Open Agenda

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Tuesday 18 September 2012
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Agenda Item 4 Open Agenda

HEALTH, ADULT SOCIAL CARE, COMMUNITIES AND CITIZENSHIP SCRUTINY SUB-COMMITTEE

MINUTES of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Monday 9 July 2012 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Mark Williams (Chair) Councillor David Noakes (Vice-Chair) Councillor Patrick Diamond Councillor Eliza Mann Councillor the Right Revd Emmanuel Oyewole
OTHER MEMBERS PRESENT:	Councillor Jonathon Mitchell
OFFICER SUPPORT:	Malcolm Hines, Chief Finance officer Swann Kieran , Head of Planning & QIPP Zoë Reed Executive; Director of Strategy and Business Development Cha Power , Deputy Director Dr Ann Marie Connolly : Director of Public Health Cha Power , Deputy Director Professor John Moxham Director of Clinical Strategy Julie Timbrell, Scrutiny Project Manager

1. APOLOGIES

1.1 Apologies for absence were received from Councillors Denise Capstick and Norma Gibbs. Coucillor Jonathan Mitchell attended as a substituted for Denise Capstick , who was unwell.

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

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The Minutes of last year's Health and Adult Social Care Scrutiny Sub-committee, held on 16 May 2012, were agreed as a true and accurate record.

5. KING'S HEALTH PARTNERS (KHP)

5.1 The chair invited Professor John Moxham, Director of Clinical Strategy, to speak about the development of a Strategic Outline Case. The Director of Clinical Strategy explained that the four organisations that make up King's Health Partners KHP (South London and the Maudsley, Guy's and St Thomas', King's College Hospital NHS Foundation Trusts and King's College London) have decided to look at the case for creating a single academic healthcare organisation.

5.2 He stressed that King's Health Partners have been collaborating as an Academic Health Sciences Centre (AHSC) since 2009. He went on to state that all the partners already have good services, and this is important to note. However, he explained , all could do better and need to do much better, and believe the integration is the way to make a step change

5.3 The Director highlighted the potential to work with SlaM to better integrate mental health and physical health. He reported that clinicians know that the physical health of mental health service users is poor and vice versa.

5.4 He reported that to achieve brilliant specialist services you need scale, and that presently some are sub scale. He went on to note that since the advent of KHP AHSC the hospitals have seen the quality of people coming to work with them improve . he added that the consultant staff are supportive of this move. He said that patients also support this move and understand the rational when

the case it put forward.

5.5 The Director reminded the committee of the huge challenge to improve outcomes while reducing costs. He went on to say that collectively services need to shift the emphasis from treatment to prevention and welcomed tonight's agenda item on Public Health. He said that recent research shows we need to do much better at driving improvements and drew members' attention to the 'heat map', which he said demonstrates the level of inequality experienced in Southwark. He reported that while Southwark has a high level of red in Bromley most conditions are showing as green.

5.6 The Director commented that all the hospitals are doing well, and that all have achieved Foundation status. He emphasised that this is not driven by an outside imperative, and rather a local choice by all the hospitals to further improve quality.

5.7 He went on to explain that as part of the AHSC the whole of KHP is wrapped into 21 Clinical Academic Groups (CAG) and these comprise the building blocks for further integration. The vision is to substantially improve care through better integration and an emphasis on prevention and reduced health inequalities. He reported that KHP believe this presents a unique opportunity for KHP to be a UK top ten global provider of health services.

5.8 The Director finished his presentation by explaining that the Strategic Outline Case will be considered by partners, Trusts and Kings College London over June and July and once complete this document will be sent to the committee. The chair thanked Professor Moxham for his presentation and moved to taking questions. He started by asking how long would a full business case would take to prepare and the Director responded that this does depend on who you talk to , but somewhere in the region of 18 months to two years. The chair then asked if the business case would consider the lessons of mergers that have failed. He assured the chair that KHP would, and went on to comment that often failing organisations seek merger as a remedy for failure, but then continue to fail, or it can be a top down process; however all the trusts and partners involved are successful organisations and this is a bottom up approach.

5.9 A member then asked why a merger would make KHP more successful; and if it would not be better for the organisations to continue to work as partners utilising the CAG model and questioned the reasoning that big is always better. The Director of Clinical Strategy answered if you have specialised services for treating pancreatic cancer; brain surgery; strokes etc it turns out if the doctors repeat the procedures through practice the services improve. He gave the example of strokes service, and explained that now KHP have one service, when before there were two, and

went on to explain that similarly there is now one Bone Marrow transplant service. He went on to emphasise that you get better outcomes the more you do , and said that , for example , there are surgeons who only to do aorta surgery. A member asked if this improvement is marginal or significant and the Director said that it was significant and reported that there had been dramatic improvements in the thrombosis process following the introduction of one specialist stroke service.

5.10 The Director said that being one organisation will make it much easier to integrate services and money flows. A member asked if this will enable a shift of money to primary care and the Director agreed that it would; as fewer people will receive care in hospitals and there will be a move to integrated care in the community. A member noted that those polyclinics that remain seem to be located in hospitals.

5.11 A member asked what is going to be different and commented that people have been talking about the shift from treatment to illness prevention for some time. The Director responded that formally hospitals have tended to only concentrate on the treatment part of an illness cycle; however, KHP are interested in integration and the whole pathway. He explained that the approach would be to then invest and disinvest, nearer the start of the pathway. So for example if you put investment in smoking cessation.

