Open Agenda

Healthy Communities Scrutiny Sub-Committee

Tuesday 11 April 2017
7.00 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Contact

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Date: 7 April 2017

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The board's priorities are set out in its Joint Health and Wellbeing Strategy, this strategy outlines how the council and its partners will work together to promote integration, improve outcomes and reduce health inequalities of Southwark's residents by focusing on three strategic objectives. These are:

- Giving every child and young person the best start in life
- Building healthier and more resilient communities and tackling the root causes of ill health
- Improving the experience and outcomes of care for our most vulnerable residents and enabling them to live more independent lives

The full strategy is available here : http://www.2.southwark.gov.uk/downloads/download/3570/joint_health_and_wellbeing_strategy_2013-14

Healthy Communities Scrutiny Sub-Committee

MINUTES of the OPEN section of the Healthy Communities Scrutiny Sub-Committee held on Tuesday 28 March 2017 at 7.00 pm at Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Rebecca Lury (Chair)
Councillor David Noakes
Councillor Sunny Lambe
Councillor Maria Linforth-Hall
Councillor Martin Seaton
Councillor Bill Williams

OTHER MEMBERS PRESENT:
Councillor Richard Livingstone, Cabinet member for Adult Care and Financial Inclusion

OFFICER & PARTNER SUPPORT:
Andrew Bland, Chief Officer, NHS Southwark CCG
Caroline Gilmartin, Director of Integrated Commissioning, NHS Southwark CCG
Jean Young, Head of Primary Care Commissioning NHS Southwark CCG
Rebecca Scott, Programme Director, NHS Southwark CCG
Caroline Gillmartin, NHS Southwark CCG
Emily Gibbs, GP clinical lead for GP services
GP Federation leads:
- Dr Olufemi Osonuga, Deputy Chair of QHS
- Dr Lauren Parry, IHL Director
- Dr Rebecca Dallmeyer (QUAY HEALTH SOLUTIONS)

Jon Abott, Head of Regeneration, North, Southwark Council

1. APOLOGIES

1.1 There were apologies for absence from Cllr Anne Kirby.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were no urgent items of business.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no additional disclosures of interests or dispensations.

4. MINUTES

RESOLVED

There were two corrections to be made to the minutes of the meeting held on 21 February 2017 :

- Cllr Bill William's partner, not wife, works for GSTT.
- Cllr Sunny Lambe's wife works for NHS Greenwich, not him.

LINK TO LIVE-STREAM/VIDEO

Opening, minutes & declarations

http://bambuser.com/v/6682783

5. INTERVIEW WITH THE CABINET MEMBER FOR ADULT CARE AND FINANCIAL INCLUSION

The committee interviewed the Cabinet Member for Adult Care and Financial Inclusion, Councillor Richard Livingstone, on his portfolio.

LINK TO LIVE-STREAM/VIDEO

Part One : http://bambuser.com/v/6682785

Part Two : http://bambuser.com/v/6682803

Part Three : http://bambuser.com/v/6682816

6. SCRUTINY REVIEW - SOUTHWARK GP PRACTICES: QUALITY OF PROVISION & LOCAL SUPPORT ARRANGEMENTS

A roundtable discussion was held with the committee and the following GP Practice

stakeholders:

Andrew Bland, Chief Officer, NHS Southwark CCG
Caroline Gilmartin, Director of Integrated Commissioning, NHS Southwark CCG
Jean Young, Head of Primary Care Commissioning NHS Southwark CCG
Rebecca Scott, Programme Director, NHS Southwark CCG
Caroline Gillmartin, NHS Southwark CCG
Emily Gibbs, GP clinical lead for GP services
GP Federation leads:

- Dr Olufemi Osonuga, Deputy Chair of QHS
- Dr Lauren Parry, IHL Director
- Dr Rebecca Dallmeyer (QUAY HEALTH SOLUTIONS)

Jon Abott, Head of Regeneration, North, Southwark Council

LINK TO LIVE-STREAM/VIDEO

Part one: http://bambuser.com/v/6682857

Part two: http://bambuser.com/v/6682865

Part three: http://bambuser.com/v/6682867

7. CCG OPERATION PLAN

Andrew Bland, Chief Officer, NHS Southwark CCG, and Caroline Gilmartin, Director of Integrated Commissioning, NHS Southwark CCG presented the report and took questions from the committee.

LINK TO LIVE-STREAM/VIDEO

http://bambuser.com/v/6682822

8. GP PROPOSED MERGER

The report was noted. Members were invited to send any follow up questions to the CCG, via the scrutiny project manager.

9. WORKPLAN

The workplan was tabled and noted.

Agenda Item 6

SOUTHWARK MENTAL HEALTH SOCIAL CARE SERVICE REVIEW

Internal Review (3 month)
30th March 2017

1 Background

1.1 On 28th November 2016 the London Borough of Southwark's (LBS) Mental Health Social Care service began new working arrangements following the implementation of the Mental Health Social Care Review report (Dick Frak, August 2015). The implementation plan was presented to the Healthy Communities Scrutiny Committee on 22nd November 2016 for approval, with David Quirke-Thornton (Strategic Director of Children's and Adults Services), Richard Adkin (Project Implementation Lead, Adult Social Care), Simon Rayner (Assistant Director, Adult Social Care) and Andrew Farquhar (Operations & Development Manager, Southwark Wellbeing Hub, Together UK) in attendance.

1.2 The Review (Dick Frak August 2015) reinforced the need for strengthening the social care offer in accordance with the Care Act 2014. The aim was to enable people with mental health needs to access assessment and social care support in the community. It embodied a commitment to achieving healthier, safer and fairer communities within the Borough.

1.3 Consequently, LBS Mental Health Social Care Teams were remodelled to reflect the findings of the Review. This included the return of social care funded posts previously seconded to the Mental Health provider trust (SLaM) to the direct management of LBS.

1.4 The 'first phase' of implementation, in transforming the Social Care offer, commenced on the 28th November. The following Social Care teams have now been established:

The Mental Health Adult Care and Social Support Team, supports people with complex and long- term mental heath issues in meeting their Social Care needs under the Care Act 2014. This Team works closely with SLaM teams, as well as other council and external teams, in carrying out joint assessment, taking part in Multi Disciplinary Team discussions etc.

The Substance Misuse Team has joined the AMHP Service and Assessment and Reablement Service at Camberwell Road and provides a stronger focus on dual diagnosis.

The Reablement Team has been enhanced to become the Assessment and Reablement Team and is working closely with the Wellbeing Hub, which provides an essential broader more inclusive point of entry to Services. The Assessment and Reablement Team is collocated and working in partnership with SLaM.
The AMHP Service has been strengthened with an experienced AMHP/BIA to help manage the scale of AMHP referrals, in addition to other service pressures including the location of a centralised Place of Safety within the Maudsley Hospital site.

The Move On Support Team (MOST) is working with people with complex mental health needs who have required residential care or supported living. A 'reablement focused approach' and peer support are enabling more people to live independently, and reducing reliance on residential and nursing care. This Team moved to the base at Camberwell Road in January 2017.

1.5 3 and 6 month reviews were included in the review implementation plan to ensure that the service scrutinises progress made and identifies any key learning from the project.

2 Achievements to date (Dec to March)

TEAM & SERVICE UPDATE

2.1 The establishment of a new **Mental Health Longer Care Team (MHLCT)** to support people with complex and long-term mental health issues enabling them to live independently through creative care and support planning:. The team is comprised of Social Work and Occupational Therapy staff and has a current caseload of 285 people who have an assessed Social Care need. The team is working closely with SLaM and is developing relationships with a number of other organisations and teams in the borough.

ES (MHLCT client) is a 51yr old single man with a brain injury and diagnosis of schizophrenia who had been arrested for assaulting his neighbour when mentally unwell, leading to a lengthy admission to hospital under a section of the Mental Health Act. Social isolation and poor daily living skills made ES vulnerable to exploitation and exacerbated his mental health in the community. ES was placed in supported housing to help with safeguarding concerns and provided with a personal budget which pays for a Peer Supporter to help ES socialise for 3hrs a week and for a personal carer to visit ES three times a week to take him shopping and to help him cook and prepare meals. This support package has been successful in preventing ES from returning to hospital and he continues to make improvements in his rehabilitation.

2.2 The **Assessment & Reablement (ART)** team has been enhanced by additional Social Care staff with personalisation remaining a key element in supporting individuals and families, advocating the national and local agenda in providing choice and control over the support that individuals receive. The Team has established successful joint-working protocols with a number of teams and organisations and has participated in a significant number of joint-assessments in order to reach a more holistic conclusion regarding the service user's care and support needs, and subsequent care plan.

2.3 The ART team continues to work closely with acute psychiatric wards within the Borough to facilitate discharge and prevent readmission and the team and service manager regularly attend weekly bed management meetings with SLaM colleagues to offer professional expertise to individual cases as well as active involvement with certain service users. Moreover, the team has continued to have a positive impact in reducing the various needs of service users, with 77% of service users having their presenting needs reduced following the team's intervention.

2.4 The Service has also successfully established a **Single Point of Access** for professional referrals, with the vast majority of these coming from SLaM teams. Since the service's opening a total of 586 referrals have been received. 238 of these have resulted in an assessment of need, completed by the Assessment & Reablement Team. They have also received 47 referrals relating to safeguarding.

*"Generally my experience of the new adult social services mental health team since the changes has been good if not better than before. Assessments have been timely and full and led to allocation of workers who have been present at meetings (*Consultant Psychiatrist, South London & Maudsley NHS Trust)*."*

"It is very good that we get an instant response from the referrals [to mental health Social Care], and allocation of assessor and an appointment offered (Care Coordinator, Psychosis Promoting Recovery Community Team, South London & Maudsley NHS Trust)."

"I had a very positive experience of referring a client for blitz clean recently with a rapid turnaround when pointed out the state of urgency – I had been told to cancel but went ahead and pursued Adult

Social Care and they came good! (Manager Promoting Recovery, South London & Maudsley NHS Trust)."

2.5 The **Move-on Support Team** (MOST) continues to work with people with mental health needs who live in residential and nursing care homes and various rehabilitation settings. The Team supports this cohort to improve their wellbeing and to make meaningful choices about their lives by engaging with them in a person-centred and holistic way. They are also increasingly providing more specialised and skilled occupational therapy interventions, often working with people who are reluctant and unmotivated to change. The Team has also begun to work with a number of service users who have recently moved to mental health accommodation, to ensure that there is a firm focus on recovery, developing independence and that 'move-on' is kept on the agenda.

