Southwark Health and Adult Social Care Scrutiny Sub-Committee – February 2012

Interim Report into Southwark Clinical Commissioning Consortia

Part 1: Introduction

This report seeks to review, and make recommendations to improve, the transition to and operation of the clinical commissioning consortia that is being established in Southwark as part of the national government's changes to the National Health Service (NHS) in England. These changes will be enacted under the Health and Social Care Bill which is currently before the House of Lords at Committee Stage.

Whilst members of the Health and Adult Social Care Scrutiny Sub-Committee (HASC) have some reservations about the fundamental proposals contained within the bill and the potential detrimental impact on NHS services in Southwark it is beyond the remit of the sub-committee, or Southwark Council, to stop them. Therefore this report seeks to investigate and make recommendations to enable the changes to work as well as they can in Southwark. The overriding concern of HASC sub-committee members is the provision of high quality healthcare provision that meets the needs of Southwark's population and continually improves.

Importance

Importance of NHS to local population
Importance of existing work being undertaken (e.g. paediatric liver unit at KCH)
Importance of maintaining viable health economy

Scope of the Review

Review into the establishment, transition to and operation of a Clinical Commissioning Consortia in Southwark following changes to the NHS brought about by the government's Health & Adult Social Care Bill which is currently before Parliament.

The review will focus on:

i) Transition to the Consortia;
ii) Impact of cost savings on patient care;
iii) Conflicts of interest; and
iv) Contract management

This review seeks to influence Southwark Council, the Southwark Clinical Commissioning Consortia, the South East London PCT Cluster, the (to be created) Health & Wellbeing Board, NHS London and central government.

Achievable outcomes: influence Consortia's internal procedures; influence the transition to/setting of Consortia policies; draw attention to potential risks so that these can be mitigated by the council and consortia.

Part 2: Scrutiny of Establishment of Southwark Clinical Commissioning Consortia

Southwark Clinical Commissioning Consortia (SCCC)

The SCCC gave evidence to the committee on 29 June and 5 October 2011. In addition the HASC Chair attended a SCCC public meeting in July and the NHS Southwark AGM in September. The HASC sub-committee welcomes the open approach taken by SHC towards the scrutiny process and hopes that the recommendations contained within this report are received with the same openness.

Dr Amr Zeineldine (Chair SHC) and Andrew Bland (Managing Director Southwark Business Support Unit) gave evidence to the sub-committee to explain the transition to the consortia, the impact of cost savings (QIPP) on patient care and at the sub-committee's request the SCCC provided further clarification of its conflict of interest policies.

Consortia Background

Southwark Health Commissioning was granted Pathfinder status in the first wave of GPs in England to have been selected to take on commissioning responsibilities. Pathfinders are working to manage their local budgets and commission services for patients alongside NHS colleagues and local authorities. The new commissioning system has been designed around local decision making and Southwark Health Commissioning believes that this will lead to more effective outcomes for patients and more efficient use of services for the NHS. GP Commissioning is not new in Southwark. Southwark's General Practices have worked together as a commissioning group since the beginning of 2007 when the Southwark Practice Based Commissioning Leads Committee was established. Local GPs have a record in commissioning and service redesign. Under existing arrangements GPs have been involved in the planning of several major areas of patient care such as outpatients, walk-in centres, and local community services. Southwark Health Commissioning has the support of local GPs and doctors' representatives and the local authority and will begin testing the new commissioning arrangements to ensure they are working well before formal delegation in April 2013.

Southwark Health Commissioning consists of a board of eight GP members, four from the South of the borough and four from the North. The SCCC is chaired by Dr Zeineldine who is also a member of the PCT Board. The current SCCC membership brings together the senior management team of the Southwark Business Support Unit, the Non Executive Directors (NEDs) of the Board with responsibility for Southwark and the consortium leadership team who represent their constituent practices. All of the above constitute the voting members of the SCCC, in which the eight clinical leads hold a majority. Other non-voting members include Adult Social Care, King's Health Partners, a nurse member, a Southwark LINk representative and a representative of the Southwark Local Medical Committee.

