Open Agenda

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 14 March 2012
6.30 pm
Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Date: 9 March 2012

Agenda Item 5

Southwark Council

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Chair, Health & Adult Social
Care Scrutiny sub-Committee
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Scrutiny Team
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20 February 2012

Dear Stuart Bell

SLaM: consultation on Changes to Psychological Therapy Services and cuts to Maudsley Hospital adult mental health beds.

Southwark Council's Health and Adult Social care scrutiny committee met on Wednesday 1 February and discussed concerns raised about Changes to Psychological Therapy Services and cuts to Maudsley Hospital's adult mental health beds. A number of stakeholders and partners including Southwark LINKs, Lambeth Health Scrutiny and Southwark Pensioners Action Group have queried whether the consultation process followed, for both of these service changes, has been adequate.

Following the meeting scrutiny received some formal documentation from Steve Davidson , Service Director , Mood Anxiety and Personality Clinical Academic Group, about the Changes to Psychological Therapy Services. This documentation is helpful; however I would appreciate it if you could also fill out a 'trigger template' relating to changes being proposed for this service.

Trigger templates were devised as a reporting method for all hospital trusts to use where a service change might be deemed substantial enough to warrant further investigation by scrutiny.

The committee also requested a briefing on cuts to Maudsley Hospital's adult health beds, including details of any consultation process and timeline. Please can you complete a trigger template for this service change too.

The committee would like representatives from SLaM to attend our next meeting on 14 March. Please can you provide the requested papers by 2 March.

If you have any queries please contact Julie Timbrell, scrutiny project manager, in the first instance via email: julie.timbrell@southwark.gov.uk or by telephone on 02075250514.

Yours faithfully

Cllr Mark Williams

Chair, Health and Adult Social Care Scrutiny sub-committee

Cc Steve Davidson; Service Director. Mood Anxiety and Personality CAG.
Zoë Reed Executive; Director Strategy and Business Development.

DOCUMENT A

OVERVIEW

Overview: psychological therapy service reconfiguration:

Report for Southwark Scrutiny, February 2012

Overview: psychological therapy service reconfiguration:

1. Summary

1.1 South London and Maudsley NHS Foundation Trust (SLaM) has been working with commissioners on plans to improve secondary psychological therapies. This involves the reconfiguration of the psychological therapy provision across Lambeth, Lewisham and Southwark.

1.2 The way that psychological therapy services are currently organised can be confusing to patients, referrers and commissioners. A number of services operate in different locations, having developed independently over time. The current arrangement means that different services may be offered to people on the basis of where they live in the borough rather than for good clinical reasons. It is proposed that a single Integrated Psychological Therapies Service (IPTT) will be developed in each borough, with a single point of access to referrals from primary care and from other secondary care services.

2. The case for changes to secondary psychological therapy provision

2.1 The reconfiguration, which is scheduled to be implemented in April 2012, will lead to the creation of a borough specific psychological therapy teams in Lambeth, Lewisham and Southwark. These new teams will bring together therapy provision previously delivered in the separate services. The services for Southwark residents involved are the Traumatic Stress Service at Maudsley Hospital, the Coordinated Psychological Therapy Service Based at the Munro centre - Guys Hospital, the Maudsley Psychotherapy Service and psychologists currently working in community mental health teams (CMHTs).They will work alongside existing CMHTs and will provide patients and GP referrers with a single point of access to a range of psychological therapies, according to assessed clinical need.

2.2 There has been a substantial increase in the availability of primary care psychological therapy services for Southwark since the launch of the Borough's IAPT (Increasing Access to Psychological Therapy) service in 2008. A total of 2,152 entered treatment during 2010/11.

2.3 Though the majority of people treated by IAPT have less complex clinical presentations than those treated in secondary care, the great expansion in the availability of psychological therapies in the borough justifies commissioners intentions to make a modest shift of resources between secondary and primary care.

3.1 One of the core objectives of IAPT is to support people experiencing anxiety and depression to stay in work or support them on the journey back into paid employment, training etc.

3.2 In contrast commissioners across Lambeth, Southwark and Lewisham have had long standing concerns about the efficacy of the psychotherapy service and the limited evidence base in relation to impact and outcomes. It is also the case that the take up of psychotherapy services is significantly under represented by people from BME communities in contrast to IAPT and indeed primary care counselling services where take up is broadly reflective of the Borough's population profile.