In recent months, MOST has supported a service user to move from a 24 hour supported living project to the newly opened extra care housing scheme. The service user had been keen to move into his own flat for many years, to have space/light to work on his paintings and somewhere he would be proud for his family to visit. He is delighted that this has now happened for him. Although he continues to experience symptoms of his mental disorder, he is now in an environment in which he feels a sense of home and has furnished and decorated his new flat to his own taste and preferences. He continues to be co-worked by SLaM and MOST, he is receiving the right level of support to meet both his health and social care needs

2.6 The Southwark **AMHP Service**, strengthened by an additional social work advanced practitioner post following the implementation of the Review, has benefitted from colocation with the Council's mental health service and the core AMHP staffing team. The AMHP provision is now more clearly underpinned by broader social care values and aims. The focus is enabling people to remain living at home and/or reducing the duration of their inpatient admission via more consistent approach to referrals/assessments. Since the Review Implementation, the Team has received a total of 220 referrals, as of the time of the review, including 128 from hospital sources (SLaM community and inpatient teams, A&E, general admission wards etc.).

2.7 The Council's **Substance Misuse Team** has been co-located with the Adult Mental Health Social Work Service since 28/11/2016 at 27 Camberwell Road, reinforcing the Service's commitment to dual diagnosis whilst also enrichening the professional staffing body and affording related opportunities for a more compressive approach to Social Work. This move has resulted in better communication across the service for those service users known to multiple teams. At the time of this internal Review the team had received 46 new referrals since December 2016.

3 What Needs To Be Achieved

3.1 Improved use of case management systems - Mosaic. (New Local Authority IT system). To enhance individual and team performance analysis by utilising reporting and other tools available to the Service through Mosaic. Continue the modernisation of the Service through information and other time/performance management systems.

3.2 More work is required to ensure the integration of social care values within the mental health crisis care pathway in the borough – Home Treatment Team and Psychiatric Liaison at King's College Hospital and Guy's & St. Thomas' Hospital – to reduce unplanned admissions, provide earlier assessment and intervention and facilitate earlier discharge, reducing reliance on hospital based services and secondary care health services.

3.3 Continue to strengthen links with LBS Housing department in order to enhance the Local Authority offer, with a particular focus on supporting people with hoarding issues or anti social behaviour.

3.4 Further develop working links with GPs and supporting Local Care Networks by offering strong social care input within a primary care setting and the Wellbeing Hub.

3.5 To extend and further strengthen working relationships with the Voluntary Sector.

3.6 Co-production of services with users and carers, especially in relation to Peer Support – fostering a more inclusive relationship in relation to commissioning/designing services.

3.7 Stronger role with supporting the Transition of young people with Mental Health problems.

3.8 The Implementation Plan recommended further phases of service development but this needs to be tied in to the Joint Mental Health and Wellbeing Strategy.

4 Partnership & Integration

SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST

4.1 The Service has continued to maintain a strong working relationship with colleagues at **SLaM**, with senior managers from both organisations meeting on a fortnightly basis as part of a '**Partnership & Integration**'' working group, whilst team managers meet on a monthly basis to discuss any case specific or general issues. In addition, LBS Social Work managers are in regular attendance at weekly Trust '**Bed Management'** meetings and '**DTOC' (Delayed Transfer of Care)** calls, whilst an LBS service manager jointly chairs the fortnightly Southwark **personalisation and placement panel** and monthly **forensic placement panel**.

4.2 Whilst LBS teams continue to work with SLaM colleagues on a daily basis, including through the joint assessment of service users, the list below underlines a few key areas in which the mental health division has promoted partnership and ensured a strong Social Care focus at multi-agency discussions:

Attendance at

- Monthly '**Complex Needs Advisory Panel'**
- Monthly '**High Support Team/Supported Living Team interface mtg**.'
- Monthly '**SLaM/CCG Task & Finish placement monitoring mtg**.'
- Attendance at some **SLaM clinical mtgs**.

- Involvement in **SLaM/CCG interview panels**

OTHER ORGANISATIONS & PROFESSIONALS

4.3 Since implementation, the Service has also sought to engage a number of other stakeholders in Southwark with the Assistant Director and Project Implementation Lead attending **GP Locality meetings** in the north and south of the borough on 23/02/2017 to present and explain the changes to Mental Health Social Care and how to access the Service. The Service is also represented at the following meetings:

- **Community MARAC**
- Regular meetings with **Look Ahead Housing, SLaM** and other **Housing providers**
- **Hoarding Panels**
- **Cator Street Extra Care Housing Steering Group**
- **MOST** participate in regular meetings with **nursing and residential care providers**
- Regular contact with **home care providers**

- **Substance Misuse Team Panels**
- **NRPF Operations Board**
- **Temporary Accommodation Working Group**
- Close working with **Experts by Experience**

- **Senior Management Team Meeting** (Mental Health, Learning Disabilities, Transitions)

4.4 The Service continues to enjoy a strong relationship with Third Sector providers. The **Wellbeing Hub** remains closely associated with the Service and has a direct line to the Single Point of Access for referrals and general Social Care queries. The Assessment & Reablement team meet with hub managers on a monthly basis. The Assistant Director for Mental Health is to provide an update on the progress and implementation of the review at the **Provider Led Group Forum** hosted by Community Southwark.

5 Key Issues

5.1 As outlined in this document, the Single Point of Access (SPoA) has received a significant number of referrals since implementation and is looking at ways to manage the volume of referrals.

5.2 Following the establishment of a Single Place of Safety (S136 Suite) at the Maudsley, the out of hours AMHP service has had increased referrals. However, with the recently agreed Memorandum of understanding, with the other 3 boroughs, the referrals and workload have been shared between the 4 boroughs and has mitigated most of this extra work for Southwark. This area will require ongoing monitoring and liaison with SLaM.

5.3 Following the implementation of the Review, the Council needs to work further with SLaM to ensure both organisations are clear about the adherence to statutory responsibilities with regards to safeguarding.

5.4 The newly developed service needs to consolidate the teams further, by improving internal working relationships and support networks, to offer good development and training opportunities, so as to enhance good social work practice.

Simon Rayner

Assistant Director

London Borough of Southwark

March 2017

Southwark Council

Mental Health & Substance Misuse Service

Southwark Adult Social Care

Contents Page

1. An overview of Southwark's mental health and substance misuse adult social care services

At the London Borough of Southwark we are committed to ensuring a fairer future for all our residents. As part of our commitment we aim to understand the diverse needs of all those that reside in our communities, act to ensure that everybody has access to appropriate advice and information, and ensure that those who need extra assistance receive appropriate support.

If you need care and support and have a mental health impairment/illness or substance misuse problems, you may be able to access support from one of the range of services run by Southwark's Adult Social Care Mental Health services. Dependent on your needs we may be able to help you in a range of ways, including (but not limited to) –

- Adapting your home environment to help you with daily tasks.
- Referring you to appropriate accommodation in order to meet your housing and care and support needs.
- Communicating with a range of professionals in order to safeguard you from abuse or neglect.
- Arranging for you to receive support by an independent advocate.
- Arranging a recovery programme to address substance misuse problems.
- Supporting you to do things for yourself so that you do not need other people to do them for you.
- Assessing whether you should be detained in hospital in order to assess and/or you.
- Assessing and supporting your carer.

If you – or those who support you – contact us we will find out as much about your needs as possible. If it appears that you may be eligible to receive support from the *Assessment and Reablement Team* (page 6), the *Approved Mental Health Professional* Team (page 10), the *Substance Misuse Team* (page 13), the *Long Term Team* (page 16), or the *Move on Support Team* (page 18), we will arrange for a member of staff at the appropriate service to contact you as soon as possible. Following assessment, if we confirm that you have unmet eligible needs we will develop a Care and Support Plan with you and support you to meet the needs and goals that are important to you.

If we assess you and find that you do not have eligible needs we will provide you with appropriate information and advice, and sign-post you to appropriate community services and resources.

If your needs arise from a physical disability or your age you can visit 'My Support Choices' at www.southwark.gov.uk for more information about our older people and physical disability services may be able to work with you.

You can find more information about care act eligible needs at www.scie.org.uk.

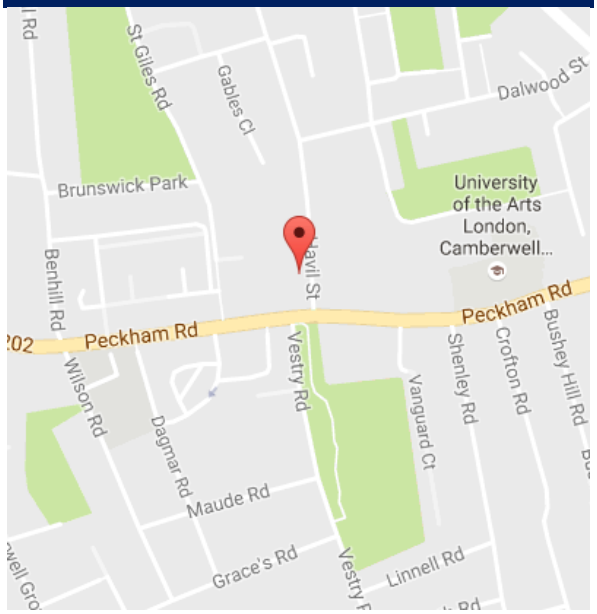
2. Accessing adult social care mental health services in Southwark

If you have care or health needs you probably receive support to help you improve and/or manage your needs. We work in partnership with a wide range of professionals and organisations which can make referrals to us about you. The professionals that you work with (for example your GP, housing officer or therapist) will talk to you about making a referral to us if they believe it is suitable.

If you currently do not receive support from any organisations and you believe that you would benefit from care and support from Adult Social Care, we recommend that you approach the Southwark Wellbeing Hub. The Wellbeing Hub will provide you with information and advice about the suitability of a referral to Adult Social Care. If your needs warrant care and support from Adult Social Care they can complete a referral for you. They may also be able to link you into other services that may be more appropriate for your needs. Alternatively you can raise your care and support concerns with your GP. Your GP can refer you to the South London and Maudsley (SLaM), who in turn can refer you to us if they believe it will be of benefit to you.