Whilst the previous Primary Care Trust structure was not perfect and did have a democratic deficit, the sub-committee is concerned by the closed nature of commissioning consortia as set out by government, as the only people who can be guaranteed to sit on the board are local GPs. Whilst this may bring benefits it is also worrying that there is only a relatively small pool of people from which lead GPs can be elected (and indeed take part in election). This is not a criticism of existing GP leads but highlights potential problems that could develop in the future and tries to mitigate against these. It is understood that Southwark Health Commissioning has co-opted members onto its board which is a welcome step. The sub-committee recommends that this practice of co-opting members onto its board continues

in the future to broaden the range of experiences available when making commissioning decisions.

Due to the controversial nature of the changes being made by national government it is vital the consortia builds trust with the resident population, council and other local providers and organisations. It is also important for patients to feel that they are being listened to, as David Cameron has said “no decision about me, without me”. Therefore the sub-committee urges that a culture of listening and consultation with patients is developed and built upon to ensure that it remains front and centre in commissioners’ minds. Initial steps have already been taken by SHC, which are to be welcomed, however this must continue.

Southwark Health Commissioning 2011/12 business plan outlines the trajectory for delegation, whereby SHC takes on responsibility for commissioning (i.e. spending taxpayers’ money). The timetable for delegation can be found at appendix 1. Essentially by January 2012 SHC will be responsible for a budget of £421million which is c.80% of total NHS spend in Southwark. Nationally GP-led consortia will be responsible for spending £80billion on an annual basis; this represents 80% of total NHS spending. It is critical the people responsible for spending this money have comprehensive structures to deal with conflicts of interest and prevent possible misappropriation of tax-payers money.

Conflict of Interest

The sub-committee agreed to look at SCCC’s conflict of interest policy and their contract management arrangements. SCCC’s current conflict of interest policy can be found at appendix 2. HASC sub-committee members feel that while these measures are a good starting point they are not rigorous enough. There are potential conflicts of interests that will arise for GPs in their new role as commissioners. GPs bidding as providers who are also commissioners is a key tension in the new arrangements set out by national government. As mentioned above the SCCC and NHS SE London are already looking at how conflicts of interest could be managed locally, but guidance should be set out nationally on how such conflicts are managed.

It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that such training continues and a programme of ‘refresher’ training and sharing experiences and best practice from other public bodies and clinical commissioning groups takes place.

In addition, given the importance of the SCCC’s work and the vital need for transparency to build public confidence in the new arrangements and to allow proper accountability the sub-committee recommends the following:

a) All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.
b) Meetings of the SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private. A similar model to the council should be adopted whereby any ‘closed items’ can be discussed in private, but minutes of the non-public part of the meeting should be published.

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c) Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.
d) The register of interests should be updated within 28 days, of a change occurring.
e) Southwark's HASC sub-committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark HealthWatch, SHC Chair and the local press.
f) If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.
g) Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.
h) In line with best practice a new clause be added to the SHC/SCCC's conflict of interest policy to emphasise: "That a member in possession of material non-public information that could affect the value of an investment must not act or cause others to act upon that information".

King's Health Partners

On 5 October 2011 the sub-committee took evidence from Professor John Moxham, Director of Clinical Strategy for King's Health Partners (KHP). KHP is an Academic Health Sciences Centre (AHSC), which delivers health care to patients and undertakes health-related science and research. This type of organisation is fairly common amongst the leading hospitals and universities around the world. KHP is one of the UK's five AHSCs. It brings together a world leading research led university (King's College London) and three NHS Foundation Trusts (Guy's and St Thomas', King's College Hospital and South London and Maudsley).