3.3 By referring people to a single point of access to psychological therapies it will be possible to ensure that people receive a full assessment and are directed promptly and efficiently to the right treatment and care. This may be a formal psychological treatment, or treatment by the CMHT, or they may be appropriately directed to a range of other primary care services such as IAPT other community based support.

3.4 A peer support / group co-ordinator role is also being developed which will be responsible for developing a range of groups and peer support systems that may be accessed as an alternative to formal treatment or used whilst an individual is waiting to see a therapist.

3.5 The proposal is being made to reconfigure all the current psychological service elements into a single team, rather than looking at each element separately, on the grounds that making changes to the whole service in this way will resolve the historical fragmentation of the service, and improve the experience of local residents.

3.6 Moreover, this approach will achieve the financial efficiency savings required for the next three years, creating greater stability for the service in the longer term. Undertaking a series of smaller changes over a longer period of time would lead to the risk of more fragmented, poorer quality services.

3.7 Projections about the impact of these changes upon staffing and activity has been circulated widely by one of the SLaM clinical service leads, as part of a response to the internal staff consultation. This information is inaccurate and does not accurately represent the current proposal. Whilst the total reduction in funding will be approximately 22%, the aim is to achieve efficiencies within the new services which will limit the planned reduction in activity to approximately 10%. This equates to a reduction per annum in assessments from 498 to 448. The total staffing of Southwark psychological therapy services will reduce from approximately 16 to 13 whole time equivalents.

3.8 The new system of assessments should allow a more consistent process of prioritisation of referrals, and will identify referrals to secondary care which can be more appropriately managed elsewhere.

3.9 It is proposed that SLaM will work closely with commissioners and primary care referrers to monitor demand for the new service on a monthly basis. If it is apparent that demand for the service exceeds provision, whether by the development of waiting lists or other measures, SLaM will respond promptly to manage this using a range of

measures including discussions with primary care and other referrers, and other providers of psychological therapies. If appropriate it would be possible increase capacity of psychotherapy quickly by using a 'bank' of sessional therapists developed with the support of the existing NHS Professionals staff bank. Consideration would be given as to whether this the best option at that point, based on patient needs.

4. Equality impact

4.1 The initial equality impact screening undertaken by SLaM has not indicated any differential impact on vulnerable groups. lndeed, while people from Black and Minority Ethnic (BME) communities have historically been under represented in their use of secondary psychological therapy services, it is expected that by bringing the process of referral to all psychological therapies into a single pathway, the more representative levels of access currently achieved by CMHTs and by IAPT (primary care psychological therapy) services will be delivered throughout the secondary care service.

4.2 The clear linkage between psychological therapy services and community mental health teams presents a framework where medical, psychological and social needs can be addressed in an integrated approach. This will enable services to respond flexibly to a broader range of issues should they be presented.

4.3 We are aware of the potential impact on residents in each borough of the current economic down turn which may lead to a greater need for mental health support. We do not expect this to increase demand for the psychological therapies delivered by these teams to a significant degree as most people treated in these services have long standing difficulties with mood and relationships, commonly related to early traumatic experiences, rather than triggered by recent or short term social stressors. Demand for treatments related to short term anxiety and depression in response to stressors is provided largely by the Increased Access to Psychological Therapy teams (IAPT), which are well developed in Lambeth, Southwark and Lewisham.

4.4 A more detailed equality impact assessment is attached.

5 Service user and staff involvement

5.1 The proposal forms part of an ongoing review of care pathways in the Mood, Anxiety and Personality Clinical Academic Group at SLaM. Service users were involved in workshops held on 28th February 2011, 28th March 2011, and 23rd May 2011. Addressing inconsistencies in access to services was identified as a priority by our Service User Advisory Group. This group comprises people with experience of Mood, Anxiety and Personality Disorder services, and works closely with clinicians and managers in the development and delivery of services. The group has been involved in the development of this proposal.

5.2 The model of service change originally proposed has been revised as a result of discussions with staff. A staff consultation was launched on 9th December 2011 and ended on16th January 2012. We are now in the process of considering the responses from this consultation and will then discuss the next steps with our commissioners.