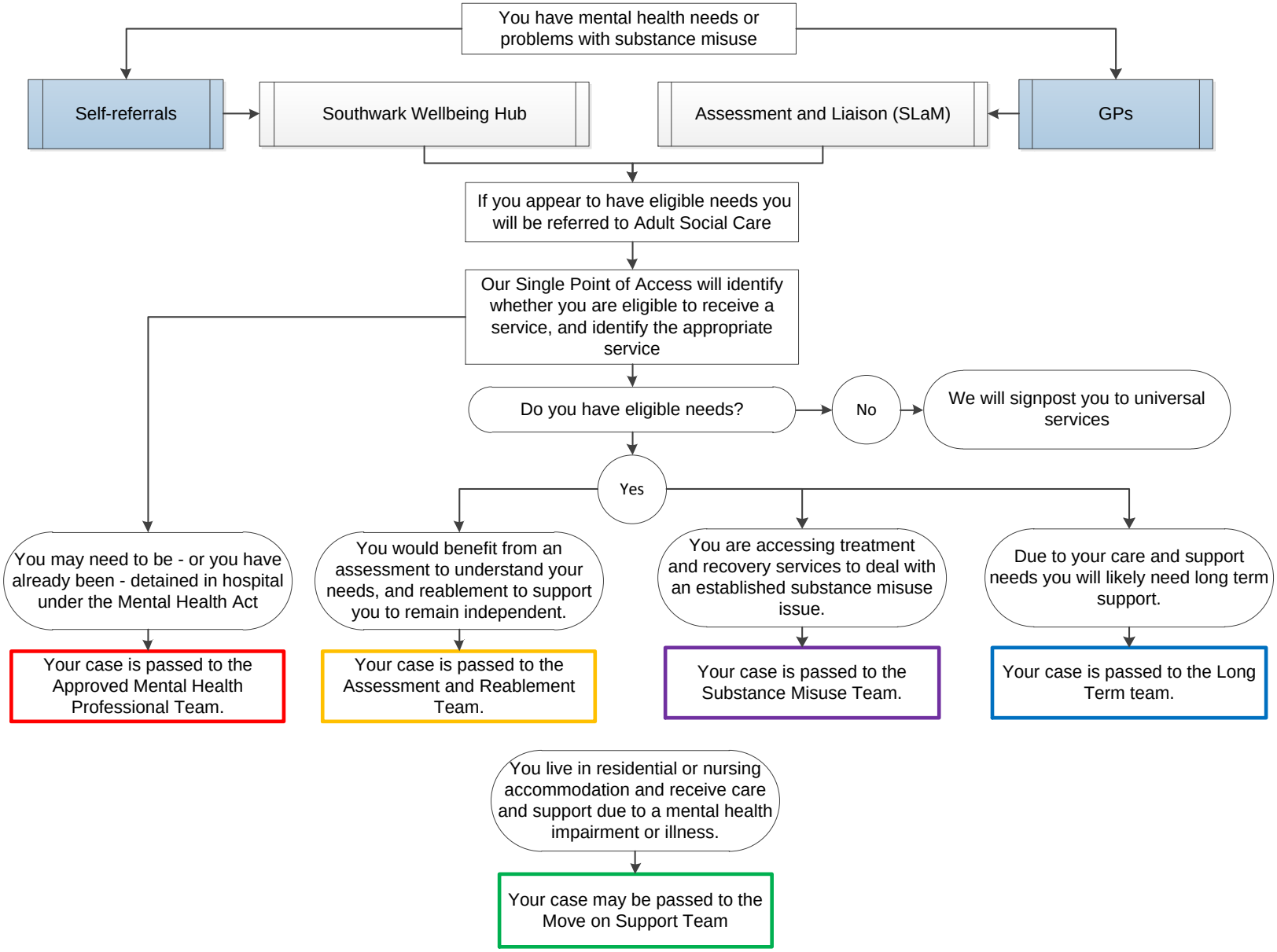
If you are referred to us we will consider your referral and ensure that the details go to the appropriate team as soon as possible so that they can take appropriate action.

Southwark Wellbeing Hub



Thames Reach Employment Academy
29 Peckham Road
London
SE5 8UA
Email:0203 751 9684
Telephone: southwarkhub@together-uk.org

3. Mental health and substance misuse adult social care pathways



4. Southwark's mental health adult social care services

Assessment and Reablement Team

Most people want to remain as independent as possible for as long as possible, however some people need help to go about their daily lives. If you have never accessed social care before and you have a mental health impairment or illness the Assessment and Reablement Team will likely be your first port-of-call within Adult Social Care.

We will assess your care and support needs, and if it appears that you have eligible needs we will work with you to help you take back control of your life. We provide a range of care and support interventions focused on:

- helping you to do things for yourself so that you do not need other people to do them for you;
- enabling you to relearn or regain the confidence to remain independent in your own home;
- maximising your independence, choice, and quality of life;
- achieving the outcomes that are important to you.

About the team

The Assessment and Reablement Team is made up of a mix of Social Workers and Occupational Therapists. We are based at 27-29 Camberwell Road, London. SE5 0EZ.

Who we work with

In order to benefit from our services you must be aged between 18 and 65, ordinarily be a resident of Southwark, have a mental health impairment or illness, and have Care Act eligible needs as a result of your mental health condition.

If you meet the above criteria we will put measures in place to enable you to better manage your care and support needs. If after 13 weeks we believe that you still need care and support to meet your eligible needs, we will refer you to an appropriate Adult Social Care team to continue working with you.

Exclusions

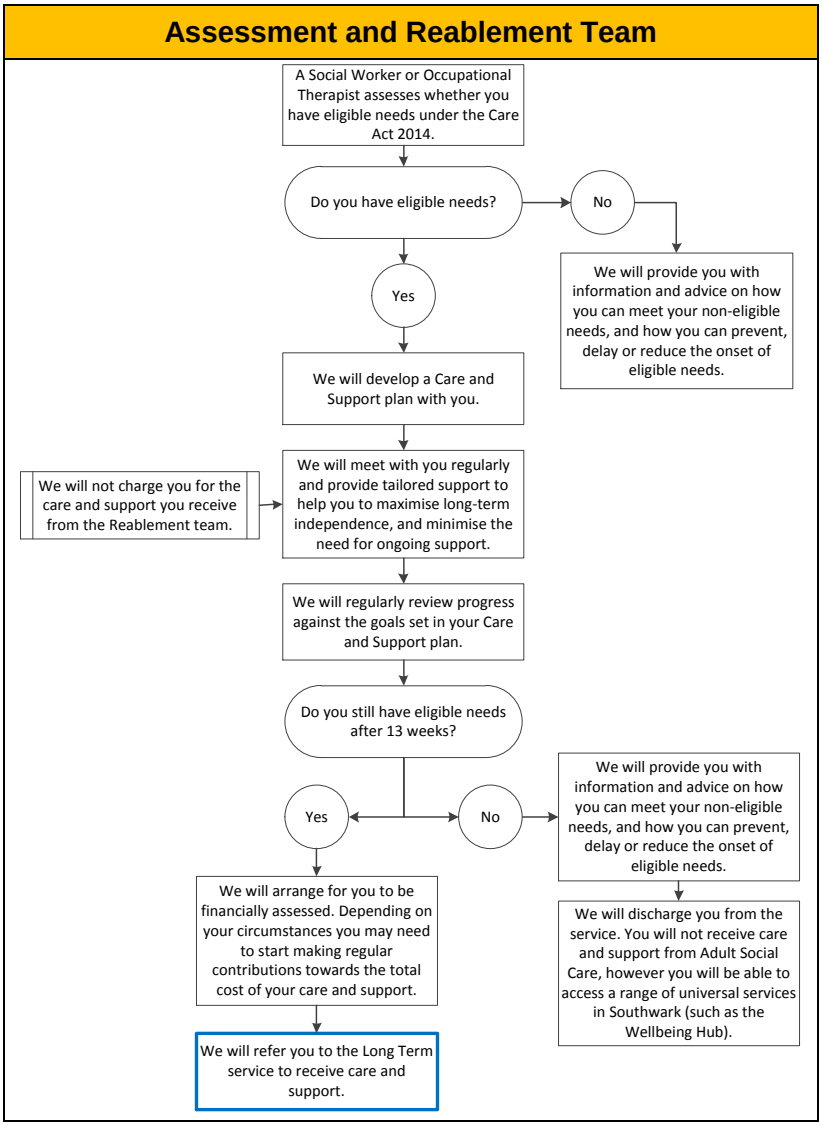
We cannot work with you if you already receive support from another Adult Social Care team, or you require end of life care.

What can I expect from the Assessment and Reablement Team Service?

Assessing your needs

In order to determine whether you are eligible to receive support from the Assessment and Reablement Team, we will assess your needs if you appear to have care and support needs as a result of a mental health impairment or illness. Your assessment will either be carried out by a Social Worker or an Occupational Therapist. We will assess your needs on the same day if you appear to be in urgent need of care and support. If your needs do not appear to be urgent we will conduct a Needs Assessment within 7- 28 days.

We will build a full picture of your needs with you during your assessment so that we understand the impact that they have on you, and so that we can help you to identify which measures will best help you to manage them. We will ensure that your assessment has your wellbeing at its heart, and lays the foundations to maintain or improve any eligible needs through the achievement of outcomes that are important to you.



We will usually need to speak to the people who support you and who know what your needs are (for example family, a carer, your GP, the Community Mental Health Team). If other assessments have been carried out by colleagues in other areas (for example health or housing) we may need to know the outcome of these assessments. While we assess your needs we will put services in place to meet the eligible needs we believe that you may have so that there is not a delay in providing you with appropriate care and support.

If at the end of the assessment we believe that you do not have eligible needs we will confirm our decision in writing. We will also provide you with the details of other services that may be beneficial to you, and provide you with information and advice in order to prevent, delay or reduce the onset of care and support needs.

Your Care and Support Plan

The objective of the Assessment and Reablement Team is to use timely and focused intensive interventions in order to:

- maximise service users long-term independence, choice and quality of life;
- minimise on-going support required;
- deliver services that deliver quality outcomes while also providing good value for money.

We will work with you to develop a Care and Support Plan if we assess that you have eligible care and support needs. We will use the plan to identify how we will work with you in order to help you to achieve greater independence. We will also use the plan to record the steps that you can take to help improve your wellbeing and general quality of life.

