is in place a policy has been developed for Kingston CCG.

Reason for Governing Body Review:

Note the establishment of PCRS policy and process for Kingston CCG.

Key Issues:

1. The participation in PCRS by the CCG will not be promoted to prescribers – this is to ensure prescribing decisions are not influenced by the availability of a rebate scheme.

2. The schemes available will be publicly available on the CCG websites to comply with the London Procurement Partnership principles.

3. Clinical appropriateness of the rebate scheme will be reviewed by the Kingston and Richmond Medicines Optimisation Group, and signed off at Director level.

4. The policy will also be taken forward with South West London CCGs to develop a unified process through the appropriate governance route.

Conflicts of Interest:
Approval of assessment and sign off could lead to potential conflict of interest for members that have an association or consult on behalf of Pharmaceutical Industry/Licenced Medicines being assessed.

Mitigations:
Any declaration of interest would need to be declared prior to discussion and Chair of committee to decide whether member should be excused during decision making.

Recommendation:
The Governing Body is asked to note the policy.

Corporate Objectives This document will impact on the following CCG Objectives:	Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation.

Risks This document links to the following CCG risks:	The policy will allow Rebates Schemes to be considered by KCCG providing additional assurance for risk control.
Mitigations Actions taken to reduce any risks identified:	Development of this policy and process to ensure robust scrutiny and identification, adoption and implementation of primary care rebate schemes.

Financial/Resource/ QIPP Implications	QIPP primary care prescribing

Has an Equality Impact Assessment (EIA) been completed?	N/A
Are there any known implications for equalities? If so, what are the mitigations?	N/A

Patient and Public Engagement and Communication	No patient and public engagement in drafting policy – the availability of a rebate scheme will not be promoted to prescribers so clinical decisions are not influenced.

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	Integrated Governance Committee	Tuesday, 21 August 2018	Concerns raised: GPs would be instructed to prescribe particular branded medication –this would not be the case as generic prescribing would be recommended where clinically appropriate in the same way. Perception of data in FOI requests – concerns about the disclosure of patient identity to Pharma were expressed but the data would be fully aggregated and unidentifiable. Transparency and motives of the pharmaceutical companies / ethics - the products would not be promoted to the prescribers in any way so should not affect prescribing habits. Legal advice was in place and a level of Governance needs to be agreed to ensure we are not influencing the rebate scheme. The pharmaceutical company would only receive aggregate transaction data, volume usage and provide a monetary rebate. Monetary rebate from Pharma should not be put into the GP primary care

			prescribing budget so it is totally separate from the prescribing incentive scheme
	Medicines Committee	Wednesday, 07 November 2018	Agreed with the recommendations made. It was suggested that the contact for the rebate claims should be via finance team rather than the medicines optimisation team to protect the integrity of the team.
	Joint Executive Management Team	Monday, 26 November 2018	The recommendation was to update the policy to reflect the LPP principle and include details of rebates schemes on the CCG website. To consider a SWL wide policy. For further discussion at a Joint Governing Body seminar.
	Joint Executive Management Team	Monday, 21 January 2019	With the assurance that it would now fully meet LPP requirements, the policy was approved for use in both Kingston and Richmond CCGs. Kingston and Richmond CCGs MO team agreed to lead on a piece of work to obtain a unified SWL process through the appropriate governance route.
	K& R CCGs Integrated Quality Governance Committee	Tuesday, 19 February 2019	Policy approved

Supporting Documents	LPP Primary-Care-Rebate-Schemes-Principles-NHS-London-Procurement-Partnership LPP Primary-Care-Rebate Pharmaceutical Industry Scheme Governance Review Board 467-eoe-pis-governance-review-board-o

NHS Kingston Clinical Commissioning Group

NHS Richmond Clinical Commissioning Group

PRIMARY CARE REBATE SCHEME (PCRS) POLICY AND PROCESS

CCG Policy Reference: xxxxxxx

THIS POLICY HAS BEEN APPROVED BY KINGSTON & RICHMOND CCGS INTEGRATED QUALITY GOVERNANCE COMIMITTEE, AND WILL HAVE EFFECT AS OF MARCH 2019

Target Audience	Kingston and Richmond CCGs, Medicines Optimisation Team
Brief Description	To facilitate and support the decision making around signing up to primary care rebate schemes within Kingston and Richmond CCGs.
Action Required	**1. Upload policy on GPTeamNet** **2. Upload active Rebates on relevant CCG website**

Document Control	
Policy Title:	**PRIMARY CARE REBATE SCHEME (PCRS) POLICY AND PROCESS**
Original Policy Author(s):	KCCG
Membership of Policy Development Group	
Policy Owner:	Medicines Optimisation Team/ Fergus Keegan
Reviewed by:	Integrated Governance Committee
Consultation:	Kingston and Richmond Medicines Optimisation Group, Joint Executive Management Team
Quality Assured by:	K&R CCGs Integrated Quality Governance Committee
File Location:	xxxx
Approval Body:	K&R CCGs Integrated Quality Governance Committee
Approval Date:	19/02/2019

Document Review Control Information

Version	Date	Reviewer Name(s)	Comments

Document Information:

Title /Version Number/(Date)	PRIMARY CARE REBATE SCHEME (PCRS) POLICY AND PROCESS /Version 1/20190220
Document Status (for information/ action etc.) and timescale	For governance
Accountable Director	Fergus Keegan
Responsible Post holder/Policy Owner	Emma Richmond
Date Approved	19/02/2019
Approved By	K&R CCGS Integrated Quality Governance Committee
Publication Date	xx
Review Date	31/12/2021
Author	Medicines Optimisation Team
Stakeholders engaged in development or review (if relevant)	n/a
Equality Analysis	n/a
Contact details for further information	Kingstonccg.medicines@swlondon.nhs.uk Richmondccg.medicines@swlondon.nhs.uk

Associated Policy Documents

Reference	Title
LPP Primary-Care-Rebate-Schemes-Principles-NHS-London-Procurement-Partnership	LPP Primary-Care-Rebate
Pharmaceutical Industry Scheme Governance Review Board	467-eoe-pis-governance-review-board-o

Glossary

Term	Definition

Content:

1: Introduction

Pharmaceutical industry partners often offer rebate schemes to primary care organisations (PCOs) which can free up funding for the CCG to enable investment in other areas of healthcare.
In entering in to such schemes with a pharmaceutical industry partner, there are a number of questions which must be asked to ensure that the proposal is in the best interests of both patients and the organisation.

2: Rationale

Price reductions on branded products are not available when items are prescribed on FP10; the NHS Prescription Services division of the NHSBSA will reimburse dispensing contractors at the manufacturer's list price. Primary care rebate schemes provide a mechanism for the manufacturer to enable CCGs to benefit from discounted prices for branded medicines that are otherwise only available to hospital or to be reimbursed for the difference between the list price and the NICE-agreed Patient Access Scheme price.
Legal advice sought by the London Procurement Partnership (LPP) in 2012 concluded that primary care rebate schemes are not unlawful and are within the powers of CCGs to agree to, provided they meet certain requirements.
It would be preferable if pharmaceutical companies could simply offer the medicines at a lower price to the NHS, however, it is recognised that this is not possible due to the impact on European and global markets.

3: Good practice principles for Primary Care Rebate Schemes (PCRS)

The following principles set out:

- Standards by which offers of a rebate scheme should be reviewed and approve to ensure schemes are assessed in a robust, transparent and fair manner.
- Process following approval, to enable schemes once approved to be processed efficiently.

3.1 Product related

a. Before any consideration of price, the clinical need for the medicine and its place in care pathways should have been agreed by established local decision-making processes. The clinical decision should inform the financial/procurement decision and not vice versa.
b. Health professionals should always base their prescribing decisions primarily on assessments of their individual patients' clinical circumstances. The impact of a rebate scheme is a secondary consideration. **To ensure this principle remains, the availability of a rebate will not be advertised or promoted to practices.**
c. Any medicine considered under a PCRS must be licensed in the UK. Where there is more than one licensed indication for a medicine, a scheme should not be linked to a particular indication for use.
d. Rebate schemes promoting unlicensed or off label uses must not be entered into. All recommendations for use of a medicine within a PCRS must be consistent with the Marketing Authorisation of the medicine in question i.e. the PCRS should only advocate the use of the drug in line with the data sheet for the drug in question.
e. Medicines not recommended by NICE might still be the subject of a PCRS, but specific and documented consideration must be given to how such a product can properly be recommended to prescribers notwithstanding NICE's position. The CCG will need to explain how the scheme helps it meet its duty to use its resources effectively, efficiently and economically.

3.2 Rebate scheme related

a. All items considered for rebate should be recognised as suitable for prescribing in primary care. Formulary decisions are made at the local Trusts Drugs & Therapeutic Group. Decisions from this group are reported back through Kingston and Richmond Medicines Optimisation Group for governance process. This ensures the decision-making processes for formulary approval are clinically-led and involve all appropriate stakeholders, including both primary and secondary care and patients where appropriate.

b. Rebate schemes should be approved through robust local governance processes that include the Medicines Optimisation Group and Director Level approval (Director of Quality / Director of Finance).
c. The administrative burden to the NHS of setting up and running the scheme must be factored into assessment of likely financial benefit of the scheme. Consideration should be given to audit requirements, financial governance, data collection, any other hidden costs and practical issues such as the term of agreement.
d. Primary care rebate schemes should be agreed at a statutory organisational level; they should not be agreed at GP practice level.
e. Schemes encouraging exclusive use of a particular drug should be avoided.
f. Rebate schemes are not appropriate for medicines in Category M and some medicines in Category C of the Drug Tariff, because of the potential wider impact on community pharmacy reimbursement.
g. Ideally the PCRS should not be directly linked to requirements to increase market share or volume of prescribing.
h. A volume based scheme should only be agreed if clinically appropriate. However, the administrative burden of monitoring such a scheme should be carefully considered.
i. Commissioners should ensure that a formal written contract is in place, signed by both parties to ensure (i) that the terms of the scheme are clear and (ii) to maximise the legal protection. All negotiations around a scheme should be expressed as being "subject to contract" i.e. not binding until the formal contract has been signed by both parties.
j. PCRS agreements should include a right to terminate on notice (i.e. without having to have any reason for doing so) with a sensible notice period e.g. three or six months.
k. The need for exit criteria and an exit strategy should be considered before a scheme is agreed. It is essential to allow flexibility to respond to emergence of significant new clinical evidence, or significant changes in market conditions. A shorter notice period should be agreed in these circumstances.