Their aim is to create a centre where world-class research, teaching and clinical practice are brought together for the benefit of patients. They aim to make sure that the lessons from research are used more swiftly, effectively and systematically to improve healthcare services for people with physical and mental health care problems. At the same time as competing on the international stage, their focus remains on providing local people with the very best that the NHS has to offer. The aim is for local people to benefit from access to world-leading healthcare experts and clinical services which are underpinned by the latest research knowledge. There will also be benefits for the local area in regeneration, education, jobs and economic growth.

Professor Moxham explained to the sub-committee the importance of integration and collaboration for KHP to improve patient outcomes. Within KHP there are 21 'Clinical Academic Groups' (see appendix 3) that integrate services across the partners, this pulls together knowledge, experience and expertise across the different hospitals and leads to better patient outcomes. There are four main streams to this integration:

1) Integrating Services across the partners
2) Integration of clinical service with academic activity
3) Integrating mental and physical health
4) Integration of core patient pathways

He explained to the sub-committee that this level of integration, to improve patient outcomes, is reliant on collaboration between all parts of the local health system, and indeed the local authority. Sub-committee members have concerns that the introduction of private providers into this system through 'Any Qualified Provider' could have a detrimental impact on the development of KHP and the continual improvement of health outcomes for our residents. This concern is based on the reality that private providers are in part motivated by profit (which is wholly understandable) and that if collaboration was not deemed to be in their business interests then further integration and improvement of patient outcomes could be jeopardised. Therefore the sub-committee recommends that the SCCC's tendering process

for any service includes standard clauses in the contract to ensure collaborative working and integration continue to take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority.

King's College Hospital and Guy's and St Thomas' Hospital Trusts

Sub-committee members visited both hospitals (a visit to SLaM is being organised) and met with the Chief Executive and Chair of KCH and the Chief Executive of GST. Members also saw the Specialist Stroke Unit and A&E at KCH and the A&E at GST. The sub-committee would like to thank both hospitals for hosting members and shining a light on the work that they do.

At KCH it was clear the hospital excels in certain types of treatment and care, for example Paediatric Liver Transplants, Neuro-Sciences and Stroke Care. At GST it was also clear that the size of the trust allows cross-working between types of clinician that leads to innovative forms of treatment for patients. As discussed in more detail above King's Health Partners is driving such integration and collaboration even further which is to be commended.

At KCH concerns were raised by management that if income streams were removed (i.e. other providers were commissioned by the SHC) then the financial viability of KCH would be put at serious risk. This is a serious concern of the sub-committee, as it would be unacceptable for the specialisms and work of any acute trust and KHP to be put at risk as this would be detrimental to serving the health needs of the local population. This is not to say KCH (and GST and SLaM) should not be challenged to deliver more cost efficient forms of care, but that the viability of the institutions should not be put at risk. Therefore the sub-committee recommends to the SCCC:

a) That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers.
b) That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASC) for consideration and should be deemed a 'substantial variation' and be submitted to the HASC sub-committee for scrutiny, including outsourcing
c) The sub-committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'
d) The HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision.
e) As a contractual obligation all providers should be subject to scrutiny by the HASC sub-committee just as NHS ones currently are.

Impact of Cost Savings on Patient Care

In addition to the changes to NHS Commissioning described above the government has also required the NHS to make total savings in England of £20billion,at a time when Southwark's population is increasing by 2% per annum. The impact of these savings on patient care in Southwark has been included in this report to highlight potential problems and areas of pressure within the system.

NHS Southwark Performance

A full breakdown of performance data for Southwark can be found at Appendix 4 (taken from Southwark NHS' Annual Report 2010/11). This shows an underperformance for the 18 week waiting time target, it also shows worryingly high failures to meet targets for Breast Screening, Cervical Screening, Smoking Quitters and immunisation of children – particularly those aged 5. Additional areas of concern are alcohol consumption, sexual health and childhood obesity, currently at 25.7% of year 6 pupils (age 11-12). We will have to await next year's report to assess performance for the current financial year. Failure to improve on these targets would be of deep concern to the sub-committee.

Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, it is recommended that the HASC sub-committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health.

Contract Management

With delegation of budgets to the SCCC comes responsibility for making commissioning decisions and tendering contracts. This may be self-evident but is worth highlighting and dwelling upon. The SCCC currently uses the expertise of Southwark PCT's Business Support Unit (BSU) who provide them with commissioning support. In April 2013 SCCC will be able to decide who provides this commissioning support in the future.

One of the unfortunate consequences of central government's changes has been the breaking of the very close working between Southwark PCT and Southwark Council. In the immediate future the working relations developed between BSU and SC staff will almost certainly remain, however, in the future these working relationships may erode as they are not formally codified as they were in the past. This could lead to a lack of integration at all levels of both organisations which could impede improvement in health outcomes for Southwark's residents. The sub-committee therefore recommends SHC and its BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing).

As part of the move to 'Any Qualified Provider' it is more than likely that at some stage a private provider will be commissioned to deliver health services in some form in Southwark. Given the mixed experience that parts of the public sector have had with private providers (e.g. Southwark's housing repairs service and call centre) it is imperative that SCCC take a robust approach to contract management, both in drawing up contracts and in monitoring them when signed.

The recent experience and problems caused by the collapse of Southern Cross care homes and the levels of poor care provided at other privately run homes should act as stark warnings to health care commissioners. It took several years for their flawed business model to be exposed (when market conditions changed). To avoid any repeats of this in the health care system the sub-committee urges the SCCC to introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on the financial position of the provider on a quarterly basis and that robust monitoring of satisfaction amongst patients placed with those providers takes place.

There have been previous instances of tendering out NHS services, for example in April 2004 it became possible to outsource primary care out of hours services to independent commercial providers. John Whitting QC, a specialist barrister in clinical and general

professional negligence, has reviewed the subsequent CQC and DH reports and inquiries into this and in June 2011 stated that:

"It identified staffing levels that were potentially unsafe, significant failures of clinical governance caused directly by overly ambitious business growth and failures to investigate or act upon serious adverse incidents. The CQC chairman concluded that 'the lessons of these failures must resonate across the health service'." (John Whitting QC, New Statesman, 23/06/2011)

The sub-committee recommends that SCCC works closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational abilities. The details of this arrangement should be for the SCCC to decide, but contract management and effective monitoring must not be an afterthought in any potential tendering process but at the centre.

Further info required: TUPE – If a service is tendered out to a private or other provider will the staff currently providing the service be covered by Transfer of Undertakings (Protection of Employment) TUPE legislation?

Part 3: Conclusions and Recommendations

In summary, the sub-committee's recommendations are listed below, the body(ies) which the sub-committee is seeking to adopt the recommendation are italicised in square-brackets at the end of each one.

Recommendation 1

That the practice of co-opting members onto the SCCC's board continues in the future to broaden the range of experiences available when making commissioning decisions. *[SCCC, NHS SE London]*

Recommendation 2

Given the importance of SCCC's work and of the vital need for transparency to build public confidence in the new arrangements, that:

a) All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.
b) Meetings of the SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private. A similar model to the council should be adopted where by any 'closed items' can be discussed in private, but minutes of the non-public part of the meeting should be published.
c) Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.
d) Declarations of Interest are recorded at the beginning of meetings and recorded in sufficient detail in the minutes.
e) The register of interests should be made public by being published online, in an easy to find location. To avoid confusion the SCCC should use consistent terminology when referring to *declarations* of interest and *the register* of interests.
f) Southwark's HASC sub-committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark LINk/HealthWatch, SCCC Chair and the local press.
g) If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.
h) Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.
i) The SCCC ensures there is a non-executive non-GP 'Conflict of Interest Lead/Tsar' on its board and amends its constitution accordingly.
j) In line with best practice a new clause be added to the SHC/SCCC's conflict of interest policy to emphasise: "That a member in possession of material non-public information that could affect the value of an investment must not act or cause others to act upon that information".
k) The SCCC should develop a comprehensive policy for handling and discussing confidential information.
l) In the interests of transparency, the SCCC should publish the results of election ballots for the 8 lead GPs, in addition they should publish full details of the ballot process and who conducts the ballot.