We will identify whether you need a higher or lower level of support. We will also ask you to think about what you would like to get out of the reablement sessions and where you see yourself at the end of the 13 week period. We will use this opportunity to communicate honestly with you about what we believe you will get out of the sessions, and what is likely to happen at the end of the 13 weeks.

Paying for your Care and Support

We will not charge you for the care and support that you receive from the Assessment and Reablement Team. However, if at the end of the 13 weeks you still need care and support from Adult Social Care you will need to undergo a financial assessment to identify whether you must make a contribution towards the costs of meeting your care needs. If your assessment concludes that you have sufficient income and access to capital (for example you own a property, or you have savings, stocks or bonds), you will need to make regular payments towards the total cost of meeting your care and support needs. How much you will be charged is dependent on your individual circumstances.

Providing a reablement service

If we assess that you need low to medium support we will visit you once a week. If we assess that you have higher needs we will increase the frequency of the visits in order to ensure you get the care and support that you need.

During your reablement sessions we will support you to take practical and sustainable steps to help you maintain your wellbeing. The reablement service that you receive will be tailored to meet your individual needs, but may include a range of practical steps and solutions to maximise your independence, such as –

- Practicing tasks with you.
- Adapting your home environment to help you with daily tasks.
- Prompting you and giving you reminders.
- Discussing alternative ways of completing tasks.
- Meeting people and agencies with you.
- Using schedules or checklists.

We will help you to identify ways to address your needs by accessing your own knowledge, strength and internal resources. If you need extra support making decisions we will identify possible solutions for you so that you can choose the one that works best for you. If an important decision needs to be made as a matter of urgency (for example action is needed to prevent you from being evicted) we will work with you and those that support you to make decisions in your best interests in a timely manner.

We will regularly review your progress against the goals set in your Care and Support Plan. If new needs arise, or the actions/steps that we identified with you do not appear to be helping we will consider what other care and support may help you to improve or maintain your wellbeing, and use your reablement sessions to implement these.

Our aim is that by the end of the 13 week period we have provided you with the insight, knowledge, skills and tools with which to look after yourself without the intervention of Adult Social Care. If we assess that you are able to manage your needs (you no longer have eligible needs) we will provide you with information and advice about how you can prevent, delay or reduce the onset of care and support needs, and signpost you to community services we think may be of benefit to you.

If at the end of the 13 week period we believe that you still need additional care and support, we may provide you with reablement support for a few more weeks to see if that helps; alternatively we will refer you to an appropriate Adult Social Care service (for example the Mental Health Long Term Care Team) so that they can continue to meet your needs. We will arrange for you to be financially assessed as you may need to start contributing towards the costs of your care and support. We will also provide you with information and advice about how you can prevent, delay or reduce the onset of care and support needs, signpost you to community services we think may be of benefit to you, and give you information and advice about the costs associated with Adult Social Care.

Approved Mental Health Professional Service

Sometimes it is necessary to detain a person in hospital under the Mental Health Act 1983 to ensure that they receive necessary mental health treatment and care, and to safeguard their welfare and the welfare of others.

If your mental health deteriorates and it is necessary to consider detaining you in a hospital without your consent, in order to ensure that your rights are protected and that you are not detained unnecessarily an Approved Mental Health Professional will –

- assess your mental health and ensure that you are also assessed by medical professionals;
- work with your 'nearest relative' to ensure that their views are sought, and that they are able to represent you;
- identify the least restrictive option to treat you safely.

About the service

The service is staffed by Social Workers who are additionally qualified as Approved Mental Health Professionals.

Who we work with

Any child or adult referred for a mental health act assessment who is also –

- a resident of Southwark; or
- in receipt of secondary mental health care or statutory social care from Southwark (regardless of whether you are currently in Southwark or not); or
- referred (by any party) for a mental health act assessment required within Southwark's borders (for example at a Southwark hospital or police station).

What can I expect from the Approved Mental Health Service?

Mental Health Act assessments to consider detaining you in a hospital

An Approved Mental Health Professional will assess you as soon as possible following your referral. In order to understand the impact of your 'mental disorder' on your wellbeing, among other things the Approved Mental Health Professional will:

- attempt to discuss your case with your nearest relative and seek their views about what is best for you. He/she will also attempt to speak to any other persons with an interest in your care and treatment (for example family and friends, advocates, carers);
- consider your wishes and needs;
- consider your cultural background, social and family circumstances, age and physical health.

Mental Disorder

A mental disorder is defined as 'any disorder or disability of the mind'. The following conditions may qualify –

- Depression and Bipolar disorder.
- Schizophrenia and delusional disorders.
- Personality disorders.
- Mental/behavioural disorders caused by psychoactive substance misuse.

The above is not a definitive list.

You will also need to undergo medical examinations from two appropriate medical practitioners

during this time, the Approved Mental Health Professional will decide whether to apply for your detention in hospital once he/she receives their reports/recommendations. Before making a decision to detain you the Approved Mental Health Professional must first consider whether your needs can be managed in the community with appropriate care and treatment. The Approved Mental Health Professional will choose the least restrictive option to ensure your safe care and treatment whether this is in the community or in hospital. He/she will also consider the impact detaining you will have on you and the people who are close to you.

Decisions not to detain in hospital

If the Approved Mental Health Professional decides that it is safe and in your best interests to manage your needs in the community he/she will identify appropriate measures so that your care and health needs can be met, and act to ensure that you receive support from appropriate parties.

Decisions to detain in hospital

The Approved Mental Health Professional will inform you of their decision as soon as possible. He/she will also inform your nearest relative, the medical practitioners involved in your assessment, your GP and any other parties involved in your care and treatment. If you have any dependents (for example children, any vulnerable adults that you care for or pets) he/she will take steps to ensure that appropriate arrangements are in place for them. The Approved Mental Health Professional will also ensure that your property is secured where necessary.

Approved Mental Health Professionals can make applications for the following Mental Health Act hospital orders –

- section 2: enables your detention in hospital for assessment (or assessment and treatment) for up to 28 days so that the hospital can determine your mental health treatment needs, and start appropriate treatment.
- section 3: enables your detention in hospital for mental health treatment for up to six months (initial period). Your nearest relative can prevent a section 3 application by objecting to it.
- section 4: enables your urgent admission in the event of a mental health crisis for up to 72 hours whilst a decision about a section 2 or 3 order is determined.

You and your nearest relative will be provided with information about the Independent Mental Health Advocacy Service if a decision is made to detain you. For more information on Advocacy please see section 6.

Appointing a nearest relative

If you do not have a nearest relative and you are not willing or able to apply to the county court to appoint one, an Approved Mental Health Professional will make an application on your behalf.

Nearest relative

Your nearest relative is not necessarily your next of kin. Your nearest relative can help make decisions and representations on your behalf to protect your wishes and rights.

1. Husband, wife or civil partner (including cohabitee of six months or more).
2. Son or daughter
3. Father or mother
4. Brother or sister
5. Grandparent
6. Grandchild
7. Uncle or aunt
8. Nephew or niece

Your nearest relative can make important decisions on your behalf under the Mental Health Act 1983 (amended 2007). Only one person can serve as your nearest relative at any one time.

In some instances it may not be appropriate for your nearest relative to represent your interests, for example –

- They cannot support you due to an illness, or they move far away.
- They are no longer willing to support you due to the burden of other responsibilities (family, work etc).
- They are not acting in your best interests.

If your nearest relative is unwilling or unable to exercise their nearest relative powers on your behalf they can delegate the role to another suitable person (for example a family member, friend or carer). Alternatively any other suitable person can apply to the county court to appoint a new nearest relative. If you are unwilling or unable to make an application to appoint a new nearest relative and no other suitable person is able or willing, an Approved Mental Health Professional will make the application on your behalf.

Mental Health Act Community Treatment Orders

A Community Treatment order is a health order (not a local authority order), an Approved Mental Health Professional must agree to the order (and ensure that the order is legitimate and proportionate to your needs). Once applied your community consultant psychiatrist will be responsible for the order and any conditions it imposes upon you.

Community Treatment Orders
To be eligible for a Community Treatment Order you must be detained on a Treatment (section 3 or section 37) order. Community Treatment Orders have conditions attached which you will need to abide by, for example staying at a particular address, attending particular activities and/or therapies.

Guardianship Orders
A guardian will act in your best interests, help you to manage your wellbeing and help you to live as independently as possible within the community. Local authorities or individuals such as family or friends can be appointed as a guardian

Mental Health Act Guardianship orders

This is a local authority order (not a health order). The assessment process is the same as it is for section 3 order. Conditions of guardianship which you may be required to adhere to might include that you –

- you live in a certain place;
- you attend appointments for medical treatment, occupation, education or training;
- a doctor, AMHP or other relevant person is able to access and visit you where you live.

Discharge

If you are detained under a section 2 or 3 order your nearest relative can apply for your discharge. Your consultant psychiatrist can also discharge you as soon as they feel it is safe and appropriate to do so.

If you do not believe that you should have been detained (or should continue to be detained) you can apply to the First-Tier Tribunal (Mental Health). The hospital must provide you with information about the tribunal when you are detained. If the Tribunal believe that you should not be detained or subjected to a Community Treatment Order they will order that you are discharged. Similarly you can request that the Tribunal end the guardianship relationship, or your nearest relative can apply to end the guardianship order by writing to the local authority.

Paying for your Care and Support

If you are being discharged from a section 3 order you are entitled to receive Section 117 (S117) 'aftercare'. This means that you will be exempt from being charged for any social care costs incurred in relation to your mental health.

Substance Misuse Team

People abuse drugs and alcohol for a variety of reasons. The effect of substance abuse on people with an addiction, their family and friends and on their communities is often harmful.

If you have a substance misuse issue and you and you are committed abstinence we may be able to help you. We can assess your needs and refer you to a range of abstinence based recovery programmes. During this time we will also work with you to develop personalised support to improve your wellbeing, and support you to maintain an abstinent lifestyle within your community.

We will continue to work with you following your rehabilitation in order to help you maintain your recovery. We will use this time to link you into a range of community resources to help you to take back control of your life, and to maximise your opportunities and independence.

About the team

The team is made up of Social Workers and Care managers. We are based at 27-29 Camberwell Road, London SE5 0EZ.

Who we work with

In order to benefit from our services you must be aged 18 or older, have Care Act eligible needs, and you must also be in the process of accessing local treatment and recovery services to address your drug or alcohol misuse issues. You must also ordinarily be a resident of Southwark.