3.3 Information and Transparency

a. Kingston and Richmond CCGs will make public (for example on their website) the existence of any PCRS they have agreed to.
b. Primary care organisations should not enter into any PCRS which precludes them from considering any other schemes subsequently offered by manufacturers of competitor drugs, should they wish to do so. These PCRS should all be considered using the same criteria.
c. There should be no requirement to collect or submit to the manufacturer any data other than volume of use as derived from NHSBSA Information Services (ePACT) prescribing data.
d. PCRS agreements must meet the requirements of the General Data Protection Regulation and patient confidentiality must never be compromised.
e. Commissioners should not enter schemes that require them to provide information to a manufacturer about competitor products market share.
f. Freedom of Information – As a general principle information relating to rebate schemes is likely to be releasable, these issues should be discussed with the manufacturer before a commissioner enters into any agreement with them. Ideally, provisions about FOI requests and commercially sensitive information should be contained in the contract.
g. Discounts and details of any PCRS offered should be allowed to be shared within the NHS. This should be agreed as part of the PCRS contract.
h. All proposals must be treated equally and decisions made will need to stand up to scrutiny if questioned.
i. The rebate schemes will not be shared or promoted to prescribers to ensure no shift in prescribing behaviour.

Any rebate scheme must be compatible with the effective, efficient and economic use of NHS resources. Although these Good Practice Principles can help CCGs assess these schemes, the CCG will need to be assured that the schemes offered do not breach any other UK legislation, in particular, reimbursement for pharmaceutical services according to the Drug Tariff, duty to comply with the DH's controls on pricing made under the 2006 Act, the Medicines Act, the Human Medicines Regulations 2012, the Bribery Act, EU law and the public law principles of reasonableness and fairness.

4: Process for assessment, sign off and monitoring

4.1 Assessment

A Senior Pharmacist for the CCG will:

a. Assess each viable proposal using the principles outlined above or those which have already been assessed by PrescQIPP Pharmaceutical Industry Scheme Governance Board (Appendix 1)
   PrescQIPP Pharmaceutical Industry Scheme Governance Board classifies the assessed schemes as follows:
   - **GREY**- Scheme considered; no significant reservations
   - **AMBER** – Scheme considered; not fully appropriate
   - **RED** – Scheme considered; inappropriate

b. First consider schemes which have gone through the PrescQIPP Pharmaceutical Industry Scheme Governance Review Board with a grey (scheme considered; no significant reservations) or amber (scheme considered; not fully appropriate) rating. Additional rebates may be considered as required.
c. Use the checklist (Appendix 1) to support local decision making, fully documenting the assessment of the rebate scheme.
d. Co-ordinate and manage all approaches from the pharmaceutical industry with proposals for reimbursement or risk share schemes.
e. Provide a summary of each proposal against the above criteria which describes the mechanism of rebate but not the amount (Appendix 2).
f. Discuss this summary with the Kingston and Richmond Medicines Optimisation Group to obtain clinical approval of the rebate scheme.

4.2 Sign-off

a. Chief Pharmacist to seek final agreement with Director of Finance/Director of Quality/ or via Finance committee as required.
b. The Director of Finance along with the CCG Chief Pharmacist/ Director of Quality will sign off final contracts for each rebate scheme when fully approved.
c. Contract to be held by Finance Team.

4.3 Claiming Reimbursement

Details of how to claim reimbursement will be included in the contract for individual schemes. The CCG will generally be required to make a claim within 28 days of the end of each quarter or alternative period agreed. Claims will be made according to the specific instructions in the agreement. In some cases this may be by e-mail, attaching the relevant epact data, to the company address as instructed in the agreement. In other cases an invoice may be required. Reimbursement to the CCG account can generally be expected within 28 days of the claim via BACS transfer.

The CCG acknowledges that receipt of a rebate is a taxable event on which the CCG must declare output tax to HM Revenue & Customs.

Rebate claims should ideally be made via finance team, to protect the integrity of the Medicines Optimisation Team.

4.4 Monitoring

A copy of the contract will be kept of all rebates or local discount schemes entered into by the Kingston and Richmond CCGs together with the completed checklist and relevant paperwork. Claims made and income from each scheme will be shared by the CCG Finance Team with the Medicines Optimisation Team.

Pharmacy Technician/ Pharmacist for the CCG will:

a. Provide ePACT data, if applicable/relevant

b. Produce a monitoring report, detailing the medicines for which rebates have been agreed, a summary of the rebate agreement and the total amount of rebate received. Report will be presented to the Financial Delivery Group regularly (minimum annually).

Senior Management Accountant for the CCG will:

a. Submit rebate claims to the pharmaceutical company
b. Process and monitor payments from Pharmaceutical Manufacturer
c. The funds generated by a rebate scheme will be held in the budget where the saving has been made (i.e. Prescribing Budget as a separate line).
d. Report to the Finance Committee

5. Audit and Review

The Director of Quality / Chief Pharmacist will be responsible for audit and adherence of the policy which will be reviewed every 3 years.

6. Definitions

NHSBSA ePACT - An online application giving authorised users access to prescription data.

PrescQIPP – NHS funded not-for-profit organisation that supports quality, optimised prescribing for patients. They produce evidence-based resources and tools for primary care commissioners, and provide a platform to share innovation across the NHS.

7. References

References taken from Internet sites

NHS London Procurement Partnership (2012) ***Principles and Legal Implications of Primary Care Rebate Schemes*** - http://www.lpp.nhs.uk/media/43744/Primary-Care-Rebate-Schemes-Principles-NHS-London-Procurement-Partnership.pdf (accessed - 06/03/2018).

PrescQIPP https://www.prescqipp.info/primary-care-rebates/projectsection/projects/pisgrb#prescqipp-s-pharmaceutical-industry-scheme-governance-review-board (accessed - 07/08/2018)

8. Appendices

Appendix 1

Primary Care Rebate Scheme (PCRS) Decision Form
Confidential

Date:	
Name of drug:	
Company name:	
Company contact:	
Version of contract:	

		Governance	**YES / NO**	**Additional comments**
PrescQIPP		Has rebate been through Pharmaceutical Industry Scheme Governance Board**?** Classification: Green/Amber/Red		

		Assessment of good practice principles	YES / NO	Additional comments
1.Product related	**1.1**	Is the medicine currently included within the local Trust Formulary (please specify) and available to prescribe in Primary Care?		
	1.2	Does the medicine have more than one licensed indication for use? (The scheme should not be linked to a particular indication for use)		
	1.3	Is the medicine within category M or C of the Drug Tariff? (The scheme should not be linked to a medicine withing cat M or C)		
	1.4	Resilience of the product within the rebate contract – availability of the product should match the likely uptake. Reassurance will be sought that any significant increase or spike in demand can be managed by the company.		
2. Rebate scheme-related	**2.1**	Is the rebate 'price discount' scheme?		
	2.2	Is the termination notice 3 or 6 months?		

Appendix 2

Summary of assessment from the Decision Form

Select:	**Yes / No:**
No reservations	
Minor reservations only – details below	
Major reservations – details below	

Comments:	

KCCG / RCCG Senior Pharmacist	Name	Signature
Date of assessment:		
Director of Quality	Name	Signature
Director of Finance	Name	Signature

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Attachment N2

Public sector equality duty

Annual report January 2019

Contents

1. INTRODUCTION

This report, for the period January to December 2018, brings together information and evidence which demonstrates how NHS Kingston Clinical Commissioning Group (CCG) is meeting its statutory duties under the Equality Act 2010.

This report will cover the following core business areas:

- Commissioning
- Primary care
- Contracts, tenders and performance
- Engagement and consultation
- Partnerships and public health
- Patient Advice and Liaison Service and Complaints
- Serious Incidents
- Safeguarding
- Workforce

In May 2018, Kingston and Richmond CCG agreed joint corporate objectives:

1. Enable local people, patients, carers and stakeholders to have greater influence on the services we commission and keep the patient voice at the centre of what we do.
2. Improve the quality, safety and effectiveness of healthcare services and ensure that national performance targets are met and that people experience high quality care.
3. Work in partnership with local health and care providers, commissioners and the voluntary sector to improve and transform services that achieve better health outcomes, are accessible and reduce inequalities.
4. Ensure the continued development of the CCG as a clinically-led and well governed organisation with strong leadership, effective membership and staff engagement.
5. Achieve a financially sustainable health economy balancing the need for effective use of resources and better value for money with the need for innovation.

2. LEGISLATIVE CONTEXT

The Equality Act (2010) imposes a duty on all public bodies carrying out public functions to promote equality and eliminate discrimination.

There are nine protected characteristics covered by the duty: age, sex, race (including nationality and ethnicity), gender reassignment, sexual orientation, religion or belief, disability, marriage & civil partnership and pregnancy & maternity.

Specific duties that need to be undertaken by Kingston CCG are:

- Annually publish relevant, proportionate information demonstrating compliance with the Equality Duty. The information must be published by January 31 each year in an easily accessible format. Consideration needs to be given to the following:
    - Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
    - Advance equality of opportunity between different people from different groups; and
    - Foster good relations between people from different groups.
- Set specific, measurable equality objectives based on the evidence submitted.
- Subsequent objectives must be published every four years.

3. EQUALITY OBJECTIVES

The following objectives are identified for 2018 – 2021:

- To engage with our diverse communities ensuring their needs are taken into account when commissioning, designing and co-producing services.
- To embed equality and diversity principles by developing and supporting staff and governing body members to promote and champion equality in all aspects of the CCG's work.
- The CCG will demonstrate and report in the annual report each year that it is a fair and inclusive employer that recognises the value of diversity.
- Maintain good governance to improve equality and diversity performance through the Equality Delivery System (EDS2).

The EDS2 is a tool developed by NHS England to help organisations, in partnership with local stakeholders, to review and improve their performance for people with protected characteristics protected by the Equality Act 2010.

4. ABOUT KINGSTON

Kingston is a small outer London borough with a population of 179,600 (Populations and projections Kingston JSNA, 2018). Our population is an ageing and relatively affluent one, but this hides small pockets of relative deprivation. The physical health of people in Kingston reflects the overall affluence of the area with a lower prevalence of many diseases than London as a whole. The increase in life expectancy has important implications for the health and social care system.