6. **Conclusion**

6.1 In our view, changes to the provision of psychological therapy in Lambeth, Lewisham and Southwark will lead to an improved service to patients and commissioners. The changes are based upon a service model which we have been providing in Croydon for some time.

DOCUMENT B

DETAILED PROPOSAL

Mood Anxiety and Personality Clinical Academic Group

A proposal for the reconfiguration of psychological therapy services in Lambeth, Southwark and Lewisham

Version and history: Based on paper reviewed by the working group on 7.11.11 and presented at staff workshop 14.11; updated by Jonathan Bindman 26.1.12 to support scrutiny briefing; this version is informed by staff consultation responses but is not part of the formal response.

Introduction

Current Services

Psychological therapies within the MAP CAG are provided in primary and secondary care in a range of settings. The IAPT services provide psychological therapies in primary care according to clear protocols, are currently being re-tendered by the PCT, and do not form part of this proposal.

In secondary care, psychological therapies may be provided by therapists, principally psychologists, working in borough based Community Mental Health Teams (CMHTs), or in specialised services which may treat patients of more than one borough. Some of these services also treat patients referred from other boroughs, at tertiary level.

The specialised services considered in this paper which provide psychological therapies to patients of Lambeth, Southwark and Lewisham are: the St. Thomas's Psychotherapy Service (SPS) in Lambeth, the Co-ordinated Psychological Therapy Service (CPTS) in Southwark, and the Traumatic Stress Service (TSS) and the Maudsley Psychotherapy Service (MPS), which serve patients of all boroughs. In addition, psychologists working in secondary care are included, whether working entirely within CMHTs (as in Southwark and Lambeth), or serving CMHT clients from a separate base in the Lewisham Psychological Therapy Service (LPTS).

The Centre for Anxiety Disorders and Trauma (CADAT) delivers psychological treatments to primary, secondary and tertiary care. It has been subject to a review concurrent with this proposal, and the treatments it provides in secondary care are also considered here.

The day services for patients of Lambeth, Southwark and Lewisham, the Cawley Centre and the Intensive psychological treatment Service (IPTS) are excluded from this proposal, as are inpatient services which may be offered to patients on psychological therapy pathways.

Case for Change

Discussions with commissioners in the three boroughs over a long period of time have indicated a desire for change, though with local differences detailed below. Commissioners in all boroughs have invested substantially in IAPT services which have delivered a large expansion in evidence based psychological therapies delivered in primary care in the last two to three years. A common theme of these discussions is that while they accept that many of the patients seen in secondary care present a level of clinical complexity which makes treatment in IAPT unsuitable, they anticipate at least a modest shift of resources from secondary to primary care. At present, referral routes between primary care and IAPT are largely independent from referral routes to secondary care, and there is no clear numerical evidence of a shift in demand between them. However, at the request of commissioners the previously established joint panels of commissioners and clinical staff have extended their remit to review referrals to MPS in both Lambeth and Southwark, and have identified a minority of cases as suitable for management in primary care.

The delivery of outcome measures and evidence based treatments is also a common theme of discussions, given that IAPT is set up to deliver these in a highly structured manner, and produces clear evidence of benefit for patients. For various reasons both the research evidence and the delivery of local outcome measures in secondary care psychological therapy services tends to be less satisfactory than in IAPT and commissioners have expressed concern about this.

The CAG business plan in 2011/12 planned to identify £250K efficiency savings through a review of psychotherapy services delivered in Lambeth and Southwark. This review focused on Maudsley Psychotherapy Services and St Thomas's Psychotherapy. The review highlighted the difficulty in managing services together when they are subject to different funding streams (currently a mix of block and cost per case), and the consequence that reducing staffing reduces cost per case income. The results suggested that it would be difficult to deliver significant savings through small scale change, and might lead to fragmented, poorer quality services. The planned savings were not achieved, and it is clear that the efficiency savings which are required in current business plans will be best achieved through service redesign, rather than mere reduction in activity which is likely to result in frustrated demand and poor patient and commissioner experience.

Commissioner intentions

Lambeth

Lambeth PCT gave six months notice to Maudsley psychotherapy services in April 2011 (ending 30th September 2011) of their intention to decommission the service.