5.12 A member asked about clinical self-interest and the Director mentioned that Dr Cosgrave in America has a philosophy of putting patients first and doctors last. Decisions will are also be driven by data on outcomes.

5.13 A member said that a patient reported that they were first treated in Kings and then at St Thomas hospital, however the consultant could not read the scans or look at test results. The Director responded that all the Trusts IT systems are not fully integrated yet; because this would mean all the hospitals adopting the same system. Progressing this level of integration would be easier if we had one overall boss. The member asked if that means you are intending to procure one IT system and he responded that the technicians are now talking about linking devices.

5.14 A member asked how integration would make a difference to tackling health inequalities. She noted that we have been working on this for years and by now there should been marked improvement. The Director responded that are many causes that would benefit from an integrated approach including the underlying determinates such as this as housing; jobs; economy. He noted the single greatest cause of lung cancer is smoking which very associated with socio economic status. He noted that the poorest of the poor are single women with children. He went

on to comment that over the last 40 years there have been little change in the 5 year survival rate for lung cancer despite medical advances; it remains around 7%. However, there has been a large fall in its incidence due to smoking rates falling from 45% to 22%.

5.15 A member commented that one of the problems has been expensive drugs not being available to all. He went on to speculate that the health service will develop so there will be a private service that can supplement the more ordinary health service. He asked if people on the NHS plus pathway might well in future be able to access a subsidised market and get drugs and devices at a price they can afford. The Director of Clinical Strategy answered that there is nothing that you cannot get at a public hospital that you get at a private hospital.

5.16 A member asked how the consultation would involve patients and the response was that there are many patient groups, the governors and around a thousand volunteers. He assured the committee that patient involvement is very important to the partners.

5.17 The Director was then asked if there will be a reduction in hospital provision and if the merger poses a risk to patient care. He assured members that the merger would not be a distraction from patient care.

5.18 A member asked if a big trust could pose a conflict of interest with the commissioning of services by doctors on the new clinical commissioning committees. The director responded that the Health and Wellbeing Board may a find a route through some of those conflicts of interest. The member commented that a merger is one way of mitigating against the dangers of any qualified provider destabilising the system. However, he questioned the likelihood of Monitor considering that the merger could be a monopoly provider. The Director responded that Monitor would take a view on the competition angle.

5.19 The chair asked if the committee can expect an answer on if this is likely to proceed by the end of the month and the Director confirmed that the three Trust boards and Kings College would be given information by end of the month, which they will then consider. The chair thanked the Director of Clinical Strategy for his presentation and said that the committee intend to keep the merger under review.

RESOLVED

The chair asked KHP to keep the committee updated on progress and provide the Strategic Outline Case when, and if, this is produced.

6. MENTAL HEALTH OF OLDER ADULTS (MHOA)

6.1 Zoë Reed Executive; Director of Strategy and Business Development and Cha Power; Deputy Director MHOA Clinical Academic Group presented. The Deputy Director explained that the proposal to develop a Specialist Older Adults Home Treatment Team is aimed at both reducing costs, and moving more towards community care and home treatment. He said that they want to improve the service by providing home treatment to older people.

6.2 The Deputy Director reported that they have been discussing this model with Lambeth and Southwark commissioners and now MHOA want to develop a pilot. He explained that before the service could not offer support at the weekend and evenings, which meant the only option was for staff to bring older people needing care into hospital, and consequently many older people then became institutionalised. He reported that similar projects in other hospitals have reduced demand for beds by 30 %. He went on to emphasise the project intends to work with people who want this services. He explained that for this to work the initiative needs family and clients engagement.

6.3 The Deputy Director explained that the teams will be made up of nursing and social work care staff, and that these staff members will act as a bridge between different services.

6.4 He went on to explain that the pilot has a number of stakeholders involved in its development and there will be a user involvement group. A member asked if these groups have been set up and the Deputy Director confirmed that they have, and that they will be meeting shortly. He reported that the proposal has been taken to the older people's partnership board and to staff.

6.5 The chair invited questions and a member asked how intense the care would be. The Deputy Director said that this could be high intensity care, with three to four visits a day for up to an hour, however usually twice day initially. He said that medication is a big part of home treatment.

6.6 A member asked if the project is proposing nobody would be admitted. The response was no, and that a 30% reduction to inpatient care could be expected in inner city areas. He explained that the service often depends on social support. He reported that there is additional spare capacity in Bethlam Hospital, Ladywell Unit at University Hospital Lewisham and at other locations. He added that availability could depend on the sex of the client and provision available.

6.7 Members asked how the project will be evaluated and manage risks. The Deputy Director assured members that if they were seriously concerned then the service would continue to bring people into hospital. He reported that this is a proven practice, which is in use with adults and used in Australia with older adults .

6.8 The Deputy Director reported that the Equality Impact Assessment (EQI) is to be developed, and a work in progress, to which a member commented that he considered it good practice for an EQI to be imbedded right from the start. The Deputy Director responded that this is a developing document that being updated with relevant data. A member commented that he hoped that they are now collecting data across all protected characteristics. He went on to comment that this is not supposed to be a retrospective exercise and that it would appear that the pilot had been designed before the EQI had been completed. He pointed out that the Trust has a duty to comply with legislation. The chair requested that an updated EQI be sent to the committee.

6.9 A member asked why there is separate work being done with a user involvement group and Nuala Conlan, MHOA lead for older people's involvement, commented that this group is working at a slower pace and feeding into the stakeholder group. The member enquired as to why there was no direct user representation on the stakeholder group and the chair requested that a user representative attend the next committee meeting.