The challenges we face in Kingston:

- Cost pressures in the health and social care system due to the rise in an ageing population - requiring more extensive health and social care interventions.
- An increasing number of older people living alone. Projected figures show that the population will grow by 9% between 2017-2027, with more very old (over 90).
- A rising number of patients with dementia-related health problems.
- Cardiovascular disease and cancer are the two leading causes of death, followed by respiratory disease.
- All three major causes of death have preventable risk factors such as smoking, diet, exercise and excess alcohol consumption.
- Last years of life are lived with a disability for an average of 12.7 years for men and 15.2 years for women.

A snap shot of Kingston:

- The population has become more ethnically diverse, from 16% Black and Minority Ethnic (BME) groups in the 2001 census to 26% BME in the 2011 census. The projected population forecast projects that 32% of people in Kingston is from a BAME group in 2018. White British people are the single largest groups, making up 54% of the population (the remaining 14% are White Irish and other White). The largest absolute growth is projected in Other white groups (projected growth of 4,922 people) and the Other Asian groups (projected growth of 5,064 people). The largest percentage growth Is projected in the Bangladeshi group (54%) and the Arab group (34%).
- In mid-2018, a projected 41% of children and young people aged 0-17 in Kingston will be from a BAME groups, projected to rise to 47% by 2028.

- The 2011 census showed that 12% of the Kingston population has a limiting long-term illness. 2.5% of Kingston residents claimed Disability Living Allowance (DLA) in February 2016, compared to 3.6% for England as a whole.
- Kingston has a higher than London average number of people aged over 65 years and a higher than England average number of people aged under 18 years.
- With regards to diverse religious beliefs, the 2011 census found that the largest groups are Christian, Muslim, Hindu and no religion.
- Kingston has a lower than the England and London average number of people claiming carers allowance.
- Nationally, it is estimated that lesbian, gay and bisexual people constitute 5-7% of the total adult population.

More details on Kingston's health can be found in the Joint Strategic Needs Assessment (JSNA) web pages: (https://www.kingston.gov.uk/info/200365/joint_strategic_needs_assessment)

5. ORGANISATIONAL CONTEXT

The CCG is a membership organisation, made up of 21 local GP practices serving people across the Royal Borough of Kingston upon Thames.

The CCG commissions community services with Your Healthcare CIC and is lead commissioner for Kingston Hospital NHS Foundation Trust. We are also a partner commissioner for:

- St George's University Hospitals NHS Foundation Trust
- South West London & St George's Mental Health NHS Trust
- Camden and Islington NHS Foundation Trust

Kingston CCG has delegated responsibility for commissioning of primary care medical (GP) services.

5.1 Kingston & Richmond CCGs

In April 2017, Kingston CCG combined working arrangements with neighbouring Richmond CCG as part of the South West London Health and Care Partnership (SWLHCP). Whilst retaining their own governing bodies and remaining accountable

for their own populations, Kingston and Richmond are managed under one senior management structure across the two CCGs.

6. CCG GOVERNANCE

The CCG's governing body has a collective responsibility to ensure compliance with the public sector equality duty both as an employer and commissioner of healthcare services.

The director of corporate affairs and governance is the executive lead for equality and diversity reporting into the executive team, integrated governance committee and there is a GP member lead for equality and diversity on the governing body.

The CCG is a partner on the Health and Wellbeing Board (HWB) which is responsible for Kingston Health & Wellbeing Strategy and the Joint Strategic Needs Assessment (JSNA).

7. COMMISSIONING

All commissioning projects (from strategy through to procurement) are required to have due regard to the potential impacts of the project on our local communities and particularly groups with protected characteristics.

The CCG has an equality impact needs assessment (EINA) process to ensure a proportionate response informed by the impact and sensitivity of each project.

The EINA process should be followed for all projects where the CCG has been identified as the lead organisation. For joint projects across health and social care, with other CCGs or providers the lead organisation's equality analysis process will be used.

In developing the EINA process it should ensure that findings from EINAs are referred to in governing body/committee reports, to enable challenge and request for assurance of equalities by governing body/committee members. Equalities training for governing body members is also part of the process.

As part of the joint approach to working across Kingston & Richmond CCGs we have introduced a single EINA process.

Commissioners have a role in promoting equality across the local health system through their contracts with providers to ensure that providers are aware of their duty under the Equality Act 2010 and that the service specifications for the commissioned services clearly set out the requirements for protected groups where there is a need to do so.

The CCG's programme management office (PMO) is a central support structure that provides support and quality assurance for Kingston and Richmond CCGs priority commissioning programmes, which include Quality, Innovation, Productivity and Prevention (QIPP) programme. QIPP aims to ensure that each pound spent in the NHS is used to bring maximum benefit and quality of care to patients.

As part of the project management process both equality and quality impact assessments are included. This ensures an overview of the potential impact of each project is considered on groups with protected characteristics and other locally identified communities.

Stakeholder analysis is also included to ensure relevant stakeholders are identified and engaged as part of the process.

7.1 Community Commissioning

The CCG is responsible for commissioning community health services on behalf of the Kingston GP registered population in line with their health needs and to ensure that the services commissioned and provided are accessible and available to all those who are referred into them including those patients from protected groups, including carers.

The services commissioned are based on evidence based best practice to ensure that the care and treatment delivered is effective and assessments consider the individual needs of patients within the context of best practice and outcomes, as well as deliver value for money.

Equality is also promoted through the NHS standard contract framework which details current legislation and includes service specifications that cover access, service delivery, etc. The National NHS standard contract framework service condition SC13 (equity of access, equality and non-discrimination) outlines the requirements on providers to meet the Equality Act 2010.

Providers are expected to comply with the equality outcomes and demonstrate their compliance against these, through publication of an annual equality duty report as noted in the contract schedule 6 reporting requirements.

Kingston's most significant community provider is Your Healthcare – a community interest company which is commissioned to provide a wide range of community health services.

7.2 Acute care

Kingston CCG is the lead commissioner for Kingston Hospital NHS Foundation Trust (KHFT) responsible for commissioning services from the trust on behalf of Richmond, Sutton, Merton and Wandsworth CCGs as well as several associate CCGs. We are responsible for the services commissioned and for making sure they are accessible and available to all those referred to them including individuals in any of the protected characteristic groups. Where patients attend other hospitals, the lead commissioner for those hospitals is responsible for demonstrating compliance with the equality outcomes.

Our services are commissioned on evidence based best practice to ensure the care and treatment delivered is effective and assessments consider the individual needs of patients within the context of best practice and outcomes, as well delivering value for money.

Equality is also promoted through the NHS standard contract framework which details current legislation and includes service specifications including access and service delivery. The National NHS standard contract framework service condition SC13 (equity of access, equality and non-discrimination) outlines the requirements on providers to meet the Equality Act 2010.

Providers are expected to comply with the equality outcomes and demonstrate their compliance against these, through publication of an annual equality duty report as noted in the contract schedule 6 reporting requirements.

Monthly clinical quality review group (CQRG) meetings between KHFT and the SWL CCGs bring together clinical leads, commissioners and quality leads from each of the CCGs and the Trust to discuss and make decisions on aspects of quality and safety.

Equality is promoted through the NHS standard contract framework which details current legislation and includes service specifications that cover access, service delivery, etc. The National NHS standard contract framework service condition SC13 (equity of access, equality and non-discrimination) outlines the requirements on providers to meet the Equality Act 2010.

7.3 End of life care

During the year Kingston and Richmond CCGs worked with local health and care partners including the voluntary sector, patients and carers to develop an End of Life Care Straetgy to support Every resident in Kingston and Richmond deserves to be confident that the health and care system will give them and their families the support they need when they are coming to the end of their life.

Over the next 3 years the strategy aims to support Kingston and Richmond CCGs to commission adult and childrens's end of life and palliative care services and support community development that draws on current best evidence. It will also consider the support needs of those affected by the impact of death in different circumstances such as suicide, sudden death, maternal death or loss of a child.

Our core focus will be on five broad objectives:

- compassionate community development,
- person-centred and holistic advance care planning,
- improving experience for patients and those important to them as well as frontline staff,
- reducing inequalities and
- effective commissioning for end of life care

We will work with specialist paediatric teams, social care and other relevant agencies to ensure that the end of life care needs of neonates, children and young people are met through a comprehensive model of palliative care for children and young people.

Training will be provided for staff supporting patients with dementia who are at the end of life.

Training will be available for staff covering the diversity of beliefs for various groups and to ensure that these are at the forefront of providing end of life care. We will endeavour to ensure any patient information produced is accessible to all patient groups in line with the Accessible Information Standard.

7.4 People with complex needs

A key focus for the CCG is working with providers to ensure that care for patients who are frail and/or have complex needs is tailored to individual needs and that no-one is disadvantaged.

This includes establishing teams made up of existing health and care professionals from primary, community, hospitals, mental health and voluntary sector organisations. Working together the team will plan and manage care to support people with complex needs in managing their conditions, avoid crisis and reduced unplanned admissions in their local area.

These areas cover a 50,000 population, aligned to GP practices. The teams will support early discharge from hospital and end of life care for those requiring care in hospital. This is about organisations working together to support involves developing care plans that supports individuals to manage their conditions, avoid crisis and reduce unplanned care needs using risk stratification.

7.5 Musculo-skeletal services (MSK)

Kingston and Richmond CCGs have been working together to redesign and improve the MSK pathway as an LDU and with the other CCGs in the South West London (SWL) Alliance.

Improving and expanding the MSK Single Point of Triage (SPT) service in 2018-19 was the first phase of this work. This was in response to a local need and because NHS England identified Musculoskeletal (MSK) Triage as a high impact intervention and mandated CCGs put MSK triage services in place.

While both CCGs put MSK SPT services from as far back as 2011, during 2018-19 the scope of both services were expanded and some improvements were made to the service. Changes were made between April 2018 with the streaming of pain management referrals starting from July 2018. As such is anticipated that the scheme will deliver some benefits and savings during 2019-20.

The MSK SPT services provide specialist clinical review of referrals after a GP has made a routine or urgent referral for a musculoskeletal condition (orthopaedics, rheumatology and MSK pain). These services triage referrals virtually received via the NHS e-RS system (as opposed to seeing the patient face-to-face).

The underpinning principles is that more patients should be seen by the right person, in the right place, first time.