What can I expect from the Substance Misuse Team?

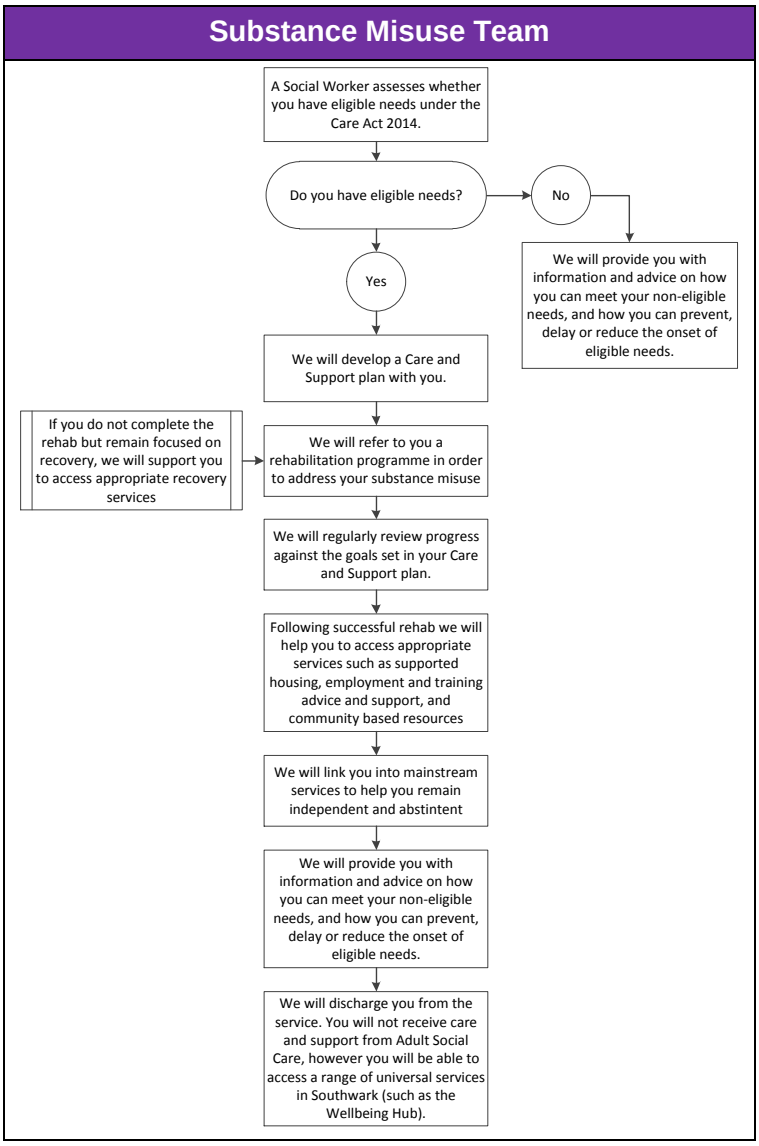
Assessing your needs
In order to determine whether you are eligible to receive support from the Substance Misuse Team we will assess your needs if you appear to have care and support needs. We will aim to meet with you soon after you are referred to us. Your assessment will be carried out by a Social Worker or a Care Manager.

We will build a full picture of your needs through the assessment process to determine what areas of your life you need support with. We will ensure that your assessment has your wellbeing at its heart, and we will use the assessment to identify which resources will help you to manage better.

We will usually need to speak to the people and agencies who support you and who know what your needs are (for example Lifeline, family, a carer, your GP, the Community Mental Health Team, or other Adults Social Care teams). If other assessments have been carried out by colleagues in other areas (for example health or housing) we may need to know the outcome of these assessments.

If at the end of the assessment we believe that you do not have eligible needs we will confirm our decision in writing.

If we assess that you are not eligible to receive a service from Adult Social Care, we will provide you with the details of other services that may be beneficial to you, and also provide you with information and advice in order to prevent, delay or reduce the onset of care and support needs.



Your Care and Support Plan

We will work with you to develop a Care and Support Plan if we assess that you have eligible care and support needs. We will use the plan to identify how we will work with you in order to maximise the chances of achieving abstinence, and to help you to achieve greater independence. We will also use the plan to record the steps that you can take to help improve your wellbeing and general quality of life.

Paying for your Care and Support

You will need to undergo a financial assessment to identify whether you must make a contribution towards the costs of meeting your care and support needs. If the assessment concludes that you have sufficient income and access to capital (for example you own a property, or you have savings, stocks or bonds), you will need to make regular payments towards the total costs of meeting your care and support needs. How much you will be charged is dependent on your individual circumstances.

Providing a Substance Misuse Service Team

Once we have agreed a personalised package of care and support with you we will act to ensure appropriate measures are put in place to meet your needs, for example we can:

- arrange a 12 week residential rehab for you. Alternatively, if you have a stable home environment it may be better for you to attend a non-residential rehab programme;
- arrange specialist counselling for you. We can also refer you to support groups and mutual aid;
- provide your family and carers with information, advice and support.

We will meet with you every 3 months to review your needs and to see how you are doing. If new needs arise, or the actions/steps that we identified with you do not appear to be helping, we will consider what other care and support may help you to improve or maintain your wellbeing.

As your recovery continues, we will work with you to help you integrate back into the community. Following successful rehabilitation and continued abstinence we can work with you to help you to access a range of services, including (but not limited to) –

- Supported housing.
- Employment, education and training information, advice and support.
- Peer mentoring.
- Psychotherapy.
- Mutual Aid

Our aim is to help you to become as independent as possible so that you are able to maintain your abstinence based recovery on a long term basis. If, for any reason, you are unable to maintain abstinence based recovery, we will help you to access alternative care and support options that are appropriate to your needs at that time.

Long Term Team

Some people need ongoing care and support in order carry out tasks and activities which most people take for granted. If you have a mental health illness or impairment and you are likely to require long term care and support as a result of your eligible needs, we can work with you to develop a Care and Support Plan, and provide appropriate support and interventions.

About the team

The team is made up of Social Workers, Occupational Therapists and other staff with social care mental health expertise. We are based at We are based at 27-29 Camberwell Road, London. SE5 0EZ.

Who we work with

In order to benefit from our services you must be aged 18 or older, you must ordinarily be a resident of Southwark, and you must have Care Act eligible needs due to a mental health illness or impairment such as depression, anxiety, schizophrenia bipolar disorder or personality disorders. We can also work with you if you have substance misuse issues in addition to mental health concerns.

The Long Term Team usually works with adults who have multiple and complex needs, and who consequently require ongoing care and support over a longer period. We also work with adults who are difficult to engage and who might benefit from an assertive outreach approach.

What can I expect from the Long Term Team?

Assessing your needs

If you are assessed as eligible to receive a service from the Long Term team we will arrange a convenient time and place to meet with you in order to complete an assessment of your needs with you.

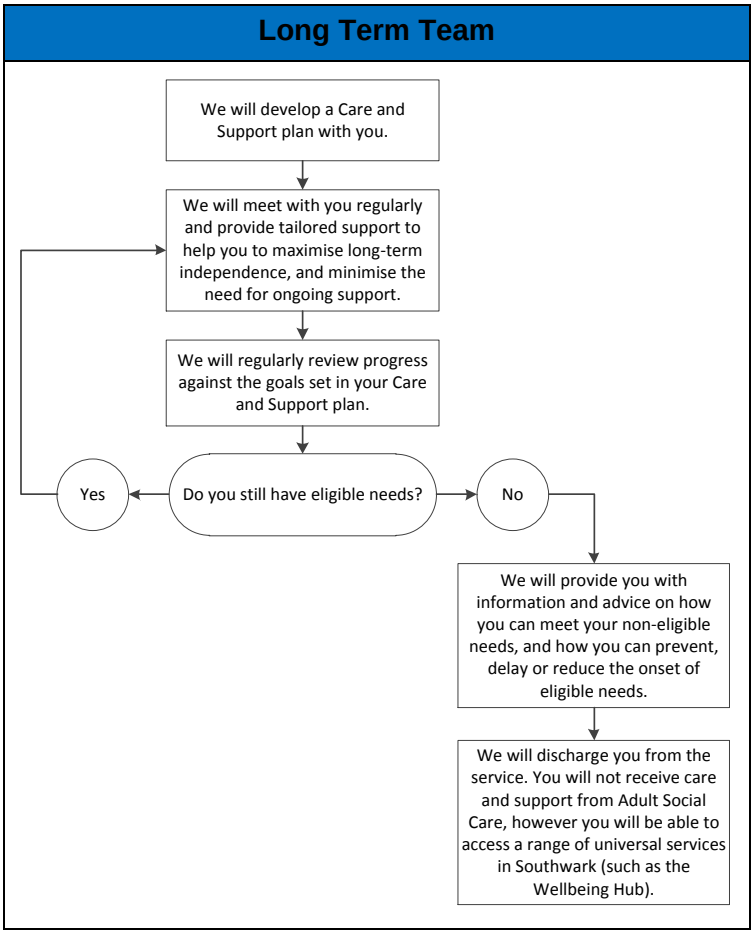
We will build a full picture of your needs with you during the assessment so that we understand the impact that they have on you, and so that we can help you to identify what measures will best help you to manage them.

We will ensure that your assessment has your wellbeing at its heart, and lays the foundations to maintain or improve any eligible needs through the achievement of outcomes that are important to you. Among other things, we will try to learn more about:

- your independence;
- difficulties you face;
- your personal and domestic routines;
- what help and support you already have;
- what help you think you may need;
- your involvement with family, friends and the community.

We will usually need to speak to the people who support you and who know what your needs are (for example family, a carer, your GP, the Community Mental Health Team). If other

assessments have been carried out by colleagues in other areas (for example health or housing) we may need to know the outcome of these assessments. While we assess your needs we will put services in place to meet the eligible needs we believe that you may have so that there is not a delay in providing you with appropriate care and support.



If at the end of the assessment we believe that you do not have eligible needs we will confirm our decision in writing. If we assess that you are not eligible to receive a service from Adult Social Care, we will provide you with the details of other services that may be beneficial to you, and also provide you with information and advice in order to prevent, delay or reduce the onset of care and support needs.