6.10 Members asked about risk management and commented that have been some incidents of concern where older adults have come to harm in the community. The Deputy Director assured members that there would be risk assessment done with senior practitioners, psychiatrists and community social work team. He commented that there are risks factors in hospital with a greater chance of suicide due to depression. He said that he saw this initiative as positive risk taking, however he went on to assure member that if clients went down hill then the service would bring people in.

6.11 The Deputy Director was asked to confirm that there are two processes going on – one providing home care and the other bed reduction. He responded that this pilot is not taking beds taking away as MHOA agreed with commissioners to do a pilot. The member asked if there was an agenda to reduce beds and the Deputy Director responded that home treatment would lead to a reduction, not an obliteration, of the need for beds and that practice in other areas had shown that there will be a reduction. The member asked for clarification that during the pilot there will be no reduction in beds and the Deputy Director assured the sub-committee that there would not be. .

6.12 A member asked why the service had taken so long to introduce this initiative if the clinical evidence was that it was beneficial, and asked if this was to save money or improve care. The Deputy Director explained that there was extra money available for adult's services to do the initial investment. The Director of Strategy and Business Development explained that ultimately they do anticipate financial savings, which are needed at this time. She went on to explain that a while a couple of beds will not make much difference a whole ward is significant because this can cost a million pound a year to run but a team is half that cost.

6.13 Members asked if there will be equal access to beds from Lambeth and Southwark residents and the committee was assured the sub-committee that there would be. A member asked if there were complex cases that need to stay in hospital and the Deputy Director replied that 40% of older people who come in do not return home. He explained if admission can be prevented then this number would be reduced, and noted that if people come into hospital then they deskill.

6.14 A member commented that she liked the home treatment model, however she commented that if people who live alone there needs to be contact with neighbours and housing managers. She also voiced concerns that people are heavily drugged. The Deputy Director responded that if they get permission then they will contact wider social networks of family and neighbours, and added that staff try to give appropriate medication not over drug

6.15 MHOA staff were asked about older people with an acute need for both physical and mental health needs and the sub committee was told that the service are developing services in partnership . They said that they do provide a mix and agreed that sometimes both are needed.

6.16 A representative of LINKs Southwark commented that people in wards get care, and went on to query the care burden on carers and social workers. The chair requested that SlaM respond to this in writing.

RESOLVED

Officers were requested to send the committee the:

- Draft Equalities Impact Assessment
- Draft risk register

The committee requested a quarterly update of statistics on the:

- Number of people being seen by home treatment team
- Number of home visits

- Number of hospital admissions
- Number of emergency weekend hospital admissions

Officers were requested to attend the next meeting with a user representative.

A written answer was requested by the LINk on the care people receive in wards and the potential care burden on families and social services if the home treatment model is adopted.

7. PUBLIC HEALTH

7.1 The chair welcomed Dr Ann Marie Connolly, Director of Public Health and Professor Moxham, Director of Clinical Strategy, to present on Public Health. The Director of Public Health went through the presentation circulated with the agenda.

7.2 She referred to the health system triangle that considers the determinants of good health. The bottom layer refers to good education, social structure, jobs, and income. She noted that behaviours likely to lead to poor health outcomes tend to come in clusters and are related to deprivation.

7.3 The Director of Public Health referred to the statistics that show that women and men's life expectancy in Southwark is improving, but there is a large variation depending on social and physical deprivation.

7.4 She noted that Chronic Obstructive Pulmonary Disease (COPD) is higher than the national average, as are cardiovascular disease, particularly CHD & strokes, and lung cancer. Mental Health is also a major cause of morbidity. There is an emphasis on long-term conditions – improving the quality of care and quality of life.

7.5 The presentation outlined some of the risks factors: smoking, poor diet, obesity, lack of exercise and alcohol consumption. She outlined the four emerging Southwark Health and Wellbeing priorities as: prevention or reduction of alcohol-related misuse; coping skills, resilience and mental wellbeing; early intervention and families and, lastly, healthy weight and exercise.

7.6 The Director of Public Health referred to research by the New Economics Foundation that identifies ways to keep healthy: connection through relationships; being active; keep learning; taking notice and giving of oneself.

7.7 At the end of the presentation the Director of Public Health

concluded by saying that improving health is about acting on the wider determinants of health and the prevention of risk factors. There is also an emphasis on early detection of conditions through cancer screening, NHS Health Checks and improved management of common chronic health conditions.

7.8 The chair thanked the Director of Public Health and invited Professor Moxham, Director of Clinical Strategy, to present and he also referred to his presentation, circulated with the agenda. He emphasised Kings Health Partners collaborative approach to Public Health. Alcohol is top priority of their Public Health strategy. This is a priority as hazardous and harmful drinking is a chronic condition with huge numbers presenting at St Thomas Hospital.

7.9 There is a strong emphasis on smoking cessation, and a focus on staff quitting. Staff who do not smoke are better carers and strong proponents of public health. The strategy focuses on those who are likely to smoke a lot, such as porters. He explained that KHP are looking at smoking as a chronic disease.

7.10 The strategy in aiming to diagnose people with HIV promptly and hospital are trying to do routine testing.

7.11 There is an emphasis on identifying patients with mental health issues who are users of other services. The Psychological Medicine CAG is focusing on improving mental health of patients with chronic diseases. They are identifying depression in clinics (e.g. Diabetes, Rheumatology) and delivering treatment.