7.6 Effective Commissioning Initiative

In 2018 SWLHCP refreshed the Effective Commissioning Initiative that covers 55 treatments and procedures against which the CCGs have considered evidence of clinical practice, the clinical cost and the cost effectiveness of the treatments . This is driven by the need to ensure that NHS funded treatments are evidenced-based, clinically effective, safe and access to treatments across south west London (SWL) is equitable for patients with similar clinical need, hence reduces variation in care.

The policy makes provisions for clinicians to apply to a SWL funding panel for individual funding for patients where they consider that the patient need is exceptional or has a rare condition.

7.7 Mental health

The CCG's most significant mental health provider is South West London and St George's NHS Mental Health Trust (SWLStG). Richmond CCG is the lead commissioner for SWLStG's on behalf of Kingston as well as a number of other CCGs.

SWLStG provides safe and effective mental health care and other services for the benefit of the communities it serves. The trust is commissioned to provide a wide range of mental health services including in-patient and community-based services for children, adults, older adults and individuals who have been through the criminal justice system.

SWLStG's presents its equality and diversity toolkit to the monthly clinical quality review group (CQRG) which brings together clinical mental health leads, commissioners and quality leads from SWLStG's, CCGs across south west London and has service user and carer representation. The CQRG then monitors the agreed actions of SWLStG's.

Services commissioned are based on best practice evidence to ensure that the care and treatment delivered is effective. Assessments must consider the individual needs of service users within the context of best practice and outcomes. We recognise that people with mental health needs can be adversely affected and have

worse health outcomes in terms of both their physical and mental health. The CCG is committed to working towards parity of esteem for people with mental health needs, and is investing in mental health to meet the improvements set out in the Five Year Forward View.

The following are some of the commissioning projects undertaken during the year that highlight how the CCG has paid due regard to impact on local communities and groups with protected characteristics and other locally identified groups.

7.8 Physical health checks for people with serious mental illness (SMI)

The CCG is working with SWLStG and primary care to improve the physical health outcomes of people with mental health needs. People diagnosed with an SMI have a lower life expectancy and do not routinely access screening which supports early diagnosis of serious physical health problems. The aspiration is for 60% of people diagnosed with an SMI to have a full physical health check within 2018/19. The CCG has commissioned support to achieve this within primary care.

7.9 Thrive Kingston

Kingston's mental health strategy (Thrive Kingston) sets out to improve and enhance the mental wellbeing of people in Kingston by supporting better prevention, preventative services and early intervention, and to transform the experience and care of people with mental health problems, their families, friends and carers.

It covers prevention and wellbeing in all age groups and is focused on mental health services for adults (aligned with children's mental health service plans). This means people with mental health problems, however severe or mild, can live their lives as fully as possible. Over 200 people participated in co-producing the strategy.

During our engagement, people with mental health needs and their carers told us that their priorities were prevention, early intervention, being connected to the community, access to support and joined up care. To deliver this we identified further priorities such as leadership, quality and workforce development. This strategy seeks to address the health inequalities often experienced by people with mental health needs.

7.10 Increasing Access to Psychological Therapies (IAPT)

The CCG has continued to increase the number of people with common mental illnesses (CMI) and will meet the national target in 2018/19. The IAPT provides support to people wherever possible within primary care and receive secondary care services only when needed. This is in line with delivering equality with physical health services and is how people have told us they prefer their care to be delivered. The service has also begun to deliver dedicated programmes for people with long term conditions such as diabetes, where improved mental wellbeing can support better management and recovery of physical health conditions.

7.11 Child and Adolescent Mental Health Services (CAMHS)

Working in partnership, Kingston and Richmond CCGs fund CAMHS transformation programmes designed to transform mental health care for children and young people.

Key themes underpinning the transformation programme:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

It also addresses the mental health issues for key vulnerable groups that are nationally recognised as being at risk of the effects of health inequalities. These are children and young people:

- In the justice system
- With autistic spectrum disorders and or learning disabilities
- Looked after children
- With conduct disorders and/or Attention Deficit Hyperactivity Disorder (ADHD)

We have also introduced some new service developments:

- Reduced the waiting times from over 18 weeks for children due to have autism assessments.

- Worked with parents, carers, local authority colleagues, clinicians and the voluntary sector to both understand the needs of families and carers locally and planning how to better support them.

A series of consultation meetings organised and led by parents and carers from stakeholder groups representing Special Education Needs and Disabilities (SEND), ADHD and the National Autistic Society was attended by 60 parents across Richmond and Kingston and a range of issues were identified.

This was followed up with co-designed and co-delivered workshops with SEND Family Voices and ADHD Richmond (our parent/carer groups) to review the current ASD and ADHD pathways and redesign a new local pathway to provide specialist assessments to ensure that waiting times are improved for those aged 6-18 with suspected autism (without complex co-morbid problems, such as additional physical and / or mental health problems).

Following this engagement, autism assessments are now available locally in Richmond through a specialist clinic in the borough. Patients will be able to have their assessments locally rather than having to go to hospital.

The same arrangements started in Kingston in September 2018 and is currently being delivered in five schools throughout the borough.

Engagement and involvement is a key part of the CAMHS transformation programme to ensure that the focus of mental health support addresses a very broad spectrum of need. An example of this are the conversations held across south west London boroughs with children and young people during the year to develop and implement a whole systems approach to reducing the number of children self-harming and improve the support provided across SWL boroughs. More detail about this engagement and its impact is set out on page 22.

8 PRIMARY CARE

Primary care in Kingston aims to deliver a high standard of care to all.

Primary care is often the first point of contact with the NHS and has a significant role to play in empowering people to look after their own health, stay healthy and well and to enable them to become an active part of their own communities. When people are unwell, either temporarily or if they are living with a long term condition, it is a primary care professional who will be providing the majority of care and advice. If we do not ensure that our primary care service and staff are treating all with

equality, respect, dignity and understanding this will have a direct impact on a person's health.

The CCG commissions extended access to GP services for residents in Kingston throughout the year; this includes appointments booked with a GP and the facility for patients not registered with a Kingston GP to walk in and be allocated the next free appointment. This is an important access point to services for a range of vulnerable people.

We work with practices to ensure the promotion of GP online. Patients can use GP online to book appointments, order prescriptions and access elements of their patient records online. Some concerns have been expressed by community groups representing people with a disability that whilst recognising greater use of technology is a positive step it could be a barrier for some people with a disability. There is a need to ensure the NHS continue to invest in and value face to face consultations and appointment booking systems.

Kingston has completed its first year of the social prescribing pilot in partnership with Macmillan cancer charity. As part of this work the social prescriber has been engaging with several community groups/organisations in collaboration with adult social care. An initial evaluation report has been considered by the Primary Care Commissioning Committee.

The Primary Care Forum continues to meet and is an opportunity for practice patient participation groups (PPGs) to engage, communicate and strengthen the patient voice and feedback to commissioners. Support has been provided to PPGs to help them function as effective feedback groups including a best practice guide to help practices set up a PPG, and individual practice support for establishing virtual PPGs.

We continue to support patients that have been impacted by the unforeseen practice merger of Kingsdowne and Central surgery. The CCG has supported practice based work to ensure vulnerable patients have continuing service and repeat routine appointments, providing confidence that their patient notes would be transferred across smoothly.

The August 2018 GP Patient Survey included the findings that 85% of patients rated their experience at the last GP appointment as either very good or good.

This indicates a very high level of satisfaction overall with GP care locally. However, the results are not disaggregated by protected groups. We are aware that there are some variances in access to primary care services, which impact on patient experience and outcomes.

We take a partnership approach to provide targeted outreach to ensure that all Kingston communities receive the best primary care and achieve the best outcomes:

- Working closely with public health and other stakeholders, including probation officers, to ensure offenders being released can register with a GP
- Supporting asylum seekers and the homeless community to access primary care services
- Identifying people with learning disabilities and making sure they receive their annual health check, as required
- Developing a set of service pledges and patient responsibilities for GP practices and pharmacies to help us achieve consistently good services across Kingston and Richmond.
-

9 PARTNERSHIPS

Kingston CCG works collaboratively with a range of local organisations and agencies to strengthen its commissioning work.

9.1 Commissioning across South West London

The NHS, local councils and the voluntary sector in south west London are working together as the South West Health and Care Partnership to deliver better care for local people. Organisations providing health care in six London boroughs are working together as four local partnerships to improve health services in Croydon, Sutton, Kingston and Richmond and Merton and Wandsworth.

Since the publication of the south west London sustainability and transformation plan (STP) in November 2016, we have continued to work together across south west London to engage with our stakeholders and local people.

Following a year of engagement with stakeholders and local people, a draft refreshed strategy document was published in November 2017. The document focuses on partnership, prevention and keeping people well, recognising the greatest influences on our health and wellbeing are factors such as education,

employment, housing, health habits in our communities and social connections which are best approached locally at borough level. Combined with further engagement in 2018, a local health and care plan for Kingston will be published in July 2019. This will focus on how we can work in partnership to meet the local challenges we have set out in the discussion document and provide the best care for people with complex needs. We will continue to work together with local people, community organisations and our partners to put these plans into action in the months and year to come.

Kingston CCG works collaboratively with a range of local organisations and agencies to strengthen its commissioning work.

9.2 Kingston Health and Wellbeing Board

Kingston Health & Wellbeing Board (HWB) brings together the CCG, council, Healthwatch, NHS partners and the voluntary sector to manage the Council's public health functions and ensure that health services within the borough are properly integrated between providers. Kingston HWB is responsible for developing Kingston's Health and Wellbeing Strategy and the Joint Strategic Needs Assessment (JSNA)

9.3 Healthwatch Kingston

We continue to work with and develop our relationship with Kingston Healthwatch who have representation as a non-voting member of the CCG's governing body, and who work with us as partners on a number of projects including the Kingston Mental Health Strategy. Healthwatch led the engagement process to co-develop the Mental Health Strategy and also leads on the Kingston grassroots engagement programme with SWL Health & Care Partnership (SWLHCP).

9.4 Kingston Voluntary Action (KVA) Health and Wellbeing Network

The Health & Wellbeing Network is an open network of community and voluntary organisations that provide support to local communities that improves the health and wellbeing of Kingston's population. The CCG is developing its relationship with the network and increasingly working through it to hear feedback on our engagement and equalities work and to facilitate engagement with seldom heard groups.