Your Care and Support Plan

We will work with you to develop a Care and Support Plan if we assess that you have eligible care and support needs. We will use the plan to identify how we will work with you in order to maximise your wellbeing, safety, and achieve greater independence. We will also use the plan to record the steps that you can take to help improve your wellbeing and general quality of life.

We will regularly review your needs. Over time we aim to develop a trusting relationship with you so that you feel comfortable with your Care-Co-ordinator and other members of our service.To ensure that you get the right support at the right time we will work closely with those who support you such as GP's, the NHS, housing providers and local voluntary sector organisations.

Paying for your Care and Support

You will need to undergo a financial assessment to identify whether you must make a contribution towards the costs of meeting your care and support needs. If the assessment concludes that you have sufficient income and access to capital (for example you own a property, or you have savings, stocks or bonds), you will need to make regular payments towards the total costs of meeting your care and support needs. How much you will be charged is dependent on your individual circumstances.

If you need help managing your finances we can help you to explore options such as arranging for you to receive support from an Appointee to help you manage. We can also help you to access services to seek independent financial advice and services.

Move on Support Team (MOST)

People's needs change over time, and residential accommodation and/or support packages that initially seemed suitable for them may no longer meet their needs. If you have been placed in residential accommodation due to a mental health impairment or illness, the Move on Support Team work can work with you to ensure that you are in the most appropriate placement for you.

We will review your needs and consider whether your current accommodation meets your care and support needs. If we assess that your needs are being met with an appropriate level of care and support in your current accommodation, we will work with you, those who support you and the accommodation provider to ensure that your care and support is personalised, recovery focused, and supports you to be as independent as you are safely able to be. If we assess that your needs can be met better elsewhere or in accommodation that offers better value for money whilst still meeting your needs, we will work with you and those that support you to explore alternative arrangements, and support you to move to more suitable accommodation.

About the team

The Move on Support Team is made up of a mix of Social Workers and Occupational Therapists. We are based at 20- 22 Lordship Lane, East Dulwich, London SE22 8HN.

Who we work with?

We work with adults over the age of 18 who have been placed by Southwark mental health services in certain types of accommodation, such as a residential or nursing home, supported living, sheltered or extra care sheltered provision. You will have needs that make you eligible for a service as defined by the Care Act.

What can I expect from the Move on Support Team Service?

Assessing your needs

If you are referred to our service (usually by another Adult Social Care or health service) we will arrange to meet you and those involved in your care in order to assess your needs. The assessment will either be carried out by a Social Worker or an Occupational Therapist.

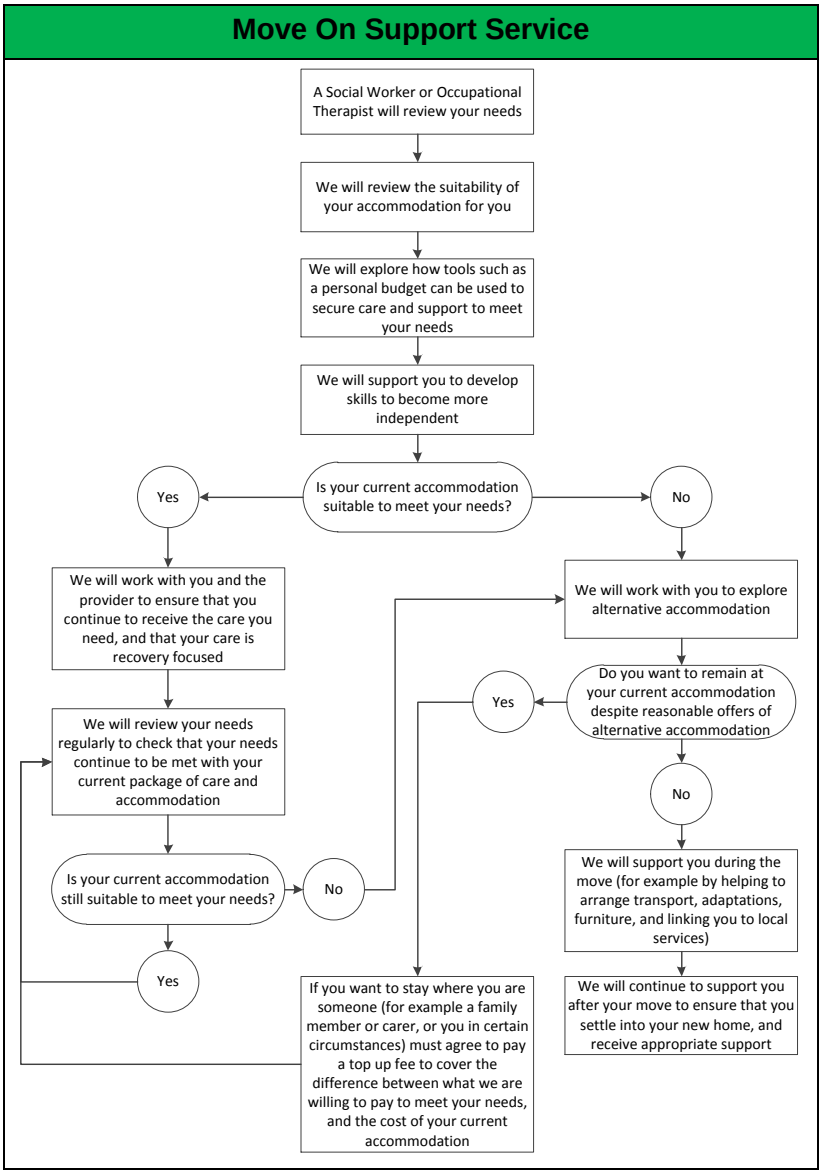
We will use the assessment to build a full picture of your needs so that we understand the impact that they have on you, and so that we can help you to identify which measures will best help you to manage them. We will ensure that your assessment has your wellbeing at its heart, and lays the foundations to maintain or improve any eligible needs through the achievement of outcomes that are important to you.

We will usually need to speak to the people who support you and who know what your needs are (for example family, a carer, your GP, a Mental Health Team, staff at the accommodation where you live). If other assessments have been carried out by colleagues in other areas (for example health or housing) we may need to know the outcome of these assessments. We will also use this opportunity to complete a placement review, review your current Care and Support plan and other relevant plans and assessments.

Your Recovery and Support Plan

We will work with you to develop and review your Care and Support Plan once we have assessed your needs. Your needs are unique and we will support you to achieve outcomes that are meaningful and improve your wellbeing. This may mean working with you to develop or regain skills or pursue an interest you may have. We will also explore how tools such as personal budgets can be used to help secure a personalised package of care and support to meet your needs. We will also speak to the accommodation provider to explore how they can better support you.

We will use the plan to identify whether you are ready to live in a less supported setting with a package of appropriate care and support. On some occasions, it may be that you need a higher level of care than is currently provided.



Considering your accommodation

Your current accommodation may no longer be suitable for you for a number of reasons, for example –

- When you were originally placed in the accommodation there may not have been suitable accommodation in Southwark. As a consequence you have been placed outside of Southwark.
- During your stay in the accommodation you have developed the knowledge and skills to function more independently and no longer need the level of support on offer.
- Your care needs have lessened or stabilised and you are able to manage your affairs more independently. Alternatively your needs may have worsened and you need more care and support.
- Although you still have the same level of care and support needs, your goals have changed and the accommodation you are in is no longer able to meet them.
- It is possible to meet your accommodation and care needs with a package that offers better value for money.
- You want to move on to different accommodation.

These assessments may determine that you are in the best place for you, in which case we will work with you to ensure that you continue to get the support that you need until such a time that it is suitable to reconsider your accommodation again.

We will work with you to explore alternative accommodation if we assess that your needs can be met better elsewhere. We will communicate openly with you and those that support you about the type of accommodation that we believe is suitable for you. If we identify suitable accommodation which is of better value, we may reconsider how much it is reasonable for the council to pay towards meeting your accommodation needs. If you opt to stay in your current accommodation or you identify other accommodation which costs more than we believe it is reasonable to pay to meet your needs, a family member or friend (or you in certain circumstances) will need to agree to pay the difference between what we are willing to pay and the cost of your current accommodation. This 'top-up' payment will need to be paid for the duration of your stay, so it is important that whoever makes the payments is willing and able to continue making them.

Making move-on arrangements

We fully understand that moving from one place to another can be a significant upheaval. The Move On Support Team will work closely with you to create a move on plan and support you to make the transition as smooth as possible.

You are the most important person when it comes to making decision about any new accommodation. We will provide you with a number of accommodation choices to choose from, and we will support you to explore and visit the available accommodation. There are several ways that we can support you with the move, including working with agencies that may be able to assist with transport, looking at any adaptations or 'assisted technologies' that may help, and arranging furniture etc.

We will continue to support you when you have moved and ensure that you have settled into your new accommodation. We will also get in touch with any local services that you may be interested in.

Support after your move

Following your move we will continue to meet with you to ensure that you are settling in well. We will review your Recovery and Support Plan periodically to ensure that the care and support that you receive is suitable for you.

Paying for your Care and Support

You will have already been financially assessed to see how much you are able to pay towards meeting the costs of your care and support before we start working with you. Depending on your circumstances you may not be making any payments towards meeting your care and support needs, or you may already be making regular payments. We will arrange a review of your financial circumstances to ensure that you are making the right financial contribution if your circumstances change.

5 Functions delivered across the services

The functions described beyond this point (Safeguarding, advocacy and carer support) are delivered by all the Adult Social Care Teams mentioned in this document.

Safeguarding you from harm

Everybody has the right to a life free from fear, to be treated with dignity, to have their choices respected, and to not be forced to do things against their will. Safeguarding refers to the process of keeping adults at risk safe from abuse and from neglect.

We take your wellbeing very seriously. If there are concerns that you are being abused or neglected we will evaluate the risk and act to ensure that you are safe from immediate danger. We will usually speak to you about what you would like to happen. If you would rather that we do not take further action we will usually respect your decision, however if you do not have the mental capacity to make a decision or there are vital or public protection concerns we will need to open a safeguarding enquiry.

During the safeguarding enquiry we (or someone acting on our behalf, for example staff where you live if you are in residential accommodation) will talk with you, those who support you and with relevant professionals in order to –

- Gather and share information.
- Establish the facts.
- Ascertain your views and desired outcomes.
- Assess your need for protection and support and protect you from abuse and neglect in accordance with your wishes where possible.
- Decide follow-up action regarding the person or organisation responsible for the abuse.
- Put measures in place to safeguard you while enquires are undertaken.