7.12 The Director concluded by emphasising 'Value-Based Health Care' because it can improve quality, efficiency and sustainability of care across our health and social care economy. He explained that "Value" is defined as outcomes that matter to patients, divided by the costs of achieving those outcomes, over the full cycle of care.

7.13 The chair thanked both presenters and invited the sub committee to ask questions. A member commented that the evidence had highlighted smoking as a key determinant of health, but it was not in Southwark's four emerging priorities. He asked why that was. The Director of Clinical Strategy said that he agreed with the emerging priorities as all critical, however he explained that as a respiratory specialist he sees smoking as a key health issue to tackle,. He went on to commented that smoking is now being conceptualised as an inherited disease and its adverse health impacts are considerable, for example its negative effective on maternal and pre natal well being. The Director of Public Health explained that in the process of deciding the four emerging priorities there had been advocates of a number of issues and a choice had to be made. She explained that one of the criteria was that the issues would be something that the Health and Wellbeing

Board could best address collectively.

7.14 A member asked about the increase in tuberculosis and the Director of Public Health agreed to send a short update report. A member raised concerns about smoking and teenagers and referred to a report she had read that teenage smoking is on the increase. She raised her concerns about the selling of single cigarettes and the importance of educating teenagers. The Director of Clinical Strategy commented that one of the most at risk groups was African Caribbean males at 37%.

7.15 A member refereed to the book 'Nudge' and asked if this could be a useful approach to tackling unhealthy behaviours. The Director of Clinical Strategy commented that vouchers for fruit and vegetables and gym membership are not enough to tackle these types of systemic problems. It noted that it took legislation to ban smoking from public places to effect a significant reduction in smoking. He advocated a similar approach to obesity, for example banning vending machines selling junk food from public places. He said that we need, as a democracy, to get to this place and that can take years of campaigning. He went on to say that we are now an early on in the journey to tackle obesity and commented that if you invite chocolate bar manufactories to discuss the matter they will only offer to manufacture smaller bars.

7.16 The Director of Public Health concurred and noted that those on a better income and with high levels of skills are much more able to maintain a proper diet. She noted that nourishment of children is particularly crucial . The Marmot report evidenced that the foundation for children's health is laid down by the age of two. She added that there is some scope for Nudge to do the inverse of what big industry to persuade us to eat cheap poor quality food.

7.17 A member asked about the possibility of using Nudge to make fine grained changes to behaviour and went on to ask if he thought there needed to be more national coordinated action on diet. The Director of Clinical Strategy agreed that there did need to be national action , as well as citywide action, and referred to the role of the New York mayor in banning alcohol consumption in public places. The Director of Public Health questioned the national political will to take such action but said there are still opportunities at a local government level. For example, licensing trading outlets, school and public spaces, working with fast food outlets to improve the food they provide. She said that fine-grained actions with diverse communities are also effective as is giving information to parents.

7.18 A member commented that planning is an important power and mentioned the saturation of fast food outlets in places such as Walworth and noted that supermarkets often promote food that is

detrimental to people's health. He agreed that the planning process could be used to constrain commercial outlets food promotion practices that are so detrimental to wellbeing. Lastly he commented that there is an opportunity for the council to radically expand the opportunities for people to grow there own food.

7.19 Facilities for outdoor play was raised by a member and the directors both agreed that this was important and that children need more exercise; both in free play and in supervised activities. Physical activity that is integrated into daily life, such as walking is also important.

7.20 A member asked about breast and cervical early screening for cancer and similarly education about prostrate cancer in men, and asked if this was important. The directors agree that early detection was a key part of their respective strategies.

7.21 A member of the public asked about the delivery of alcohol and drug treatment service at Marina House and the chair requested that the Director of Clinical Strategy provide an update.

7.22 A member commented that making links between planning, education and housing and the Health and Well Being board would be important. The chair noted that Public Health is proposed as a review subject for this administrative year, and will therefore be discussed at more length during the work planning process.

RESOLVED

The committee requested that:

- Professor Moxham provided an update on Marina House and the delivery of services; particularly any that continue to treat alcohol and drug addiction from this.
- Dr Ann Marie Connolly provide any available evidence on the increase in tuberculosis

8. SOUTHWARK CLINICAL COMMISSIONING COMMITTEE (SCCC)

8.1 The chair reported that he had been contacted and asked to contribute to a 360-degree review of Southwark Clinical Commission Group (SCCG). The chair also reported that he had

been asked to endorse the bid for delegated authority, but he thought that this required more deliberation, given the independent role of scrutiny. The vice chair commented that he would like to consider this further once he had had a chance to review the paperwork.

8.2 The chair then invited Malcolm Hines, Chief Finance officer, and Swann Kieran, Head of Planning & QIPP to present the report on SCCG implementation of the recommendations of the recent scrutiny report, and give an update on SCCG's transition to full delegation.

8.3 The Chief Finance officer commented that the recent scrutiny report had been very helpful in considering the governance process and the report covers the detail of this. He went on to explain that once the authorisation process is complete the SCCG will be a new organisation, and as such they need buy in from all stakeholders. He went on to explain that all GP practices would be member practices.

8.4 He explained that the authorisation process follows national guidance with local implementation. Southwark is in the second of four waves and intend to complete the next stage into this process by 1st September, when the SCCG will submit a portfolio of evidence. This will include a constitution. The chair requested that this be sent to the committee.