9.5 Kingston Race Equality Scorecard

The Race Equality Scorecard brings together quantitative evidence on six different key indicators to help inform the decision making process of public authorities, and to equip local communities with the tools necessary to hold them to account.

10. PATIENT AND PUBLIC ENGAGEMENT

It is a key priority for us to engage with and ensure the views of our community are heard. There are groups within our local population who face specific barriers to being involved in our work and whose specific needs must be considered. These include those with protected characteristics as well as those groups that experience less access to services and poorer health outcomes eg. Insecurely housed or homeless people, gypsy traveller groups, refugees and asylum seekers, sex workers, people with disabilities and people with drug and alcohol problems.

We have established strong links with community groups and networks through our local community outreach programme and the grassroots programme over the past year.

10.1 Outreach programme

We regularly visit community groups and organisations to listen to people about their experiences of local services and to help them to shape future service provision. Through our outreach we have had meaningful conversations with local people who do not always feel their voice is heard or who face specific barriers to being involved in our work.

10.2 Grassroots

As part of the South West London Health and Care Partnership we are working with Healthwatch Kingston to engage with local community groups as part of the grassroots outreach programme.

The programme encourages organisations or community groups to apply for small grants to run an event or activity of their choice. We attend these sessions to discuss local services provision with people we do not usually hear from to enable them to help shape future service provision. The programme encourages people who would not normally get the chance to express their views about local services

to engage with the NHS, for example children and young people, LGB&T communities, people for whom English is not a first language, carers and socio-economically deprived communities.

Through both the outreach and grassroots programme, we engaged with groups including refugees and asylum seekers, those with long-term conditions, people with mental health conditions, carers and people with learning disabilities. We heard from a range of different groups who provided in depth insight about their experiences of local health care services. The feedback from each event is used to influence commissioning of related services both locally and across south west London.

Finding your voice - KCIL – July 2018

We worked with KCIL to run a workshop for 24 people with disabilities to help them develop the confidence to articulate their challenging personal health stories. We then listened and collated their stories before feeding them back to commissioners.

Elders Empowerment Event – Staywell – October 2018

We joined 50 people aged 60-90 years from the Tamil community to help them celebrate International Day of older people with a community sports day and lunch. We listened to their experiences of healthcare and life in Kingston and asked them how we can support them to age well. They told us about accessing community support, how important peer support through community hubs can be. They felt that mental health was often ignored in the community and that there was a stigma to accessing help which could lead to depression and loneliness.

10.3 Child and adolescent mental health (CAMHS) transformation programme

Engagement and involvement is a key part of the CAMHS transformation programme in order to ensure that the focus of mental health support addresses a very broad spectrum of need. A good example is conversations with children and young people and stakeholders across SWL which have been ongoing since January 2018. This is to develop and implement a whole systems approach to reducing the number of children self-harming and improve the support provided across all south west London boroughs. Face to face focus group took place in each borough, online surveys aimed at: children and young people; parents and carers and teachers were also completed. In total, 1252 people responded to the three

surveys, with 428 young people responding, 647 parents and carers, and 192 teachers. An additional 42 participants took part in five focus group discussions.

Survey respondents by borough:

	Children & Young people	Parents & Carers	Teachers	Total
Croydon	28	32	1	61
Kingston	56	109	19	184
Merton	109	77	70	256
Richmond	128	341	20	485
Sutton	14	21	66	101
Wandsworth	43	21	18	82
Other	41	41	1	83

For the children and young people survey, 55% of respondents identified as white British and 45% as other self-reported ethnicities. For the parent and carer survey, 68% identified as white British and 32% as other self-reported ethnicities. The genders of the children of the respondents to the Parent and carers survey were evenly balanced, but slightly more females responded to the children and young people survey than males (56%, 42% respectively).

In total, 31% of young people respondents had self-harmed and 18% of parent and carer respondents had a child who they were aware had self-harmed. Additionally, 43% of teacher respondents had supported a child who self-harmed.

Examples of some of the key themes to emerge included:

- ensure any initiatives complement CAMHS rather than acting as a substitute for their services
- think carefully about whether initiatives should be targeted at individuals in need or be open to all children
- co-design the initiatives with young people and those who have experienced the issues
- work to de-stigmatise mental health problems, without normalising self-harm

As a result of this engagement, additional support through the south west London emotional wellbeing programme to a cluster of schools in the borough which will include: the delivery of a whole school approach by development of a directory of services for emotional wellbeing and resilience available to children and young

people through a digital app, access to an online peer support programme and use of additional online tools and resources.

10.4 Quality in primary care

During autumn and winter 2017/18 we worked with Richmond CCG to understand local people's perception of quality for GP practices and community pharmacies. We asked local people for their views in a variety of ways e.g. comment cards in GP practices, pharmacies and other locations across the borough and an online survey. We also had conversations with individuals or groups that we would not routinely engage with e.g. young people with additional needs, people experiencing homelessness, refugees and people with English as not their first language. We heard from over 1,154 local people registered with a GP in Kingston or Richmond. We also asked staff working in GP practices and community pharmacies via an online survey and discussions at staff forums.

We asked local people what was important to them when they visit their GP practice or community pharmacy and how they could help their GP practice continue to deliver a quality service for all patients. We asked GP practice and pharmacy staff about what good quality primary care looks like and what matters most to them about the services they deliver.

What did we find out?

- Common themes across local people and primary care staff included the skills and patient management of the GP, the appointment booking process and having quick access to appointments.
- Local people understand that GPs are under pressure and there is a shared view about the patient's role and responsibility in helping practices deliver a quality service.
- Quality for community pharmacies focused on the skills and knowledge of the pharmacist, having a good stock of medication, a prompt and efficient prescription service and advice on alternatives to replace medication.

The insight from this and previous engagement about primary care shows that there are specific aspects of the GP services which patients with additional needs e.g those for whom English is not their first language or those with a disability would need to ensure they receive a quality service. These include:

- A choice of GP for continuity of care and empathy – *My husband* [multiple conditions and visually impaired] *prefers to see a GP who is empathetic. It*

can be difficult for him to communicate and get his point across as he also has slight hearing difficulties.

- Support for communication with GP during the consultation and reception staff when booking and arriving for an appointment for those for whom English is not their first language. – *At my practice you ring at 8 am and you usually get to see a GP on the same day. However it's not possible to arrange an interpreter at such short notice. Sometimes I find it difficult to understand the recorded voice on the telephone. You are not able to book in advance and therefore plan around your life.*
- Ensure sensory and language needs are catered for when communicating with patients e.g. when being called to see the GP, information during the consultation and follow up action – *Ordering online prescriptions is not accessible for those that are visually impaired. Traditional communication should always be available for those that need it particularly, for those whose first language is not English.*
- Offer of flexible appointments for patient and their carers – *Carers should have more flexibility when visiting their GP practice. Carers should be flagged up on the system so that they are identifiable within GP practices.*
- More time to see their GP to discuss a range of issues for those who have existing conditions and multiple health needs – *A willingness to cover more than one problem. My GP always gives me time as I have quite a few medical issues.*
- Basic awareness training amongst staff to understand different conditions and patient needs. For example, carer awareness and disability awareness training – *There is not enough awareness of ME and there is generally a misunderstanding due to NICE guidelines. Student GPs are not taught about ME as part of their studies. I need to push my GP for the support that I need. I feel as though I need to prove myself and do my own research, be my own advocate. The attitude of the GP is important.*

10.5 Use of technology

There was a positive response towards the use of technology in GP practices and respondents would welcome online systems that are easier to use. Some issues to consider regarding technology e.g online consultations and booking systems for specific patient groups area:

- Older patients may not have access to the internet or be less confident with an online booking system so may need greater support in using this.

- Patients with limited English skills and disabilities may be unable to access online services, if they do not cater for their language or support needs.

View the detailed findings in the engagement review.

We will:

- use the findings from this work to inform the development of service pledges and patient responsibilities for GP practices, working with practices and local people by September 2018.
- work with our Local Pharmaceutical Committee (LPC) to take forward the findings relating to community pharmacy.

11. PUBLIC HEALTH

The CCG and public health team at Kingston Council work together to ensure health inequalities are reduced and healthcare needs are met through robust evidence gathering. Public health has commissioning responsibilities that include prevention services, 0-19 child health (health visiting and school health), sexual health and substance misuse services.

The public health teams supports the CCG's commissioning and the organisation's work together to improve the health of local people in the borough and some examples are detailed here:

11.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) is a statutory duty of the Health and Wellbeing Board (HWB). It is a joint effort by all relevant stakeholders analysing information and evidence to enable the local authority and CCG to commission services effectively and efficiently.

Kingston's JSNA is made up of a number of needs assessments for different groups of the population, each being updated on a regular basis.

The JSNA also provides in-depth analysis of the protected characteristic groups and carers in the borough. This resource is designed to assist commissioners, providers and staff to understand the different and sometimes similar needs of the diverse groups within the borough.

11.2 Self-care

Public health and Kingston CCG are working in partnership to support self-care in Kingston. Self-care is about empowering people with the confidence and information to look after themselves when they can, know where to go for help, for example from a pharmacist, local community network or voluntary organisations before seeking help from a GP. It gives people greater control of their own health and encourages healthy behaviours that help prevent ill health in the long term. In many cases people can take care of their minor ailments, promoting their independence and reducing the demand made on health and social care services.

We have worked in partnership to deliver a range of activities including developing a self-care website, hosted by the Council to signpost individuals, joint social media campaigns and various health awareness activities.

Jointly we have focused on promoting winter wellness messages and particular to groups protected under the Equalities Act through community outreach and the grassroots engagement programme. Stay well information has been provided to groups including refugees and asylum seekers, homeless people and older people.

11.3 Children and young people

Across Kingston and Richmond CCGs and with both public health teams, work is ongoing around children and young people such as child exploitation and risky behaviour. This includes the development of a child sexual exploitation (CSE) needs assessment and a risky behaviour review of young people's services across Kingston and Richmond.

12. PATIENT ADVICE & LIAISON SERVICE (PALS) & COMPLAINTS

Our customer care team deals with PALS and complaints enquiries, concerns and formal complaints relating to health services commissioned by the CCG. There are processes in place to ensure the CCG captures the relevant information and systematically records formal complaints and concerns raised through the Customer Care team.