During this time, all referrals to MPS have been triaged through Lambeth IAPT, followed by review at the specialist outpatient panel. Lambeth commissioners signalled their intention in early 2011 to undertake a strategic review of psychological therapy services led by Sarah Corlett, but during the year continued informal discussions with us, and indicated support for the principles in this proposal as it was developed by our working group. Despite expiry of the notice period, current arrangements continue. The discussions with members of the Business Support Unit and with GP leads have suggested a willingness to continue commissioning from SLAM but an intention to disinvest by around 10% of current total spend over 3 years, which as above they link to the development of primary care psychological therapies. There is also an understanding of the necessity for us to meet CIP targets of at least 12% over 3 years, and of the need for commissioners to share the responsibility for managing demand effectively (though not necessarily through current panel arrangements), and a desire for a model of secondary psychological therapy provision which offers a clear pathway to primary care referrers and provides measures of outcome.

Southwark.

Southwark also intend to review and restructure psychological therapy services. Direct discussions with them suggest a similar situation to that in Lambeth, with a desire to disinvest by 10% over 3 years, and a similar willingness to commission a model offering a clear pathway into secondary psychological therapy. IAPT is not being re-tendered but is subject to a review process involving current providers including SLAM.

Lewisham

Lewisham commissioners have expressed interest for some time in developing local psychological therapy services, and recognise that their current model of services is different from Lambeth and Southwark, with more limited provision within the borough and patients being treated at MPS on a cost per case basis. Currently they access all dynamic therapy from MPS. They recognise our need to achieve CIP targets, and welcome the proposal to develop a borough based service, but have indicated that, given that they recognise that secondary services are less developed than in other boroughs, they are not seeking to disinvest.

Move to PbR.

PbR HoNOS clustering has indicated that the majority of work delivered by MPS and TSS falls within the parameters of usual local secondary psychotherapy services. This makes it unlikely that the levels of tariff achieved through the current cost per case arrangement can be maintained once PbR is fully implemented. The apparent discrepancy in costs between MPS and SPS has been a source of concern to commissioners for some time (despite the unavailability of directly comparable costs which include estate costs) and application of a PbR tariff will make this unsustainable.

Pathway development

High level care pathways for anxiety, depression and personality disorder have been developed and agreed. Clinical protocols for diagnostic groups (Maps of Medicine) have also been developed and signed off by the MAP CAG Executive. The next steps anticipated in the process are to confirm how the interventions recommended by the pathways are accessed within each borough. Though it appears to us that the therapeutic modalities recommended by NICE are available at least to some extent in all boroughs, referral pathways are complex (in effect, any referrer whether in primary or secondary care can refer to any service in the borough or to any cost per case service) and we cannot be sure at present that people actually receive the services recommended by the pathways. Considerable local knowledge is required to refer people to the most appropriate service and this is not always present even at CMHT level, requiring the panel to redirect referrals between services (particularly between the TSS, CADAT and MPS, where accurate referral requires clinical knowledge; referrals to other services e.g. between MPS and SPS are divided by the GP practice of origin though the panel may redirect occasional referrals between them for specific reasons). The PCT has data to suggest that referral patterns from primary care are highly variable between practices. Development of the integrated services in this proposal will support delivery of the pathways.

The CAG commitment to clarity of pathway and outcomes is shared by commissioners who require clarity as to:

- which clients are served by each pathway
- what is provided
- what outcomes can be expected
- how it is accessed

At present, there is the potential for duplication of services, whether by condition (for example services for trauma being provided by CADAT and TSS (and also by MPS and CMHTs where the trauma involves early abuse) or by modality (for example CBT for various conditions being provided by CMHT psychologists, and also at SPS and at MPS). As a result, the pathways whereby people assessed as requiring particular treatments access those treatments are not transparent, to referrers or commissioners.