8.5 The outcome of the authorisation process will be known by November 2012. The Chief Finance officer explained there is a slight lack of clarity on what that will mean about the status of SCCG , and if they will still be in shadow form.

8.6 He explained that there is a process of seeking views from stakeholders, with questionnaires going to doctors, dentists and other stakeholders. A member asked if information is publically available and subject to Freedom of Information enquiries. Officers responded that that they could not be entirely sure, but presumed so.

8.7 The Chief Finance officer explained that appointments are being made now and these will include the posts of chief executive and finance officer. He reported that lay members of the board are also being recruited through an appointment process. He went to explain that they are also seeking a secondary care nurse, but this will not be an appointment from any of the local health trusts.

8.8 A member asked if it is mandatory for all GP practices to join and the Chief Finance officer confirmed it was , but the obligation was on the practices to become members rather than individual doctors.

8.9 The officers were asked how the SCCG would be held to account and it was explained that scrutiny would contribute to this process, and there is accountability through the national commissioning national office.

8.10 There was a question about the recruitment process for lay members and officers were asked for more detail. The chief finance officer referred to local advertisements and reported that they are working through the applicants to see who has the most appropriate skills. Member requested more information.

8.11 A member of the public raised concerns about how GPs respond to patients at weekends and evenings who are experiencing mental distress, and are in need of support. The chair requested a note from officers covering this question.

RESOLVED

The committee requested that SCCG Business Support Officers (BSU) provide a:

- copy of the draft constitution
- note on the recruitment process for all appointed places on the SCCG
- Information on how GPs respond to patients at weekends and evenings that are experiencing mental distress and are in need of support.

The committee will consider the request from SCCG for the health scrutiny committee to endorse the SCCG authorisation process. The chair will provide additional information to the vice chair to assist this.

9. WORK PLAN

9.1 The chair recalled that last year's visits to the acute trust hospitals had been helpful, as had the annual safeguarding review, a he favoured repeating these activities. He suggested a December cabinet member interview. He went on to refer to the three reviews which had been suggested prior to the meeting :

a) King's Health Partner merger

b) Public Health

c) Dementia

9.2 Members recalled the evidence from previous reviews on the importance of psychological health for older people in maintaining wellbeing and recommended that this be considered during the review on dementia.

9.3 It was noted that communities had been added to the sub – committee brief and it was suggested that the committee involve communities in its reviews , particularly in taking evidence.

9.4 A member requested that developments with Dulwich hospital site are kept under review, alongside the potential for more tailored local health delivery form this site.

9.5 Concerns about personalisation, safeguarding and the associated risks were raised and it was agreed a report would be requested.

9.6 The Health and Wellbeing Board was noted as key development this year and the chair advised that members attend to contribute and understand this process.

RESOLVED

Work Programme

The committee will conduct reviews on:

a) King's Health Partner merger

b) Public Health

c) Dementia

The committee will keep watching briefs and receive regular evidence on:

- Mental Health Older Adults;
- Psychological Therapy Services;
- SCCG transition to full delegation and implementation of the sub committees recommendations;
- Future of Dulwich Hospital.

Conduct an interview of the Cabinet Member for Health and Adult Social Care in December.

Receive report/s on adult safeguarding

Receive annual hospital reports/accounts

Visit the three acute trusts

Reports requested

The committee requested a report from officers on personalisation, safeguarding and the associated risks.

10. PSYCHOLOGICAL THERAPY SERVICE

10.1 The chair thanked Zoë Reed Executive, Director of Strategy and Business Development, for her recent correspondence and noted this item will be covered at the next meeting, by which time more evidence will be available.

RESOLVED

The reorganisation of the Psychological Therapy Service will be considered at the September meeting in more detail.

11. SLAM PROPOSED ROUNDTABLE

11.1 The chair drew members attention to recent correspondence inviting the sub-committee to contribute to roundtable discussions with SLaM. Zoë Reed Executive; Director of Strategy and Business Development, explained that this would be an opportunity for SLaM to explain the extent of the planed changes in a cooperative fashion. The chair commented that this would be welcome and that items that warrant further scrutiny still might come back into a more formal scrutiny process. The Director agreed and indicated that the discussions hope to look forward to changes planned over the next 2 – 5 years.

11.2 The chair and vice chair reported that they will both attend the roundtable meeting and would prefer to schedule these a few weeks before the committee meetings.

RESOLVED

The chair and vice chair will attend the SLaM roundtable consultation meetings on behalf of the committee.

Agenda Item 8

Southwark Council

Scrutiny review proposal

1 What is the review?

Public Health inequalities in Southwark, including the maternal health of the gypsy and traveller community in Southwark

2 What outcomes could realistically be achieved? Which agency does the review seek to influence?

Identify ways local providers (SCG, acutes, Southwark Council and HWBB) can tackle the worse health inequalities in Southwark.

Secondly, identify ways that the maternal health of gypsy and traveller communities in Southwark can be improved.

3 When should the review be carried out/completed? i.e. does the review need to take place before/after a certain time?

February 2013, to allow ample time before the HWBB moves from being a shadow board.

For the gypsy and traveller element of the review, the timescales would be scoping in September, October – work through the Centre for Public Scrutiny process, November take evidence.

The CfPS have agreed to work with us on this part of the review, which will allow us to learn from their experience and benefit from some dedicated resourcing from them.

4 What format would suit this review? (e.g. full investigation, Q&A with cabinet member/partners, public meeting, one-off session)

Full investigation.