PALS is provided across Kingston and Richmond CCGs which provides a greater opportunity for patient feedback. The complaints and PALS policy and the standard operating procedures set out the process for accessing the PALS and complaints

service to ensure flexibility, access and provision of patient information. Information on PALS and complaints is available on the Kingston CCG website.

When a formal complaint is made equalities information is requested.

12.1 Advocacy provision in Kingston

Patients and residents are able to access independent advocacy services within the borough through POhWer who provide information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion.

13. SERIOUS INCIDENTS & SAFEGUARDING

The CCG monitors all serious incidents for providers of healthcare to patients in south west London. This is done through scrutiny of notifications and attendance at clinical quality review groups (CQRG) and serious incident review groups (SIRG) with providers.

Jointly Kingston and Richmond CCGs lead on serious incident management for

- South West London St George's Mental Health Trust
- Kingston Hospital Foundation Trust
- Hounslow and Richmond Community Healthcare Trust
- Your healthcare Community Interest Company (CIC)

Where the CCG is lead commissioner the quality lead will run a serious incident review panel or attend the trusts/provider serious incident review group. The purpose of these groups is to provide scrutiny of the serious incident processes, the outcomes and themes; to challenge and support the providers to embed the learning from incidents across the organisation.

Where the CCG is an associate commissioner we work with the lead commissioning CCG to assure us that the trust/provider has robust processes to manage and imbed learning from serious incidents.

The serious incident processes along with PALs, complaints and general practice notifications enables the CCG to monitor themes arising from the trusts/provider. The CCG triangulates the information from these sources to support and challenge the trusts/providers, to provide assurance to the CCG's Governing Body to ensure services are safe, high quality and to improve care for Kingston residents.

13.1 Safeguarding

One of the ways the CCG ensures that it complies with its equality duties by making sure that all services it commissions have safeguarding at their core.

The duties and functions in relation to safeguarding for the CCG are set out in NHS England's safeguarding accountability and assurance framework (June 2015). This document sets out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care.

Kingston and Richmond Safeguarding Children's Board and Safeguarding Adults Boards are supported with appropriate health representation to provide direction, advice, recommendations and support actions. CCG's are statutory members of both safeguarding adults and children's board.

The CCG's safeguarding leads work closely with providers to seek assurance that policies, procedures and training are in place to effectively safeguard children and adults at risk. There are structured mechanisms for further scrutiny via the CCG's quality, safety and performance committee and integrated governance committee.

The CCG internal safeguarding policies have been reviewed to ensure that they are in keeping with the equality duty requirements.

Kingston and Richmond CCG's promote equality and aim to address any health inequalities where these have been identified and highlighted.

Kingston and Richmond GPs are provided with quarterly safeguarding adults and safeguarding children's training update sessions which are facilitated and/or delivered by the adults and children's safeguarding leads. These sessions incorporate diversity and equality as core components of the training.

13.2 Safeguarding adults

Kingston and Richmond boroughs both have safeguarding adults boards. Richmond has a joint safeguarding adults board with Wandsworth borough. The safeguarding adults boards have equality and diversity at their core and both safeguarding adults boards give due regard to the need to eliminate discrimination, harassment and victimisation. The work of the CCG safeguarding leads ensure that there is equality of opportunity to foster good relations between people who share protected characteristics.

14.3 Safeguarding children

Kingston's Local Safeguarding Children Board and Richmond's Local Safeguarding Children Boards merged on the 0.1.04.2018. The Kingston and Richmond Local Safeguarding Children Board (LSCB) now have one set of sub groups apart from the Quality sub group where Kingston and Richmond each have their own. The Kingston and Richmond LSCB have a diverse safeguarding children multi agency training programme which is available to both CCG and provider services staff.

Kingston and Richmond LSCB has comprehensive training around diversity, equality and safeguarding children which is offered to the multi-agency workforce. This training helps professionals explore how their biases can affect work with children and families.

15. CONTRACTS, TENDERS & PERFORMANCE MONITORING

15.1 Contracts and tenders

Equality is important when contracting and tendering for health services to ensure that no part of the population is disadvantaged in terms of access and health outcomes. The CCG follows procurement rules in the tendering of services and all contracts are secured using the NHSE standard contract template which includes specific sections around the responsibility of providers with respect to equality. (Service Conditions SC13)

Patient representatives are involved in:

- Service reviews and redesign
- The production of service specifications
- Procurement panels

All new contracts, tender documents and service specifications complete an equality impact needs assessment.

The CCG uses the NHS Standard framework for all existing and newly awarded contracts, which promotes equality under service condition SC13 (equity of access, equality and non-discrimination) and outlines the requirements on providers to meet the Equality Act 2010.

For any proposed service changes we need to work to ensure EIAs are completed appropriately to identify the impact of the proposed changes for patients and in particular those from protected groups.

15.2 Performance monitoring

Achievement of outcome measures and the intelligent analysis of information provide assurance that the commissioning activity the CCG is engaged in has and will improve the health outcomes of the population in Kingston. Whilst performance has been successfully maintained over recent years, it is imperative that any performance standards seek to improve healthcare outcomes across the whole of Kingston.

The JSNA is an integral part of establishing whether all parts of the population are accessing services and contributing to the achievement of performance targets equally. Where there are apparent differences amongst populations in accessing services, targeted work aimed at improving access is carried out.

Detailed information on accident and emergency attendances, outpatient attendances and operations that take place in a hospital setting are sent to commissioners via the Secondary User Service (SUS) portal, which contains information on ethnicity, gender and age by which we ascertain how services are being utilised:

Kingston reports on achievement against the performance measures across the whole organisation on a monthly basis:

In addition, Improving Access to Psychological Therapies (IAPT) services submit data to NHS Digital, which are reported over a number of measures such as numbers of referrals, the number of people that drop out and the numbers of people that recover. These are shown by ethnic group, disability and age band.

Areas to address include:

- In some performance data, we are not able to identity the profile of patients who contribute to the achievement of the performance to ensure equity of access for all parts of the population.

- Inability to interrogate qualitative information from national surveys (such as the National GP Practice Survey or the Friends and Family Test) to ensure that there is no disparity in patient experience between differing groups.

- The population of some of the data fields for equality information within SUS needs to be improved (e.g. marital status), and some equality characteristics would need to be added to ensure a better understanding of any potential differential access to services, without small numbers making the information potentially identifiable upon publication. There is also a lack of national benchmarks pertaining to acute activity for equality information which could be used to understand where there are outlying areas within Kingston.

Below are examples of performance measures that reflect improved outcomes for groups with protected characteristics.

Achievement of performance measures that reflect improvements in health outcomes for historically disadvantaged parts of the population such as:

- Ensuring early access to treatment, both for elective operations (18 weeks) and diagnostic waits (under 6 weeks, and ensuring that mental health service users are also seen by South West London and St George's Mental Health Trust within the 18 week referral to treatment standards)
- Ongoing compliance with people experiencing a first episode of psychosis treated with an approved care package within two weeks of referral
- Ensuring attainment of the 6 and 18 week IAPT waiting times standards in 2016-17.
- Improved access to psychological therapy services (IAPT services) by people from BME groups (NHS Outcomes Framework 2.10).
- Minimal mixed sex accommodation breaches
- Health-related quality of life for carers, aged 18 and above (NHS Outcomes Framework 2.15).

The attached charts show the types of information that can be generated from SUS or the IAPT dataset.

KCCG.docx

16. WORKFORCE DATA

As of October 2018, Kingston CCG employed 46 people. The workforce data for ethnicity and religious beliefs can be found in Table 1 and 2 respectively.

Table 1

Ethnic Background	Kingston CCG (%)	Kingston borough (%)
White British	50	54.2
Asian	87	20.4
Black	64	3.2
Mixed	37	4.8

Table 1: Workforce data for ethnicity. *Borough data is taken from GLA projected ethnic make up of Kingston upon Thames 2018

Table 2

Religious belief	Kingston CCG (%)	Kingston borough (%)
Atheism	2.2	20.7
Buddhism	2.2	1.1
Christianity	30.4	52.9
Islam	4.3	5.9
Sikhism	4.3	1.5
Other	2.2	0.6

Table 2. Workforce data for religious beliefs *borough data is taken from 2011 ONS Census

Our staff team is 76% female and 24% male. 4.4% of our workforce are disabled and 70% are not.

17. WORKFORCE RACE EQUALITY STANDARD (WRES)

Implementing the Workforce Race Equality Standard is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. The WRES is there to ensure employees from

black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The WRES information provided in the table below sets out responses received to specific questions from the NHS national staff survey. In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Kingston CCG in 2017 (%)	**Average (median) for CCGs (%)**	**Kingston CCG in 2016**	**Average (median) for CCGs in 2016 (%)**
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White BME	15 -	9.5 6.7	6 -	8 10
KF 26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White BME	21 -	17.9	11	17
KF21	Percentage of staff believing that the organisation provides equal	White BME	75 -	87 5	93 -	90 67

	opportunities for career progression or promotion					
Q17b	In the last 12 months, have you personally experienced discrimination at work from your manager / team leader or other colleagues?	White BME	0 -	4.7 15	0 -	4 13

In the table above, no staff reported experiencing discrimination at work from either managers or colleagues and 75% of staff believe that the CCG provides equal opportunities for progression.

15% of staff indicated having experienced harassment, bullying or abuse from patients or relatives: when investigated further this was found to be as a result of telephone enquiries relating to continuing healthcare and mental health services.

21% of staff indicated having experienced harassment, bullying or abuse from staff. Following discussion with the Ways of Working Group the CCG promoted the policy and produced a guide for all staff. The CCG also appointed an anti-bullying guardian who staff can contact confidentially to discuss any concerns.

18. Next steps

During 2019 Kingston & Richmond CCGs will build on our joint approach for equalities e.g. shared equality objectives and equality analysis process.