[All of the above – SCCC/NHS SE London]

Recommendation 3

That the SCCC's tendering process for any service includes standard clauses in the contract to ensure collaborative working and integration continue to take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority. *[SCCC, NHS SE London and Southwark Council]*

Recommendation 4

That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers. *[SCCC, NHS SE London and Southwark Council]*

Recommendation 5

That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASC) for consideration and should be deemed a 'substantial variation' and be submitted to the HASC Sub-Committee for scrutiny, including outsourcing

Recommendation 6

The sub-committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'. *[DH, via HASC Sub-Committee]*

Recommendation 7

That the HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision. *[HWB and Monitor through HASC Sub-Committee].*

Recommendation 8

That, as a contractual obligation, all providers should be subject to scrutiny by the HASC Sub-Committee just as NHS ones currently are. *[SCCC, NHS SE London, Southwark OSC].*

Recommendation 9

Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, that the HASC sub-committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health. *[HASC Sub-Committee].*

Recommendation 10

That SCCC and its BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing). *[SCCC, NHS SE London, Southwark Council].*

Recommendation 11

That SCCC work closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational capabilities. The details of this arrangement should be for the SCCC to decide, but contract management must not be an afterthought in any potential tendering process but at the centre. *[SCCC, NHS SE London and Southwark Council].*

Recommendation 12

That the Health and Wellbeing Board has a central aim of stimulating integration and collaboration between local health care providers to improve patient outcomes. *[HWB].*

Recommendation 13

Patient views and perceptions of the level of care they receive are vitally important to improve services. It is therefore recommended that the Acute Trusts continue to conduct patient surveys, and the SCCC drives patient surveys at GP practices across the borough to capture patients' views and perceptions of their care to help understand what can be improved. *[Acute Trusts x 3 and SCCC]*

Recommendation 14

That the SCCC introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on the financial position of the provider on a quarterly basis. *[SCCC, NHS SE London]*

Recommendation 15

That robust monitoring of satisfaction amongst patients placed with all providers takes place as a matter of course.

Recommendation 16

In addition to clinical standards, set out by government, that minimum levels of patient satisfaction are included in any contracts signed by the SCCC with financial penalties if these are not met, the exact levels, and how they are measured, should be a matter for the SCCC. *[SCCC, NHS SE London]*

Recommendation 17

Guidance on managing conflict of interest for GP commissioners should be set out nationally. It is recommended that the HASC writes to the Dept of Health requesting this to take place. *[HASC Sub-Committee]*

Recommendation 18

It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that governance training continue for GP commissioners and a programme of 'refresher' training, sharing experiences and best practice from other public bodies and clinical commissioning groups takes place. *[NHS SE London, HASC]*

Recommendation 19

That the SCCC consider their capacity for developing contracts and build this into their development plan, in particular where they will access expertise in drawing contracts up and monitoring them when signed. *[SCCC]*

Recommendation 20

That the SCCC works closely with and pays close regard to the priorities of the local authority and health and wellbeing board to foster cooperation and meet the mutual goal of improving health outcomes of Southwark's residents. *[SCCC]*

Recommendation 21

That that the SCCC monitors clinical outcomes, including measures such as mortality rates, and that these are related to contracts signed with all providers, with financial penalties attached. *[SCCC]*