CADAT

There are large cost pressures across Lambeth and Southwark IAPT services, which fund a significant element of CADAT. Also, Lambeth IAPT have been given notice on their contract and are now planning to bid competitively for the re-tender. Southwark psychological therapies services are also under review and a review is anticipated in Lewisham which will affect CADATs income. National funding is becoming increasingly difficult to secure, partly due to the success of the national IAPT initiative but also due to the economic downturn, and research and development money is not predicted to increase. As a result, it has been necessary to review the CADAT service. While that review does not form part of this proposal, it was agreed that the two reviews should be carried out concurrently; firstly to ensure that any CADAT staff affected by the review should have the opportunity to apply for a post in the new psychological therapies service, and secondly because although CADAT is

located within primary care, some of its current activities overlap with secondary care.
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The proposed model

Development Process

The CAG executive agreed at a planning meeting 21st July 2011 to develop plans to establish integrated psychological therapy provision within each local borough (excluding Croydon who already have an integrated service). Integrated, in this context, means that all treatments for psychological therapies are provided by a single multi-modality team with a single point of access.

This proposal drew upon previous discussions within the CAG Executive, and a document describing a vision for psychological treatment within the CAG prepared by the Professional Heads of Psychology in discussion with colleagues.

Following the meeting of 21st July, terms of reference were drawn up and agreed by the CAG Executive for a series of four meetings (later extended to five) of a group of representatives of the Executive and professional heads, chaired by the Clinical Director, to discuss and develop the proposal. The group acted in an advisory capacity, and this proposal is made by members of the CAG Executive with managerial responsibility for the affected services, for ratification by the CAG Executive.

The proposal was presented to all staff of the affected services at a workshop on 14th November 2011, was agreed by the Trust Board on 21st November, and formed the basis of a staff consultation document which was consulted on between 9th December and 16th January. Many responses were received and have been analysed, and the CAG Executive has agreed a number of changes which form the basis of a formal response, which remains in draft pending further discussions with stakeholders.

Service Model

An integrated psychological therapies team (IPTT) will be developed in each Borough. (The use of the term team rather than service will minimise confusion with the existing Intensive Psychological Therapy Service (IPTS) at Guy's Hospital). As above, integrated in this context, means that all treatments for psychological therapies are provided by a single multi-modality team with a single point of access.

The borough IPTT will provide all specialist psychotherapies required by NICE guidelines for people with anxiety, depression, personality disorder, and post-traumatic stress disorder (PTSD), as represented in the CAG condition specific pathways. These are listed in table 1. In addition, other modalities of therapy may be provided as part of clinical studies, on the basis of evidence other than that already included in NICE guidelines, or for other specific purposes, where agreed by the managers of the service and by commissioners. For example we note the development of Young's Schema Therapy at MPS but have not included it in our list of required pathways. We also note that some staff have skills in Dialectical Behaviour Therapy (DBT) but we are currently developing this as part of the stabilisation phase of the

Engagement, Assessment and Stabilisation (EAS) pathway for borderline personality in the CMHTs.

Table 1: Modalities of psychological therapy required by CAG pathways

Individual Treatments

Cognitive Analytic Therapy (CAT)
Psychodynamic therapy
Cognitive Behavioural Therapy (CBT)
Trauma specific CBT
Eye movement desensitisation and reprocessing (EMDR)

Group Treatments

Group psychodynamic therapy
Family and couple therapy

Referral routes and criteria

Referrals to the IPTT may come from GPs, IAPT, and MAP Assessment and Treatment (A&T) Teams, and will go through a single point of access in each borough. The point of access will allow for allocation to an appropriate therapy where indicated, or (if referred by a source external to SLAM and not already assessed by A&T) will allow for diversion to the Engagement, Assessment and Stabilisation (EAS) pathway within A&T or to IAPT. The principles of stepped care, as set out in NICE Guidance for depression (and the principle extended to other conditions where feasible) will be followed, with patients allocated to short term primary care psychological treatment or other alternatives outside SLAM where possible, and to more intensive treatments as appropriate in a stepped fashion.

It is proposed that, as the model of service will be highly transparent to referrers and commissioners, and allocation to treatment will be by a clear process and on the basis of clear pathways linking need to interventions required. The current (interim) system of allocation to MPS via the Lambeth specialist outpatient panel will not be necessary.

The criteria for acceptance for psychological therapy will be that the person meets the diagnostic criteria set out in the MAP CAG condition specific pathways, and meets threshold criteria for severity which will be agreed by the allocation process, having regard to the need to manage demand for services within the borough.