We will explore joint working where it adds value across the wider Kingston & Richmond local health and care partnership - working with our key NHS, council and voluntary sector partners. This will include:

- Review effectiveness of our shared process for equality analysis across both CCGs
- Identify opportunities to run EDS2 across both CCGS and where appropriate with our providers
- Explore sharing staff training and development opportunities with NHS partners, including those in primary care.
- Review our community outreach programme to ensure the focus is on patients and local people who face barriers to who face specific barriers to being involved in our work and whose specific needs must be considered.
- Implement Workforce Disability Equality Standard

NHS
Kingston
Clinical Commissioning Group

GB 05.03.19 Attachment O

Glossary of terms

Term	Abbreviation	Explanation
4risk portal		A risk and business assurance management information software system that enables the CCG to monitor and measure its overall exposure to risk and examine the effectiveness of its control environment.
Accident and Emergency	A&E	Part of the hospital concerned with the immediate treatment of patients who have had an accident and require medical or surgical care.
Accountability		One of the three foundations of public service. Everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
Acute Services		Medical and surgical treatment and care provided mainly in hospitals. Also referred to as secondary care.
Acute Care		A branch of secondary health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.
Acute Trust		An NHS body that provides secondary care or hospital-based healthcare services from one or more hospitals.
Advocacy		Where a person acts as a champion for a patient or carer. An advocate could be one of a range of people including pharmacists, doctors, voluntary workers or the carer themselves.
Agenda for Change	AfC	Government reform of NHS staff terms and conditions.
Ambulatory Care	AC	Health services provided on an outpatient basis to those who visit a hospital or another health care facility and depart after treatment on the same day.
Any Qualified Provider	AQP	Patients can choose from a range of providers, all of whom meet NHS standards and prices. Prices paid to providers will be determined in advance by the NHS. This could be a national price list where it applies, or locally agreed price. Patients will choose based on quality and individual preferences and money will follow patients' choices. Competition will be on quality not price.
Average length of stay	ALOS	The total number of patient days divided by the number of admissions and discharges during a specified period of time, which results in an average number of days in the hospital for each person admitted.
Alternative Provider Medical Services	APMS	The Alternative Provider Medical Services (GMS) contract is the one of the contracts between general practices and NHS England for delivering primary care services to local communities. These contracts are commissioned regionally between the commissioners and a GP practice.
B		
Benchmarking		A process whereby organisations identify best performers. In particular, they examine how results are achieved in order to bring their own performance in line with the best.
Better Care Fund	BCF	A process whereby organisations identify best performers. In particular, they examine how results are achieved in order to improve their own performance
Black & Minority Ethnic Group	BME	Identified as a vulnerable group in health terms. Local health

		improvement programmes may include strategies to deal with the health needs of minority ethnic groups.
C		
Care Pathway/patient pathway		A care pathway is a patient's journey through the health (and social) care system to ensure the patient receives the most appropriate care.
Care Quality Commission	CQC	The independent regulator of health and social care. From April 2009, the CQC brought together the work of the Commission for Social Care Inspection (CSCI), the Healthcare Commission and the Mental Health Act Commission.
Case for Change		A report which presents a frank picture of where standards of care are falling short and where the safety of patients may be at risk with the aim of 'telling it like it is' so that patients, carers and stakeholders understand the need for change.
Chelsea and Westminster Hospital Foundation Trust	ChelWest	
Children's acute nursing services	(CANS)	
Choose and Book	C&B	A service that allows patients and their GP to choose the date, time and hospital for their initial referral and book it on-line.
Clinical		Relating to the treatment of a patient or to the course of a disease or condition.
Clinical Evaluation Team	CET	
Commissioning		Commissioning in the NHS is the process of ensuring that health and care services are provided effectively meet the needs of the population.
Commissioning Support Unit	CSU	An organisation that provides commissioning support services to CCGs through a service level agreement e.g. HR, communications, governance, finance, IT.
Commissioning Intentions	CIs	Describe the changes and improvements to commissioning healthcare that the CCG intends to make for the year ahead. Shared widely with providers and stakeholders and developed into a commissioning strategy plan for the coming year.
Conflicts of interest	(COI)	A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.
Clinical Evidence		Authoritative medical resource for informing treatment decisions and improving patient care.
Clinical Networks		Organisations used to deliver locally integrated services that are of consistently high quality.
Commissioning for Quality & Innovation	CQUIN	A payment framework which enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.
Community Access Strategy	CAS	
Community Education Provider Network	CEPN	Defines using education to support service transformation.
Constitution (Kingston CCG)		The constitution sets out our responsibilities for commissioning healthcare for the residents of the borough of Kingston. It describes the governing principles, rules and procedures that we have established to ensure probity and accountability in the day to day running of the CCG; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to our goals.
Continuing Care		Continuing Care services are provided in hospital, at home, in a

		care home, in a day hospital or day centre, or in a hospice. Services may include fully-funded continuing NHS health care in a care home or other setting; rehabilitation and recovery services; palliative care; respite health care; specialist health care support; specialist health care equipment; and specialist transport.
Continuing Professional Development	CPD	The means by which people maintain their knowledge and skills related to their professional lives.
D		
Delegated Commissioning	DC	CCGs to assume full responsibility for the commissioning of general practice services from April 2016.
Department of Health	DH / DoH	A department of the UK government with responsibility for government policy for health and social care matters and the National Health Service (NHS) in England along with a few elements of the same matters which are not otherwise devolved to the Scottish, Welsh or Northern Irish governments.
Directed Enhanced Service	DES	A nationally driven enhanced service to the GP contract which is commissioned by NHS England.
Directory of Service	DoS	A central directory that is integrated with NHS pathways which can be accessed if the patient does not require urgent or emergency care.
	DXS	Clinical decision support system which enables clinicians to deliver care cost effectively.
E		
East London NHS Foundation Trust	ELFT	
Emergency Admission		A patient admitted, unplanned, on the same day that admission is requested.
Emergency Treatment Centre	ETC	
Emergency Care		Providing life-saving measures in life-threatening situations.
Emergency Care Practitioner	ECP	
Emergency department	ED	
Egton Medical Information Systems	EMIS	A process for data access and reporting which allows the sharing of information between healthcare professionals.
End of Life Care	EOLC	Specialist care for all patients nearing the end of their lives.
End-to-End Pathway		A pathway which focuses on defining the complete care path from start to finish for patients. See also Care Pathway.
Estates and Technology Transformation Fund	ETTF	This is a fund for IT systems for referral management that would sit on top of the GP system.
Executive Team	ET	A team of senior managers and Governing Body GPs responsible for providing the CCG's overall management. Supports the CCG to work efficiently, effectively and economically, ensuring effective clinical engagement and promoting the involvement of all member practices in the work of the CCG.
F		
Finance and Performance Committee	F&P	
Foundation Trusts	FTs	NHS hospitals run as independent, public benefit corporations, which are both controlled and run locally.
Financial Recovery Plan	FRP	
G		
GP at Hand service		'GP at Hand' is a practice in North West London which offers general medical services to registered patients. The model focuses on a digital first service through the use of a mobile app which is provided by Babylon Health.
A GP Led Health Centre	GPiHC	Offers residents more choices and access to quality services at

		their convenience including extended opening hours and a range of bookable and walk in services for registered and unregistered patients.
General Medicine	GM	The assessment, diagnosis and treatment of disease and the maintenance of health via non-surgical means.
General Medical Services	GMS	The General Medical Services (GMS) contract is one of the contracts between general practices and NHS England for delivering primary care services to local communities.
General Practice Forward View	GPFV	The General Practice Forward View (GPFV) sets out a plan to invest £2.4 million to support GP services by 2020/21.
General Practice Patient Survey	GPPS	An England-wide survey, providing practice-level data about patients' experiences of their GP practices.
General Practitioner	GP	A specialist doctor who is qualified to assess and treat a broad range of patients from birth to end-of-life
General Practitioners with Special Interest	GPSIs	GPs that supplement their generalist role through specialist training to deliver a clinical service beyond the normal scope of general practice.
H		
Health and Wellbeing Board	HWBB	A forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of Healthwatch to work together to improve the health and wellbeing outcomes of the people in their areas. HWBB will take a lead role in the Joint Strategic Needs Assessment; promote and support joined up commissioning across NHS social care and public health; support pooled budget arrangements with other agencies such as CCGs; and undertake a scrutiny role with respect to major service redesign.
Health and Social Care Network	HSCN	The Health and Social Care Network (HSCN) is a way for health and care organisations to access and exchange electronic information.
Healthwatch		An organisation, established by the Health and Social Care Act 2012. The aim of Healthwatch is to give local people and communities a stronger voice to influence and challenge how health and social care services are provided locally.
Healthy Urban Development Unit	HUDU	Works with local, London wide and national organisations on behalf of the NHS. The HUDU ensures that new developments are planned with health in mind and helps to create healthy sustainable communities.
Healthy London Partnership	HLP	The Healthy London Partnership (HLP) brings together the NHS in London (Clinical Commissioning Groups and NHS England) and partners to deliver better health and care for London.
Health Inequalities		For example, the gap in health status and in access to health services, between different groups, social classes and ethnic groups and between populations in different geographical areas.
I		
Integrated Care System	ICS	
Improving Access to Psychological Therapies	IAPT	A programme which supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. See also National Institute for Health and clinical Excellence (NICE).

Indicator		A statistic or market that has been chosen to monitor health or service activity. For example, the number of women attending for breast cancer screening or the number of deaths from coronary heart disease in a defined population.
Information Governance	IG	Information Governance is the NHS framework setting standards of practice that enables organisations and individuals to ensure information is processed legally, securely, efficiently and effectively.
Information Technology	IT	This is the use of any computers, storage, networking and other physical devices, infrastructure and processes to create, process, store, secure and exchange all forms of electronic data.
Inpatient / Inpatient Services		A patient who is "admitted" to the hospital and stays overnight or for an indeterminate time, usually several days or weeks / a service provided to a hospitalised patient.
Integrated Governance		The means by which we pull together all the competing pressures on Boards and their supporting structures, to enable good governance (Integrated Governance Handbook, 2006)
Interoperability		The ability of computer systems or software to exchange and make use of information across services.
Individual Funding Requests	IFR	This can be made by your clinician (doctor or other health professional) if they believe that a particular treatment or service that is not routinely offered by the NHS is the best treatment for you, given your individual clinical circumstances.
Information Assurance	IA	Confidence that information and communication systems will, through their life cycle, protect the information they handle.
Integrated Care	IC	Health and social care services working together to improve the quality of care coordination and outcomes for patients and service users.
J		
Joint Strategic Needs Assessment	JSNA	The JSNA is made up of many needs assessments covering a range of health and social care topics, including cancer, diet and nutrition, end of life and carers. The JSNA aims to put these in context, exploring how the borough compares with other areas locally, regionally and nationally. It also examines what services we are currently providing, what works well and what could be improved.
K		
Key Performance Indicators	KPIs	Financial and non-financial metrics used to measure strategic performance of an organisation.
King's Fund		An independent charity working to improve health and health care in England.
Kingston Coordinated Care	KCC	
Kingston Hospital NHS Foundation Trust	KHFT	
L		
Lay Member		Lay members are non-executive members of CCG governing bodies. Each CCG's Governing Body is required to have a lay member responsible for: • Audit and governance • Patient and Public Involvement
Learning Disabilities	LD	A disorder in the basic cognitive and psychological processes involved in using language or performing