5 What are some of the key issues that you would like the review to look at?

The main health inequalities in Southwark and the maternal health of the gypsy and traveller community in our borough,

6 Who would you like to receive evidence and advice from during the review?

Acute trusts, SCG, Southwark Council, charities working in Southwark.

7 Any suggestions for background information? Are you aware of any best practice on this topic?

The Islington Council scrutiny into inequalities in their borough.

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?
e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Possibly all.

Agenda Item 9

Southwark Council

Scrutiny review proposal

1 What is the review?

Dementia

2 What outcomes could realistically be achieved? Which agency does the review seek to influence?

To ensure that the council and commissioners effectively provide for dementia sufferers and prepare for the expected increase in dementia patients in the borough.

3 When should the review be carried out/completed? i.e. does the review need to take place before/after a certain time?

By April/May 2013.

4 What format would suit this review? (e.g. full investigation, Q&A with cabinet member/partners, public meeting, one-off session)

Full investigation.

5 What are some of the key issues that you would like the review to look at?

Current provision, any current problems with standards of care/cost, expected growth of the issue in Southwark, cost pressures, other models of care and how can the council mitigate against these.

6 Who would you like to receive evidence and advice from during the review?

Patient groups, the council, SCG, patients and their family members/carers, national charities who may have done work on this issue.

7 Any suggestions for background information? Are you aware of any best practice on this topic?

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?
e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

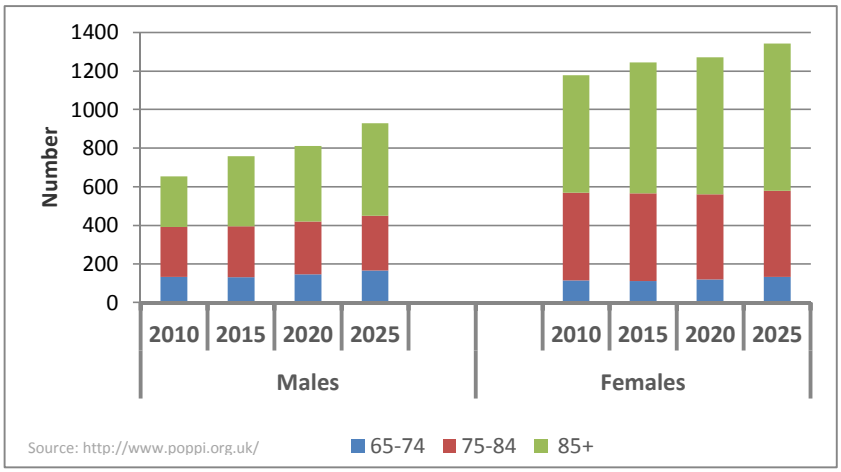
All

Older People's JSNA Factsheet : Mental Health

Summary

This factsheet covers mainly dementia and depression. Around 1800 people are estimated to have dementia in Southwark. Prevalence rises steeply with age. Under half of people with dementia over 65 appear to be recognised (on registers) with local GPs. Dementia may be a precipitating factor in admission, for example when the person forgets to take medication. The main reasons for admissions among people with dementia are preventable(falls and urinary and respiratory infections) and should be addressed. There is a local Dementia Strategy. A memory assessment service provides multi-disciplinary early intervention for people with suspected dementia. In 2009/10 service user and carers described confusing pathways, multiple assessments, delayed diagnosis and a general lack of awareness of dementia amongst involved professionals.

Figure 1: Number of people aged 65 and over predicted to have dementia by age and gender, projected to 2025, Southwark



Definitions

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO).

The local picture

Some mental health problems, notably dementia, are most common among older people. Older people with mental health problems are likely to have increased needs for care, particularly as conditions such as dementia may accompany physically frailty. This section focuses on dementia and depression.

Dementia

Dementia is a syndrome (a group of related symptoms) associated with progressive decline of the brain affecting many of the functions needed to sustain everyday life and self-care: Emotions, motivation and the capacity to cope in social situations are also affected.

Its onset may be quite slow and insidious and it is sometimes difficult to distinguish from depression. In many cases it is progressive and whilst it may be possible to manage at home in the early stages, it becomes more difficult as mental capacity diminishes. Dementia can impose enormous strain on carers.

Many cases of dementia go undiagnosed, particularly in its earlier stages: in March 2011 there were 752 people aged 65 + recorded on GP Disease Registers as being diagnosed with dementia, this was 96% of those with dementia of all ages. People with learning disability and stroke are at increased risk of dementia.

It is estimated that currently there are more than 1800 people aged 65 and over with some form of dementia rising to almost 2300.by 2082 by 2020. The majority of people with dementia are over 65 but a minority have early onset dementia (see table) Under half of people with dementia over 65 appear to be recognised (on registers) with local GPs, slightly higher than the London figure of 37% of people with dementia are recorded on GP registers.

Table 1: Estimated numbers over 65 years with dementia (Source: POPPI)

Age group	2011	2015	2020
	Men		
65-74	129	131	146
75-84	260	265	275
85 +	290	362	390
Total men	679	758	811
	Women		
65-74	111	111	119
75-84	448	455	442
85 +	640	679	710
Total women	1,199	1,245	1,271
Total men and women	1,878	2,003	2,082

The following table shows the extent to which dementia is undetected in primary care by practice, using a range of prevalence estimates (low and high). Some practices do no even achieve rates of detection based on the low estimate.