The enquiry may conclude that no further action is needed in which case we will provide you with information and advice which we believe will be of benefit to you. A Safeguarding Plan will be developed with you if the enquiry concludes that further action is needed to ensure your wellbeing. Among other things, the Safeguarding Plan will identify –

- What steps should be taken to ensure your safety now and in the future.
- Support, treatment and/or therapy that may be beneficial for you.
- Changes to the current care and support that you receive if needed.
- How to support you to seek justice.

Your safeguarding plan will be reviewed regularly to see how you are doing. Your case will only be closed once you are safe and no further safeguarding enquiries are needed.

Supported decision making

It is important that you are involved in making decisions about things that concern you. If you cannot understand or retain information you may lack the capacity to make necessary decisions. You may lack capacity - temporarily or permanently - for a number of reasons, for example you have –

- suffered short term trauma (for example concussion) which has impaired your reasoning;
- taken medication which impairs your decision making;
- a degenerative illness of the mind, for example Dementia;

- a mental disorder, for example depression and bipolar disorder, schizophrenia and delusional disorders, or a personality disorder.

If you lack capacity it may be necessary for someone you trust (family, friends, a carer, support workers) to make decisions on your behalf. If you do not have the capacity to make a specific decision we will arrange for you to be supported by an Independent Mental Capacity Advocate (see 'Advocacy' below). Where there are capacity concerns we will be guided by the following key principles identified in the Mental Capacity Act 2005 (see opposite). Decision making and actions taken on your behalf by our staff will also be respectful of:

- your age, ethnicity, gender, religion, sexuality and disability;
- your dignity;
- your previous wishes and preferences;
- the views of those who support you and who are important to you.

The Mental Capacity Act 2005

The five key principles of the Mental Capacity Act are –

- The presumption of capacity.
- The right for individuals to be supported to make their own decisions.
- The right of individuals to make decisions which may seem unwise.
- Decisions must be made in the best interests of the individual.
- Anything done for or on behalf of individuals without capacity should be the least restrictive of their rights and freedoms.

Advocacy

Taking part in assessments and planning to help us to understand and meet your care and support needs can be a stressful and sometimes confusing experience. It is important that you are properly supported during this process by someone who can represent your needs, beliefs and wishes. Usually this will be a family member, carer or friend.

If you do not have access to family, friends or a carer when we assess your needs, develop or review your care and support plan, or if you are subject to a safeguarding enquiry, we will arrange for you to receive support from an –

- Independent Advocate if it appears (or it is likely) that you will experience significant difficulty being involved in the assessment.
- Independent Mental Capacity Advocate if you do not have the mental capacity to be involved in discussions – and make decisions about – the care and/or support you may need.

If you are detained in hospital under the Mental Health Act you and your nearest relative will be provided with information and advice about how you can access support from an Independent Mental Health Advocate.

Working with carers

Southwark Council recognises the immense contribution that carers make. If you provide informal care to an adult who has a mental health impairment or illness you can access services in order to get information, advice and support about the ways in which you can prevent, delay or reduce the development of your own support needs.

If you are referred to us and you have support needs as a result of caring for a Southwark resident, we will meet with you to carry out a Carer Assessment. If at the end of the assessment we believe that you do not have eligible needs we will write to you to confirm our decision. We will also provide you with the details of other services that may be beneficial to you, and provide

you with information and advice in order to prevent, delay or reduce the onset of care and support needs.

If we identify that you do have eligible needs we will develop a Support Plan with you. We will work with you to –

- meet your eligible needs in a range of personalised ways which may include:
  - meeting your needs by providing care and support for the adult that you care for;
  - the provision of information and advice;
  - access to universal services;
  - a personal budget to spend on support/services.
- ensure the care that you provide (and the relationship with the adult that you care for) is sustainable;
- identify actions to mitigate emergencies and to manage concerns/crisis that do arise.

Because of the significant contribution that carers make, we believe it is right that we do not charge them to receive support to meet their eligible needs. We will work with you to identify how your needs can be met through measures that deliver the desired outcomes and also achieve value for money.

South London and Maudsley NHS
NHS Foundation Trust

Healthy Communities Scrutiny Sub-Committee 11th April 2017

Update report on the Southwark Mental Health Social Care Review

South London and Maudsley NHS Foundation Trust

In November 2016, the integrated mental health and social care arrangements between Southwark Council and the South London and Maudsley NHS Foundation Trust were dissolved following recommendations to the council from the Southwark social care review. The social workers, who had been working within integrated arrangements and co-located with the Trust staff in multi-disciplinary teams, moved to a central team and the local authority statutory duties under the Care Act 2014, which had been delegated to the Trust through section 75 arrangements, were returned to the responsibility of the council.

This report provides a brief progress report from the Trust's perspective since November 2016.

As the committee is aware, the Trust raised concerns about the disaggregation of the integrated arrangements to the committee in November 2016. Following the implementation of the social care review, operational managers and frontline staff from both organisations, have been working professionally and collaboratively to minimise any risks and service disruption to service users arising from the separation of health and social care functions.

Fortnightly meetings take place with senior operational staff in both organisations to jointly address problems and challenges in a timely and collaborative way, in addition to monthly management meetings between council and Trust managers. These meetings have provided a forum to enable clear communication of changes and new processes to service users and carers and staff within Southwark council and the Trust.

Through these interface meetings, the health and social care functions have been separated out and a number of operational processes and issues have been jointly worked on such as: referral processes into the central team for social care and AMHP assessments, appointeeship, carers' assessments and 'read-only' access to the Trust electronic patient records, (ePJS) for social care staff.

There remain a limited number of outstanding issues that require further discussion and agreement. In particular the Trust does not concur with the Local Authority view on the matter of safeguarding adults responsibilities which are clearly very different now, in the absence of a section 75 agreement which grants delegated authority to act. The Trust has received expert legal advice in relation to this to ensure that we act within the law in relation to NHS duties. A formal information sharing agreement and the development of a memorandum of understanding between the two organisations are the other outstanding issues.

As predicted, during this implementation phase, some problems have arisen in the short-term which have led to delays in response times, duplication and additional bureaucracy as Trust staff are now required to complete referrals to social care as opposed to having an integrated, holistic approach.

Since implementation, there have been staff shortages in the social care teams, with a number of vacant social work posts in the new teams. We believe that authorisation has now been given to recruit to these posts; so hopefully, this situation will improve in the medium to long-term.

This staffing situation has resulted in delays in referrals being dealt with and there is currently a list of approximately 200 service users, who have been referred from the Trust for Care Act assessments, being held on a waiting list. To minimise any clinical risks, Trust staff are working with social care colleagues to prioritise referrals and actions that are urgent.

As the committee is aware, the Trust was disappointed by the decision of the council to dissolve long-standing integrated arrangements and still have concerns about the potential longer-term strategic impact on the health and social care system, as outlined in the previous report to the committee in November 2016. However, the Trust remains committed to collaborative, partnership working with Southwark Council and will continue to work closely at all levels with social care colleagues. A formal independent evaluation of the impact of the review at a later stage would be welcome to inform strategic planning and development of both organisations.

Kristin Dominy
Chief Operating Officer
South London and Maudsley NHS Foundation Trust

6th April 2017

Agenda Item 8

Southwark GP Practices: Quality of Provision and Local Support Arrangements
A report from the Healthy Communities Scrutiny Committee

Introduction

For the last inquiry of 2016/17, the Healthy Communities Committee looked into the quality of provision and local support arrangements for GP surgeries in Southwark.

It focused on three key questions:

- What was the outcome of the CQC review of Southwark GP surgeries?
- What are the biggest pressures GPs are facing and what could the wider system do to help alleviate these problems?
- What is the role for (a) the council and (b) the CCG in helping to addressing the changing needs of primary care, including facilities?

Our recommendations were as follows:

1. The Committee recommends that Southwark look at the Well Centre which currently operates in Lambeth.
2. The Committee recommends that the Public Health Director look closely at the ways in which we can send a protection message to residents on issues including smoking cessation, obesity, and promote the role of health visitors and school nurses.
3. The Committee recommends that the Council consider further ways in which to provide exercise and healthy eating for its residents.
4. The Committee recommends that the Council continues to work together with the CCG to promote the medical pathways across the Borough, including local pharmacies, GPs, walk-in-centres, A&E and urgent care facilities. This should include promotion through Community Councils and Southwark Life. Further consideration should also be given to the role of MySouthwark and how this can be used to promote GP services.
5. The Committee recommends that there are stronger stipulations for the need for new health facilities as part of future planning agreements to ensure adequate provision is made available for new and existing populations.
6. The Committee further recommends that the Council works more closely with the CCG at an early stage to understand the likely pressures on general practice and build in adequate provision early in the process.
7. The Committee recommends a Memorandum of Understanding be developed which sets out the key questions to be asked of any new development in terms of addressing future population changes in respect of general practices and other health services.
8. The Committee recommends that the Council should consider negotiating lower rents for general practice as part of any new development to ensure that adequate provision is available for new and existing residents. This could include ringfencing portions of CIL to provide specifically for GP services.
9. The Committee recommends that key worker housing, or affordable housing prioritised for local workers should be seriously considered as part of any large planning agreement.
10. The Committee would therefore recommend that the CCG should monitor compliance with hospital contracts, and more effectively impose financial penalties when the requirements are not being met.
11. The Committee recommends that the CCG develop a clearer understanding of GP practice workforce and needs through the creation and use of a system-wide data set. This would enable them to better understand the issues, and create solutions to support struggling practices.
12. The Committee recommends that the CCG facilities cross-learning across general practices throughout Southwark.

The Committee would like to thank all of those who made this report possible.

Healthy Communities scrutiny sub-committee members:

Councillor Rebecca Lury – Chair

Councillor David Noakes (Vice Chair) (LD)

Councillor Bill Williams

Councillor Martin Seaton

Councillor Ann Kirby

Councillor Sunny Lambe

Councillor Maria Linforth-Hall (LD

Partners and health stakeholders:

Dr Jonty Heaversedge, Clinical Chair, NHS Southwark CCG

Andrew Bland, Chief Officer, NHS Southwark CCG

Caroline Gilmartin, Director of Integrated Commissioning, NHS Southwark CCG

Jean Young, Head of Primary Care Commissioning NHS Southwark CCG

Rebecca Scott, Programme Director, NHS Southwark CCG

Catherine Negus, Research and Intelligence Officer, Healthwatch

Caroline Gillmartin, NHS Southwark CCG

Emily Gibbs, GP clinical lead for GP services

GP Federation leads:

- Dr Olufemi Osonuga, Deputy Chair of QHS
- Dr Lauren Parry, IHL Director
- Dr Rebecca Dallmeyer R (QUAY HEALTH SOLUTIONS)

Jon Abott, Head of Regeneration, North, Southwark Council

Southwark Local Medical Committee

What was the outcome of the CQC Review of Southwark GP surgeries?