		mathematical calculations, affecting persons of normal intelligence and not the result of emotional disturbance or impairment of sight or hearing.
Length of Stay	LOS	The period of time a patient remains in a hospital or other health care facility as an inpatient.
Local Enhanced Service	LES	A locally driven enhanced service to the GP contract which is commissioned by the CCG.
Locally Commissioned Services	LCS	Another term for a LES – see above.
Locally Commissioned Services Steering Group	LCSSG	
Local Authority	LA	An administrative unit of local government.
Local Medical Committee	LMC	A statutory body recognised under successive NHS Acts, which provides advice and support to local NHS general practitioners
London Ambulance Service	LAS	
Long Term Conditions	LTC	Conditions, such as diabetes, asthma and arthritis that cannot currently be cured, but whose progress can be managed and influenced by medication and other therapies.
Local Strategic Partnership	LSP	Local Strategic Partnership: A non-statutory body that brings together the different parts of the public, private, voluntary and community sectors, working at a local level.
M		
Mental Health Trust	MHT	A Trust that provides specialist mental health services in hospitals and local communities.
Minor Injury Unit	MIU	A service for less serious injuries, such as deep cuts, eye injuries, broken bones, severe sprains, minor head injuries, minor burns and scalds.
Model of Care	MOC	An overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice and devined standards which broadly define the way health services are delivered.
Morbidity		Illness or disease
Mortality		Death. On a death certificate in England and Wales, a death is defined by a primary and underlying cause.
Multi-disciplinary team	MDT	Groups of professionals from diverse disciplines who come together to provide comprehensive assessment and consultation for a patient.
N		
National Institute for Health and Clinical Excellence:	NICE	The independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
No Cheaper Stock Options	NCSO	
North East London Commissioning Support Unit	NEL CSU	Provides expert support and advice to help clinical commissioners and NHS organisations to deliver improved health services to local populations.
Non Clinical		Staff within the NHS who do not have clinical responsibilities, e.g. administrative, IT, HR etc.
Non-Emergency		Not being or requiring emergency care. See also Emergency Care.
Novel Oral Anticoagulants	NOACs	Novel oral anticoagulants (NOACs) are a new class of anticoagulant drug and can be used in the prevention of stroke for people with non-valvular atrial fibrillation (AF).
NHS Confederation		The NHS Confederation is the membership body for all organisations that commission and provide NHS services.

NHS e-Referral service	e-RS	Combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment, book it in the GP surgery at the point of referral, or later at home on the phone or online.
NHS England	NHSE	Oversees local Clinical Commissioning Groups ensuring they have capacity and capability to commission successfully and meet their financial responsibilities. It also commissions some services directly. They also commission a range of specialist services.
NHS Outcomes Framework	NOF	The NHS Outcomes Framework sets out the results that the Secretary of State expects NHS England to deliver.
NHS Property Services	NHS PS	NHS Property Services brings property and facilities management expertise to the NHS estate.
O		
Out of Hospital Care		Services that are provided in GP Practice or clinic settings that give treatment to patients without them having to go into hospital. See also Out of Hours (OOH).
Out of Hours	OOH	Patient services provided by GPs outside of normal surgery hours. See also Out of Hospital Care.
Outcome		The result of a health intervention or treatment.
Outcomes Based Commissioning	OBC	Outcomes based commissioning (OBC) is an approach to commissioning health and social care services which rewards both value for money and delivery of better outcomes that are important to patients using the service.
Outpatient / Outpatient Services	OP	A patient who is not hospitalised for 24 hours or more but who visits a hospital, clinic or associated facility for diagnosis or treatment.
Over the counter	OTC	
P		
Palliative Care		An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, including physical, psychosocial and spiritual issues.
Pan London Network		A network across London.
Paper switch off	PSO	The standard contract for 2018/19 requires full use of the NHS e-Referral Service (eRS) for all consultant-led first outpatient appointments.
Patient Advice and Liaison Service	PALS	Provides patients, carers and their families with confidential advice and support on CCG NHS Services. All information provided to PALS is treated confidentially and no action will be taken without the agreement of the patient or the person concerned. PALS are accessible by phone, email or letter.
Patient and Public Involvement.	PPI	A way in which patients, the public, service users and carers can influence their own care and treatment, have a say in the way services are planned and run and help bring about improvements to the way care is provided. Each CCG's Governing Body has a lay member who is specifically responsible for PPI.
Patient Confidential Data	PCD	
Patient feedback		Feedback received from the public via such methods as deliberative events. See also Deliberative Event.
Patient Participation Group	PPG	A PPG is made up of patients who work together with staff and GPs to continuously improve the services and facilities offered by their practice. It also provides an opportunity to

		support the development of local NHS services by sharing patient experiences and providing a local viewpoint.
Planned Care	PC	Care provided to people which is planned in advance: e.g. surgery which a patient has been booked in for.
Primary Care		A range of out of hospital services provided by healthcare professionals such as GPs, nurses, health visitors, dentists, opticians, pharmacists and a range of specialist therapists.
Primary Care at Scale	PCAS	General practices working at scale together to deliver enhanced services.
Primary Care Commissioning Committee	PCCC	
Primary Care Operational Group	PCOG	This group will support the PCCC in its task of monitoring and assuring the primary care contracts.
Personal Medical Services	PMS	Personal Medical Services (PMS) agreements are the one of the contracts between general practices and NHS England for delivering primary care services to local communities. These contracts are commissioned locally between the commissioners and a GP practice
Prescribing Monitoring Document	PMD	
Prime Minister's Challenge Fund	PMCF	Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services, of which NHS England were asked to lead the process of inviting practices to submit innovative bids and oversee the programme.
Programme Management Office	PMO	A group or department within a business, agency or enterprise that defines and maintains standards for project management within the organization.
Provider		A hospital, clinic, health care professional, or group of health care professionals who provide a service to patients.
Public Health	PH	Public Health is concerned with improving the health of the population rather than treating the diseases of individual patients.
Q		
Quality, Finance and Performance	QFP	
Quality, Innovation, Productivity and Prevention	QIPP	A programme which supports clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements.
Quality and Outcomes Framework	QOF	Voluntary annual reward and incentive programme for all GP practices in England.
Quality and Safety Committee	QSC	
Queen Mary's Hospital, Roehampton	QMH	
R		
RAG rating		Red Amber Green (a rating system for indicating the status of something using the red, amber or green of traffic lights)
Risk Assessment		The determination of quantitative or qualitative value of risk related to a situation and a recognised threat.
Risk Management		Predictive technique used to identify and manage risks.
S		
Safeguarding		Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is a key part of providing high quality health and social care. Those most in need of protection, include: • Children and; • Vulnerable adults (people with physical, sensory and

		mental impairments, and those with learning disabilities).
Screening		Screening tests detect problems that have not yet caused symptoms. Screening may identify risk factors, genetic predisposition, and precursors, or early evidence of disease
Secondary Care		Services provided by hospitals (also known as acute care).
Section 75 (NHS Act 2006)		Allows the pooling of funds where payments may be made towards expenditure incurred in the exercise of any NHS or 'health-related' local authority. Section 75 also allows for one partner to take the lead in commissioning services on behalf of the other (lead commissioning) and for partners to combine resources, staff and management structures to help integrate service provision.
Section 75 (Health & Social Care Act 2012)		Requirements regarding procurement, patient choice and competition. This section enables the Secretary of State to make regulations imposing requirements on NHS England and CCGs in order to ensure good practice in relation to procurement, to ensure the protection and promotion of patients' rights to make choices regarding their NHS treatment and to prevent anti-competitive behaviour by commissioners with regard to health care services. This may include requirements on the use of competitive tendering by commissioners and on securing services without competition.
Serious Mental Illness	SMI	All individuals who have received a diagnosis of schizophrenia or bi-polar affective disorder, or who have experienced an episode of non-organic psychosis.
Service Level Agreement	SLA	Contractual agreements between NHS commissioners and providers.
Shared Care Prescribing	SCP	
Smoking Cessation		A nationwide NHS strategy to support people who want to stop smoking
South West London & St George's Mental Health NHS Trust	SWLStG	
Serious Incident	SI	Serious Incident: • Unexpected or avoidable death of one or more patients, staff, visitors or members of the public • Serious harm to one or more patients, staff, visitors or members of the public • A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services • Allegations of abuse • Adverse media coverage or public concern about the organisation or the wider NHS • One of the core set of "Never Events" as updated on an annual basis. The updated list for 2013-14 can be downloaded from the DH website.
Serious Incident Review Group	SIRG	Serious Incident Review Group: A CCG group led by the quality team that meets monthly to review serious incidents reported by providers where the CCG is the lead commissioner and/or where a borough patient is involved.
Stakeholder (CCG)		An individual or group that has an interest in an organisation or could be impacted by the work of the organisation
Sustainability and Transformation Plan	STP	The purpose of Sustainability and Transformation Plans (STPs) is to help ensure health and social care services in

		England are built around the needs of local populations
T		
Task and Finish Group	TFG	Sub-group which specifically reviews project.
Terms of Reference	ToR	Set out the membership, remit, responsibilities and reporting arrangements of a committee or group
U		
Urgent Decision Making	UDM	
Urgent Care (unscheduled)	UC	Care for people needing medical advice, diagnosis and/or treatment quickly and unexpectedly. See Urgent Care Centre.
Urgent Care Centre	UCC	A service primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department.
V		
Virtual Ward		A model of home-based coordinated care designed to reduce hospital admissions in a cost-effective way.
Virtual Private Network	VPN	
Vocare		Provider of outsourced quality clinical healthcare services to patients and commissioners in the UK.
W		
Waiting Time		The time which elapses between the request by a GP for an appointment and the attendance of the patient at the out-patient department or of receiving treatment.
Walk in Centre	WiC	Offers fast and convenient access to a range of NHS services, including advice and treatment for a range of minor illnesses.
Wards (Electoral)		An area within a local authority for electoral purposes.