Recommendation 22

That the SCCC appoints external auditors *[SCCC]*

Appendix 1 - timetable for delegation to SCCC

2011/12 Budget Delegation

Delegation Phase / Date	Budget Area	Budget (£m)	QIPP Gross (£m)	Detail / Complexity* (column consider the complexity of the commissioning area to inform phase)	
One – Jul 2011	Emergency PbR	49	4.8	This phase includes the following areas:	
	A&E PbR	12	0.1		
	New Outpatients	19	2.4		
	F-up Outpatients	22	1.5	Outpatient (GP referrals)	Low
	Drugs and Devices	11	0.5	Prescribing	Low
	Pri Care Prescribing	33	1.0	Urgent care (A&E / UCCs)	Med
	Corporate	17	2.0	Urgent care (Admissions)	Med
				Non GP referred outpatients	Med
				Intermediate Care / Reablement	Med
				Non-PbR Drugs and Devices	Med
Total		163	12.3	(6.3 delivered prior to delegation)***	
Two – Oct 2011	Community Services	33	1.5	This phase includes the following areas:	
	Other Acute**	166	2.6		
				Community Health	Low
				Direct Access Diagnostics	Low
				Sexual Health	Med
				Elective Care	Med
				Maternity	Med
				End of Life Care	Med
				Critical Care	High
				Specialist Acute Commissioning	High
Total		199	4.1	(3.6 delivered prior to delegation)	
Three – Jan	Client Groups	22	-	This phase includes the following	

2012	Mental Health	67	2.6	areas: Community Mental Health Voluntary Sector CAMHS Inpatient Mental Health Physical Disability Specialist Mental Health Continuing Care (inc. LD)	 Med Med Med Med Med High High
Total		89	2.6	(4.6 delivered prior to delegation)	
Other	Non-recurrent 2% Reserves / Surplus	10 11	- -		
Total		21	-		
Non-Delegated	Primary Care	68	1.2		
Total		68	1.2	(0.8 delivered - no delegation)	
Budget Total		**540**	**20.2**		

Notes:

***** SHC has sought to take early delegation for those areas that fall in areas of low or medium complexity. Complexity refers to the commissioning activity itself and SHC are equally aware of the different levels of control that can be secured over performance in these areas.

** Includes £30m budget for Specialised Commissioning which will continue to be led through the LSCG.

******* Clearly delegation is being made in-year and the figures provided above also seek to reflect the level of QIPP delivery undertaken ahead of delegation in the context of the overall QIPP challenge.

Appendix 2 - SHC's current conflict of interest policy

SCCC approach to Conflicts of Interest

1.1. A register of interests of members of the SCCC will be systematically maintained and will be made publically available. These details will be published in the PCT Annual Report. Members will also be asked to declare any interests at the start of each SCCC meeting.

1.2. To ensure that no commercial advantage could be gained, a GP lead who declares an interest in an area cannot be involved in it. If after being involved, any bids received from the lead's practice would not be accepted.

1.3. Where the business of the committee requires a decision upon an area where one GP holds a significant conflict of interest, the Chair will ensure that the individual takes no part in the discussion or subsequent decision making.

1.4. Where more than two GP leads holds a significant conflict of interest the committee will require consideration of the proposal / issue to be made by a separate evaluation panel. The evaluation panel would evaluate the proposal for quality and cost-effectiveness and if satisfied it would then make a recommendation to the Clinical Commissioning Committee, excluding the interested GP members, for decision.