Table 2: Expected versus actual numbers of overs with dementia, by practice in Southwark

Name of Practice	All over 65s as at 30.11.10	Expected prevalence of dementia high estimate +	Expected prevalence of dementia low estimate +	Actual numbers on register 2010/11
Forest Hill Group Practice	1524	134	19	22
Acorn Surgery	800	70	10	32
Lister Primary Care Centre	108	10	1	1
St James Church Surgery	307	27	4	3
The Aylesbury Partnership	1599	141	20	10
Camberwell Green Surgery	770	68	10	2
The Trafalgar Surgery	232	20	3	13
Falmouth Road Group Practice	712	63	9	7
Concordia Parkside Medical Centre	492	43	6	11
DMC Chadwick Road	635	56	8	20
Princess Street Group Practice	988	87	12	7
Queens Road Surgery	466	41	6	5
St Giles Surgery	327	29	4	4
Sir John Kirk Close Surgery	351	31	4	7
Elm Lodge Surgery	822	72	10	3
Old Kent Road Surgery	239	21	3	8
Dr Sinha	336	30	4	3
Penrose Surgery	340	30	4	7
DMC Silverlock	361	32	5	5
3 zero 6 Medical Centre	330	29	4	12
Bermondsey & Lansdowne	658	58	8	12
Manor Place Surgery	674	59	8	7

The Grange Road Practice	604	53	8	6
Borough Medical Centre	288	25	4	6
The Hambleden Clinic	280	25	4	31
Sternhall Lane Surgery	495	44	6	19
Park Medical Centre	567	50	7	8
Melbourne Grove Medical Practice	425	37	5	2
Lister Primary Care Centre	235	21	3	10
Albion Street Group Practice	749	66	9	12
Parkers Row Family Practice	529	47	7	4
The Villa Street Surgery	366	32	5	12
Blackfriars Medical Practice	432	38	5	5
The Gardens Surgery	569	50	7	2
Dulwich Medical Centre	622	55	8	39
Dr Doha	420	37	5	4
Nunhead Surgery	853	75	11	41
Surrey Docks Health Centre	392	34	5	4
The New Mill Street Surgery	319	28	4	1
East Dulwich Primary Care Centre	312	27	4	16
Avicenna Health Centre	340	30	4	1
Hurley/ Lister Primary Care Centre	323	28	4	15
Dr Lee	63	6	1	8
Dr Bradford	464	41	6	12
Lister Primary Care Centre	232	20	3	1
St Giles Surgery	485	43	6	22
Borough Medical Centre	96	8	1	32
Total	23191			

Note: + The prevalence of dementia is highly age- specific and rises steeply with age. The low estimate assumes an average prevalence of 1.25% which is the population prevalence rate in 65-69

years olds. The high estimate assumes an average prevalence of 8.8% which is the population prevalence rate in all over 65 year olds (range 65-90+). The low estimate is therefore a very conservative estimate.

Dementia may be a precipitating factor in admission, for example when the person forgets to take medication. In 2010/11 there were 774 admissions coded for dementia, and 98% of them were unplanned via A & E. Where the primary diagnosis was dementia the reason given for admission was falls, renal tract infections, respiratory infections. 30 patients were admitted on 3- 5 occasions . The estimated cost of this unplanned care was £2.5million.

Long term care is needed when remaining at home is no longer possible. The following table shows the breakdown of permanent placements by condition. Mental health conditions only result in a small number of placements. Often people with dementia first need social care in relation to physical ill- health or disability. Their dementia has a significant impact upon their need for further and ongoing support, and these figures do not show this. Older people with dementia appear to be significantly over represented within institutional care as opposed to community based provision. Social work staff and the care home providers estimate that the real proportion of those residents who may have some form of dementia is nearer to 70%.

Table3: Permanent placements of older people in Residential and Nursing Care for individual years, broken down by client group

All placements as at:	Primary Client Group	65 + Residential care	65 + Nursing care	65 + Total permanent placement
31/03/2011	Physical disability frailty and sensory impairment	256	227	483
	Mental health	25	27	52
	Learning disability	24	0	24
	Substance misuse	4	1	4
	Not allocated to client group	18	7	25
	Total	327	262	589

What we know works

Dementia can be prevented in middle age by addressing risk factors such as smoking, excess alcohol use, diabetes and hypertension. It is important to assess and diagnose people early through assessment (memory)clinics. NICE has produced an evidence based quality standard for people with dementia. The opportunity to participate in group cognitive stimulation therapy should be available in order to

optimise independence. Donepezil, galantamine and rivastigmine are recommended by NICE as options for managing mild as well as moderate Alzheimer's disease. Care should be coordinated between health and social care and the needs of the carers taken into account. The care plan should include support for activities of daily living through to joint decision making with the individual and carer and provision for end of life care when needed.

Local action

South London and Maudsley's (SLaM) Mental Health of Older Adults and Dementia Clinical Academic Group is commissioned to provide community mental health services for older people in Southwark through sector-based multi-disciplinary teams, in the north and the south of the borough. There is a local Dementia Strategy.

A memory assessment service provides multi-disciplinary early intervention for people with suspected dementia. The service offers comprehensive assessment, diagnostic and treatment functions for individuals experiencing mild to moderate cognitive decline consistent with an underlying dementia, regardless of age and who do not have an existing diagnosis of dementia.

Currently 73% of people with dementia who are eligible for a review in primary care actually receive one (QoF 2007/8).Fourteen percent (245) people over 65 were receiving social care for a mental health problem in 2007/8 (DH RAP return).