The referral pathway will be actively managed, using metrics such as the number and sources of referrals, time to allocation, and pathways to which they are allocated. A referral management group will be needed. This group will maintain an overview of all referral activity. In particular the group will ensure that the referral allocation system is managed effectively and resolve quickly any pathway disputes that may arise.

The group will comprise the Clinical Service Lead, CMHT A&T managers, a representative consultant psychiatrist, the Lead Psychological Therapist from IPTT, and the IAPT Lead.

The group will monitor the process of allocation, and may also carry out allocations directly, by attending an allocation meeting. However, other methods of working can be considered including delegation of the responsibility for allocation to subgroups, or dividing allocation geographically as convenient.

Allocation to IPTT may be direct where sufficient evidence of the criteria for treatment is available. In other cases it may follow assessment by A&T or a joint assessment between A&T and IPTT. Wherever possible, patients should not receive multiple or duplicate assessments. MAP CMHT assessment services will work to a standardised assessment, and IPTT services will develop a generic assessment process which will support all staff within secondary care to assess sufficiently to allow accurate and efficient allocation to the correct pathway.

Relationship with MAP A&T teams and the system of care within the Borough

Consideration was given in the development process to the possibility that the provision of psychological therapies could be fully embedded within A&T teams. This was rejected on the grounds that this would provide insufficient critical mass for the necessary processes of leadership, supervision and support of honorary staff, and that it was not feasible given the current size and location of MAP A&T teams. The IPTT is therefore proposed as a separate team in each borough.

However, the new IPTTs will work more closely with the MAP A&T teams than in the current model. Closer working between A&T and the IPTT than is currently possible between A&T and existing psychotherapy services will be facilitated by the common allocation process, by the borough focus of the new IPTT, and by the smaller numbers of A&T teams than previously (in Lambeth and Southwark). Other methods of developing closer working will also be encouraged, such as the provision of case discussions, supervision and training to A&T staff by IPTT staff. Co-location would of course also facilitate communication and liaison but may not be feasible and will be the subject of a separate review of accommodation for the new IPTT services.

Communication with IAPT will also be facilitated by their participation in common allocation processes for secondary care psychological therapies, as well as the supervisory and training links and joint working developed by CADAT which will be continued within IPTTs.

The role of psychologists currently delivering psychological therapies within CMHTs has been discussed in detail during the development process for this proposal. It is proposed that they join the new IPTT, and may benefit from the support of colleagues and have greater opportunities to participate in supervision and training within a larger psychological treatment service. However, the value of their current close working relationship with the CMHTs (not only in Southwark and Lambeth where they are currently fully integrated into CMHTs, but in Lewisham where they work closely with CMHTs from the centralised LPTS) is recognised. It is suggested that

they should remain co-located with CMHTs for much of the working week and should have a clear role working across and linking the IPTT and A&T teams.

The appended diagram (figure 1) shows areas of overlap between the work of the IPTT and the MAP A&T teams.

Overlap 'A' Assessment and Primary care liaison;

A psychological therapist from IPT will work jointly with the CMHT Team Manager, Consultant and IAPT lead on reviewing referrals into the team.

Referrals may be passed directly to the IPT for treatment allocation or may require a psychological therapist to take part in a joint initial assessment in the CMHT.

Psychological Therapists from IPT will also take part in the consultancy / link work arrangements put in place with local primary care practices.

Overlap 'B' Work with complex / care co ordinated clients;

IPT therapists will deliver psychological treatment or assist with the clinical management of complex patients cared for within the MAP CMHT.

Much of the work will be directed towards patients under care co ordination. The input may be delivery of specific interventions, joint therapeutic work with care co coordinator or training and supervision of care co coordinator in delivering therapy.

Funding and activity

It is anticipated that the new service will replace both existing block funded borough psychological therapy provision and cost per case services delivering standard treatment to local LSL residents. The service specification and activity of the new services will be negotiated with the local Primary Care Business Units. This will be agreed within a negotiated financial envelope designed to deliver local PCT disinvestment targets, as well as internal Trust efficiency savings.

The funding mechanism will be determined in due course by the operation of PbR tariffs but it is assumed that in the financial year 2012/13 the funding envelope will be agreed with PCTs in the form of a block, though with shadow tariffs and provision of cluster data as required.