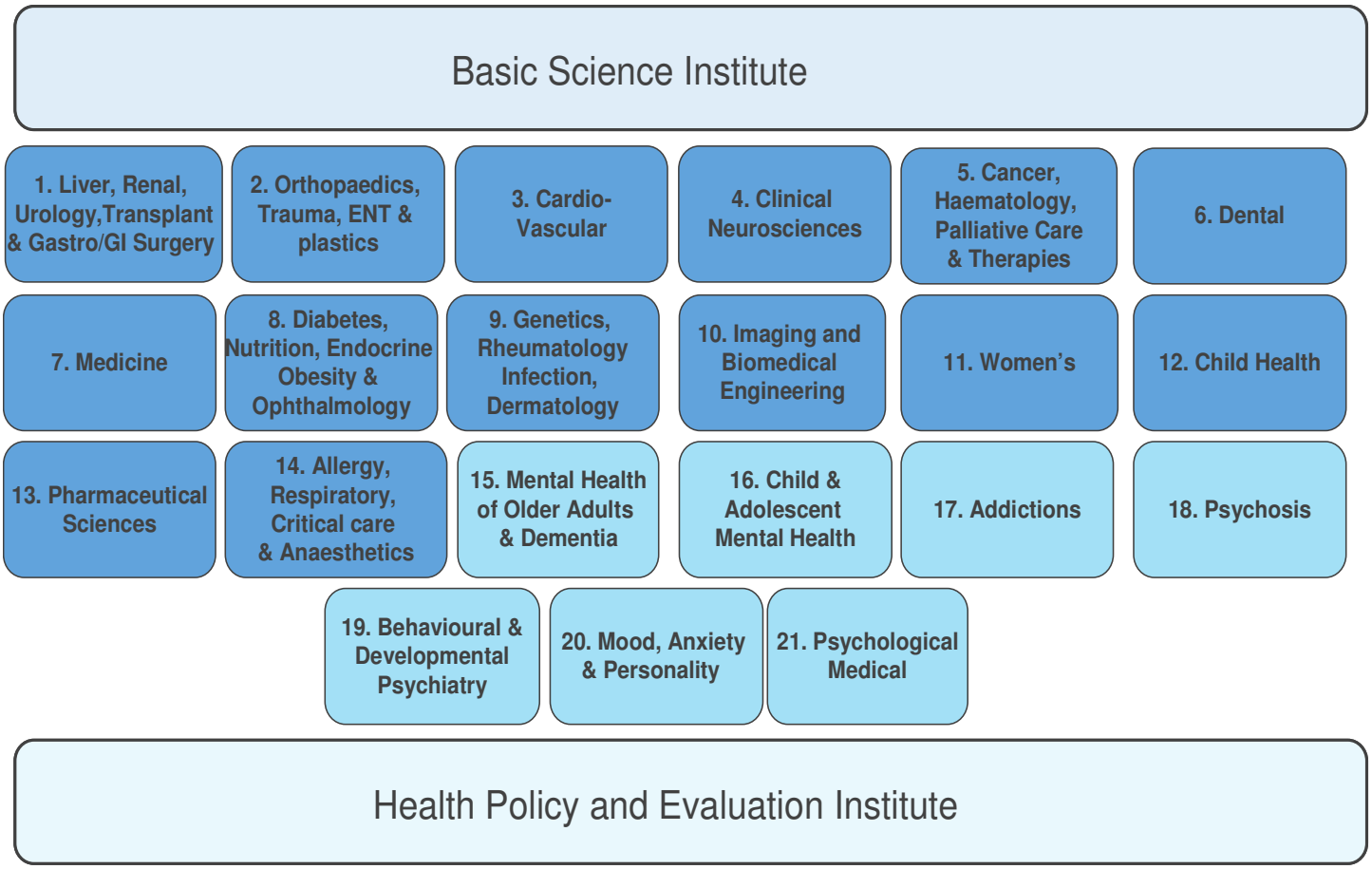
1.5. The Evaluation Panel, when called upon, will provide neutrality in the evaluation process and will have the following membership:

- One Non-Executive Director of the PCT Board
- Managing Director, Southwark BSU
- Southwark Director of Public Health (and Health & Well Being Board representative)
- Co-Opted clinical expertise if necessary at discretion of the MD

1.6. In the rare occasion where the Clinical Commissioning Committee is unable to reach a decision under these circumstances the decision maybe referred to the PCT Board.