Figure 1: GP surgery locations across Southwark

There are currently 41 GP contracts over 42 sites, and 3 sites which have multiple practices: Borough Medical Centre, Lister Primary Care Centre and St Giles Surgery. The largest GP practices, Nexus, covers the north of the borough and has 58,000 registered patients.

The average Southwark practice has 8000 registered patients and there is 1 GP per 1000 registered patients, which is comparable to Lambeth (0.95) and South East London (0.96).

There has recently been an inspection by the CQC of all GP practices. At the time of writing this report, 21 practices have been rated ‘good’, and 7 have been placed in special measures.

As a result, and alongside this work, the Clinical Commissioning Group has been setting out the way in which they will be commissioning future GP surgeries.

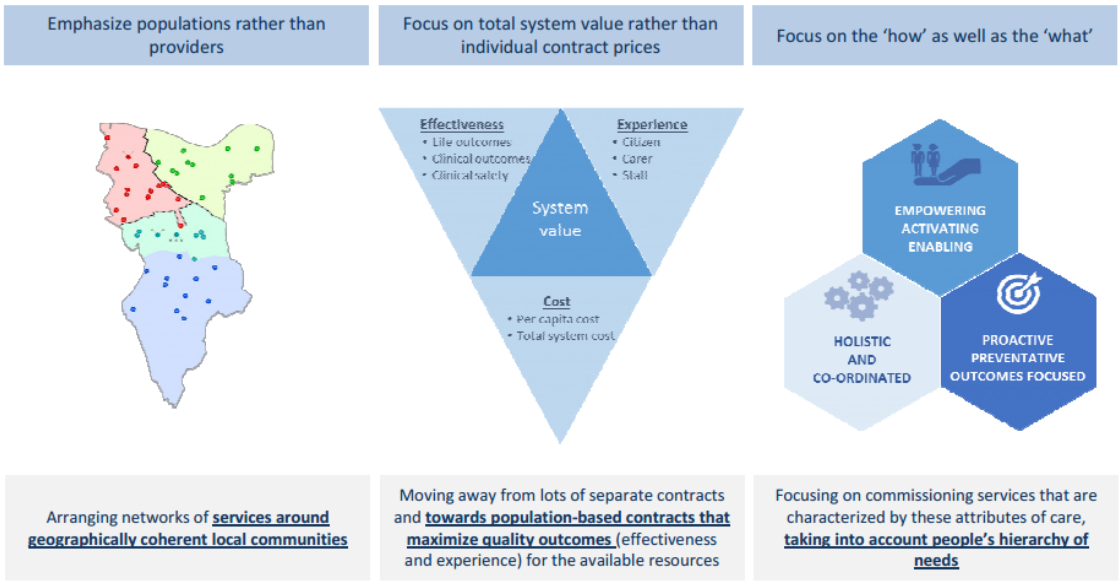


Figure 2: The CCG approach to commissioning[1]

This ultimately comes down to approaching commissioning in two ways:

- Simplifying existing contracts and incentives so that practices can focus more time and resources on delivering fewer but more important priorities, such as: improved access; improved prevention; and improved care coordination. This approach will enable our residents to experience less variation and higher quality care.
- Investing in and 'pump-priming' new ways for GP practices to collaborate and share good practice, for example by continuing to invest in the federations that GP practices have setup to help them deliver at-scale and collaborative working, and by supporting the emergence of place-based Local Care Networks.

What are the biggest pressures that GPs are facing and what could the wider system do to help alleviate these?

GP surgeries across Southwark are facing increasing pressures. These include:

- **Morale and retention and recruitment:** There is an ever-increasing workload, increasing population, increased bureaucracy and the under investment of general practice. An increasing number of GPs are locums who are choosing to follow portfolio careers which means that they might not be looking to do a large number of sessions per week in general practice.

  In the recent LMC survey, which was conducted in November/December 2016 and saw responses from 19 Southwark practices
  - 14 practices currently carry vacancies
  - 1 practice is considering closure
  - 2 practices are planning to close within the next 3 years
  - 2 practices would not rule closure out
  - 2 practices do not know if they will consider closure

[1] CCG Slides, February 2017

- **Patient Demand:** The Government's promise to patients for 8 to 8 access 7 days a week is putting increased pressure on GP surgeries, and as a result of the announcement, some patients' expectations are that they should be seen immediately.
- **Under investment in General Practice:** Funding to general practice has been decreasing in recent years. Between 2009/10 and 20013/14 funding for general practice fell by an average rate of 1.3% in real terms.
- **Premises:** Many general premises are not considered to be fit for purpose and this is a result of under investment in general practice. It is difficult for practices to expand the services they offer to patients because of the limitations and costs they face for premises development.
- The CCG also notes a number of **health factors** specifically in Southwark which impact on GP attendances:
    - Rates of preventable mortality are higher in Southwark than the national average
    - Around 66% of all deaths in Southwark are due to cancer, cardiovascular and respiratory disease
    - There were 12006 alcohol related ambulance call-outs in 1 year costing £480,000
    - There is a 7 year gap in life expectancy between more affluent and deprived areas in Southwark
    - There are over 2000 adults with dementia (4.5% of those over 65)
    - Prevalence of mental health conditions was 30% and 12% higher compared to England and London prevalence respectively
- Healthwatch also raised a number of concerns, with issues raised around identifying **GP catchment areas, and registering with GPs**, especially those with language barriers. This further leads to issues with interpretation at appointments.

Addressing with problem: The role of the Council

The Committee recommends a number of ways in which the Council can support the future strategy for GP services across Southwark.

- **Providing excellent services for children and adolescents:** Health promotion, ill health prevention and investment in children and adolescents who present with relatively minor health issues is key to saving money in the long term.

The Committee recommends that Southwark look at the Well Centre which currently operates in Lambeth.

There is also a good opportunity with the incoming Public Health Director to have a clear focus on areas of high concern for Southwark.

The Committee recommends that the Public Health Director look closely at the ways in which we can send a protection message to residents on issues including smoking cessation, obesity, and promote the role of health visitors and school nurses.

The Council's policies of Free Swim & Gym, and Free Healthy School Meals were praised by those present at the roundtable and seen as a first step towards helping change the way in which health is addressed in the Borough.

The Committee recommends that the Council consider further ways in which to provide exercise and healthy eating for its residents.

- **Working together:** The pathways for medical assistance continue to be problematic, with individuals presenting at services which may not be the best service for their needs.

The Committee recommends that the Council continues to work together with the CCG to promote the medical pathways across the Borough, including local pharmacies, GPs, walk-in-centres, A&E and urgent care facilities. This should include promotion through Community Councils and Southwark Life. Further consideration should also be given to the role of MySouthwark and how this can be used to promote GP services.

- **Regeneration:** Ensuring that there are adequate health needs is vital to the future of successful regeneration in the Borough. This Committee believes that there are ongoing concerns with large scale developments, particularly at Elephant & Castle where health needs have not been fully considered as part of the redevelopment of the area.

The Committee recommends that there are stronger stipulations for the need for new health facilities as part of future planning agreements to ensure adequate provision is made available for new and existing populations.

The Committee further recommends that the Council works more closely with the CCG at an early stage to understand the likely pressures on general practice and build in adequate provision early in the process.

The Committee recommends a Memorandum of Understanding be developed which sets out the key questions to be asked of any new development in terms of addressing future population changes in respect of general practices and other health services.

Another part of this is around the costs for general practice within any new development. There are concerns from the CCG and doctors that the high costs of new premises make them unsustainable.

The Committee recommends that the Council should consider negotiating lower rents for general practice as part of any new development to ensure that adequate provision is available for new and existing residents. This could include ringfencing portions of CIL to provide specifically for GP services.

- **Housing:** Many individuals train in the Borough and initially go into general practice. However, with rising living costs, they often only stay for a short period of time before moving out to the suburbs.

The Committee recommends that key worker housing, or affordable housing prioritised for local workers should be seriously considered as part of any large planning agreement.

Addressing the problem: The role for the CCG

There are a number of changes being made to the way in which GP services operate in the Borough.

This includes:

- **Extended access:** 7 days a week, 8am – 8pm since April 2015 with two standalone extended primary care service hubs providing additional pre-bookable and on the day urgent access to GP appointments.
- **Provider development:** Investment in GP federations supporting the resilience of GPs through business planning
- **Workforce:** Providing guidance and training, alongside supporting different ways of working e.g. medical assistants.

- **Funding:** A commitment through the General Practice Forward View of £2.4billion to support and improve general practice to 2020/2021. The CCG has committed £3 per patient in total over 2017/18 and 2018/19 to support the delivery of primary care services at scale

However, there are a number of areas where further support from the CCG would be welcomed:

- **Supporting transfer of work:** The LMC highlights a number of areas where the CCG could further support their work with the transfer of work from secondary to primary care including: prescribing, certification, poor communication, incomplete discharge summaries, patient bounce backs from missed appointments.

The Committee would therefore recommend that the CCG should monitor compliance with hospital contracts, and more effectively impose financial penalties when the requirements are not being met.

- **Workforce:** There are ongoing concerns about workforce at general practices across Southwark. There is a high turnover, both with individuals not entering general practice once qualified, but also leaving to move out of the Borough. There is a need for the CCG to play more of a role to support continuity:

The Committee recommends that the CCG develop a clearer understanding of GP practice workforce and needs through the creation and use of a system-wide data set. This would enable them to better understand the issues, and create solutions to support struggling practices.

- **Joint working:** Many of the problems experienced by one general practice are the same as those seen across the Borough. The Committee believes that these could be solved through services working more closely together to support each other, and learn from each other.

The Committee recommends that the CCG facilities cross-learning across general practices throughout Southwark.

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HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE
MUNICIPAL YEAR 2016-17

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Councillor Maria Linforth-Hall	1	Jay Stickland , Director Adult Social Care	1
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