What still needs to be done

People may not receive a timely diagnosis, and when they do, the pathway to further support and advice was poor. When they did get help it was often too late. In the absence of more timely, planned support people seek help at times of crisis when the individual situation has deteriorated to the extent that residential, nursing home and in-patient admissions remain the only option.

User/Carer Views

During 2009-10 Southwark completed an exercise to obtain the views of a wide range of stakeholders on both the Older People's and Carer's Commissioning Strategies. Service user and carers described confusing pathways, multiple assessments, delayed diagnosis and a general lack of awareness of dementia amongst involved professionals. Other issues include:

- Lack of awareness of dementia
- Early diagnosis and access to services
- Support to remain at home and more information about available services
- Support of carers

Depression

Depression is less prevalent among older adults. Depression may however develop in later life as a result of a less active daily life and reduced social contacts, loss of job and family related roles and responsibilities, death of a partner, friends and family members; insomnia; having less money, ill-health or disability; anxiety about being able to cope or long term strain from being a carer for a disabled partner or family member.

Depression may also be associated with long term conditions such as cardiovascular disease or diabetes. If depression develops and does not resolve or is not treated it may seriously affect the person's ability to look after themselves. It may also be a gateway to other illnesses.

It is estimated that there are currently more than 2,100 people aged 65 and over with depression. About a third of these people will suffer severe depression. This figure is expected to rise to 2,550 by 2025.

Table 4: Disease Registers in primary care for mental health problems among the over 65s by gender (March 2011).

		Females	Males	
	All patients (total)	Aged 65 years +	Aged 65 years +	All over 65s as a % of total on registers
Registered patients	318236	13597	10513	7.6
Dementia	752	465	257	96.0
Severe mental illness	3406	279	198	14.0

Source: QOF 2010/11

Agenda Item 10

Southwark Council

Scrutiny review proposal

1 What is the review?

King's Health Partner merger

2 What outcomes could realistically be achieved? Which agency does the review seek to influence?

This review seeks to ensure that the costs and risks of the proposed merger are fully understand by KHP. Firstly, to ensure all risks are identified, understood and mitigated against in the proposals so that as full a picture can be achieved before any final decisions are made about the merger.

Secondly, for the committee to act as an additional forum to gather views from all interested parties. This will assist in the first objective named above.

Thirdly, to make sure that the trust is not over-optimistic of the benefits of the proposed merger and that 'optimisim bias' is fully understood and accounted for in the development of the Full Business Case.

3 When should the review be carried out/completed? i.e. does the review need to take place before/after a certain time?

Completion by January 2013. If the trust proceeds with the proposed merger they would need to gain regulatory approval by April 2014, with pre-notification discussions with Monitor in April 2013. Therefore we need to complete our report in time to be considered before the KHP discussions with Monitor.

4 What format would suit this review? (e.g. full investigation, Q&A with cabinet member/partners, public meeting, one-off session)

Full investigation.

5 What are some of the key issues that you would like the review to look at?

Risk management, ensuring all risks are identified, treatment of optimism bias and the equalities impact of the proposed merger.

6 Who would you like to receive evidence and advice from during the review?

The 3 acute trusts, KCL, KHP, SCG, DH, Unions, patient groups, LiNK, SPAG, Southwark Council, local ICAS services, local representatives (drawing on their casework experience.

7 Any suggestions for background information? Are you aware of any best practice on this topic?

Any and all information about previous hospital mergers (including SLHC).

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?
e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

verbal or written submissions, meeting with stakeholders, survey, consultation event

Agenda Item 11

Office of the Trust Special Administrator
South London Healthcare NHS Trust
Queen Elizabeth Hospital
Stadium Road
Woolwich
London SE18 4QH

Sent via email

Monday 20 August 2012

Dear Cllr Williams

I am writing to you further to my letter of 19 July, in which I outlined the rationale, timetable and process for the Unsustainable Provider Regime that the Secretary of State for Health has put in place at South London Healthcare NHS Trust.

As you know, the long-term solution to the challenges faced by the health care system in south east London is one that starts with South London Healthcare NHS Trust itself but also has to fit with the broader south east London health economy. The recommendations I have been asked to produce for Secretary of State by early January 2013 will be recommendations for the optimal delivery of safe, high quality, affordable and sustainable health services for the people of south east London for the long term. You are already aware that I am very keen to engage with all six HOSCs/OSCs, as representatives for local communities across the south east London boroughs, in developing my proposals to secure clinically and financially sustainable health services and that is why I am writing to you now.

Whilst the Regime for Unsustainable NHS Providers (UPR) is a unique process under NHS legislation, and as such the usual functions and responsibilities of OSCs are different, I believe it would be beneficial if we could establish a strong programme of engagement with the Council over the period of the regime. To this end I am working with your Leader and Chief Executive in detail ahead of consultation and would like to engage with the HoSC as part of the consultation process. This starts at the start of November and we will be in touch to discuss this with you closer to the time.

I am keen to ensure that the views of your respective constituents are heard and fed into this work and so in addition to the public consultation and my work with your Leader and CEO I have asked Stephanie Hood to keep you updated on overall progress ahead of consultation.

I look forward to talking with you as part of this work.

Yours sincerely

Matthew Kershaw
Trust Special Administrator

Cc Councillor Peter John, Leader, Southwark Local Authority
Eleanor Kelly, Chief Executive, Southwark Local Authority
Hannah Farrar, Director Strategy, Commissioning and Provider Development
Stephanie Hood, Director of Communications, TSA

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2012-13**

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