Appendix 3 - King's Health Partner's Clinical Academic Groups

CAG and Research Group Structure



Appendix 4 – 2010/11 Performance data for NHS Southwark (from Annual Report)

Performance data

Table Performance on Vital Signs Existing Commitments: Outturn 2010/11

Existing Commitments	Operating standard	Actual Outturn	Traffic Light
A&E 4 hours wait	95%	97.0%	
GUM Access	98%	100%	
Delayed Discharges (per 100,000 population)	4.5	1.63	
Category A Ambulance response within 8 mins	75%	77.6%	
Category B Ambulance response within 19 mins	95%	90.4%	
Diabetic retinopathy (patients offered screening)	95%	100%	
Number of people receiving early intervention services	58	99	
Number of people receiving home treatment services	773	799	

Table Performance on Vital Signs National Priorities: 2010/11

National Priorities		Target	Actual	Traffic Light
Clostridium Difficile (C. diff.) cases		179	108	
18 weeks - referral to treatment	% of admitted patients treated in 18 weeks	90%	88.4% (March 11)	
	% of non-admitted patients treated in18 weeks	95%	88.4% (March 11)	
Cancer 2 week waits (all urgent GP referrals)		93%	96.5%	
Cancer 2 week wait (for all breast symptom referrals)		93%	97.4%	
Cancer 31 day wait from diagnosis to (first definitive) treatment		94%	98%	
Cancer 31 day wait from diagnosis to (subsequent surgical) treatment		96%	96%	
Cancer 31 day wait from diagnosis to (subsequent chemotherapy) treatment		98%	99.7%	
Cancer 62 day wait from urgent GP referral to treatment		85%	85.6%	
Cancer 62 day wait from urgent referral from national screening services to treatment		85%	100%	
Cancer 62 day wait from consultant (upgrade) referral to treatment		90%	98.1%	
Satisfaction with Primary Care Access	Access to a GP appointment in 48 hours		76%	
	Advanced booking		73%	
	Overall satisfaction with opening hours		80%	

Table Performance on Vital Signs National Priorities: 2010/11 continued

Quality stroke care	% time on stroke unit	90%	92%	
	TIA early diagnosis and treatment	60%	100%	
Mortality rates	Cardiovascular disease mortality (per 100,000 population)	101	79.45 (2007-9 pooled data)	
	Cancer mortality (per 100,000 population)	114	122.42 (2007-9 pooled data)	
Breast screening (of women aged 53-70)		70%	61.1% (2009/10)	
Cervical screening	women aged 25-49 in last 3.5 years	80%	66.5% (2009/10)	
	women aged 50-64 in last 5 years	80%	75.3% (2009/10)	
Smoking quitters		1326	1234	
Maternity services early access within 13 weeks		90%	93.5% (latest data on births is Q2)	
Teenage conceptions (rate per 1000 females aged 15-17)		67.4	63.2 (2009 data)	
Breastfeeding at 6-8 weeks		63.6%	74.4%	
CAMHS		Level 4	Level 4	
Chlamydia screening (of people aged 15 to 24)		35%	39%	
Immunisation	Immunisation rate for children aged 1 - DTaP/IPV/Hib	90%	87.9%	
	Immunisation rate for children aged 2 - PCV booster	90%	82.5%	
	Immunisation rate for children aged 2 - Hib/MenC booster	90%	93%	
	Immunisation rate for children aged 2 - MMR	90%	83.9%	
	Immunisation rate for children aged 5 - DTaP/IPV	90%	62.9%	
	Immunisation rate for children aged 5 - MMR	90%	66%	
	HPV vaccination for 12-13 year old girls	90%	63.6% (Sept 09 – Aug 10)	
Dental Access (to an NHS dentist in last 24 months		142,956	143,760	
Childhood obesity	Reception year	14.5%	14.8%	
	Year 6	28.3%	25.7%	
Drug users in effective treatment		1851	1322 (to Feb 2011)	