Activity will be agreed with the PCT, reduced to reflect the level of proposed disinvestment. Activity will be reported as numbers of assessments, numbers of individual treatments provided, and numbers of group treatments provided. Assessments and treatments carried out by psychologists currently located within the CMHTs will in future form part of the IPTT activity. It is not possible, based on existing data, to suggest what activity levels will be for specific modalities of therapy and it is proposed that the team leaders of the IPTTs, working with the CAG managers, should be able to adjust the delivery of levels of particular modalities in response to local need.

Cost per case services and the Traumatic Stress Service

A small specialist/tertiary outpatient service will continue to operate on a cost per case basis. Based on existing demand, the principal focus of this will be to deliver care options for trauma for patients from outside LSL. While it is proposed that the Traumatic Stress Service should no longer exist as a separate service, the trauma care pathway for local residents being delivered by borough IPTTs, the name Traumatic Stress Service will be transferred to an outpatient service hosted within a borough IPTT, most likely to be the Southwark IPTT. This and any other cost per case service will need to be based on a clear business case and will need to demonstrate sufficient income and indications of future demand to cover trading costs.

CADAT

CADAT will more clearly focus on those areas where it uniquely contributes to MAP CAG and KHP: research, and education and training. CADAT will maintain its existing specialist contracts (NSCT, National including named patient). It will continue to generate income through research and training / supervision. It will look to expand both these streams in the future if possible, including more training and supervision external to SLAM.

Management of demand

Demand for cost per case psychotherapy has risen in recent years, and although the block funded services have generally been effective in managing demand without excessive waiting lists, demand tends to exceed the availability of services. The reasons for rising demand are necessarily somewhat speculative, though seem to be based more on a broad cultural change in attitudes to psychological therapy generally than to measurable indicators of need, and we have no firm data to project future demand. We have speculated about the impact of the recession on demand for psychological therapies, but noted that rising trends in demand predate 2008, and may be driven by the great increase in supply of primary care psychological therapies, which unlocks pent up demand, as well as cultural factors. Given that most people referred to secondary psychological therapies have long standing issues often related to early trauma, it seems probable that the impact of more immediate stressors such as unemployment will be reflected in increased demand for IAPT services rather than in secondary care.

It is accepted that the PCT and GP commissioners share the responsibility for managing demand arising from primary care, and they will need to do so by ensuring alternatives to treatment are explored, stepped care is available and used effectively in primary care, and appropriate thresholds are applied to referrals into secondary care. However, we will support this process. An experienced psychological therapist from the IPTT will work with the MAP Community team on delivering clinical consultancy to primary care practices. The aim of such consultancy will be to support GPs to manage patients in the community as well as managing demand into secondary services. IPT therapists will provide a consultancy focus for ‘complex common patients’ (a term used in primary care which encompasses people with complex

presentations who may have mood or personality disorders underlying social problems and physical health presentations).

Within secondary care we will seek to manage demand effectively by maintaining appropriate, transparent thresholds for care using the multi-disciplinary allocation process. The involvement of senior, experienced staff in allocations and assessments is likely to improve consistency.

We will also maximise the efficiency of the service by ensuring that all staff are aware of reasonable expectations for the proportion of their time to be spent in face to face patient contacts, by using stepped care effectively to ensure that treatments are offered at the minimum length likely to be effective, and group treatments are offered wherever appropriate.

Waiting lists are not an effective form of demand management and will be avoided as far as possible by seeking to manage demand at the point of allocation. However, some fluctuation in waiting times is likely. Where this reflects failure to manage demand from primary care, this will be discussed with commissioners. If appropriate we could increase capacity of psychotherapy quickly by using a 'bank' of sessional therapists which will be developed with the support of the existing NHS Professionals staff bank. Psychotherapists working patterns at present (many working part time for our services and also working in private practice or for other providers) make it likely that sessional time can be purchased flexibly.

Staffing and Leadership

The current services are staffed by medical psychotherapists, adult psychotherapists, and clinical psychologists. All see patients for individual or group psychotherapy of one or more of the types described in table 1, and to that extent their roles may overlap. However, their training and skills differ in important ways which contribute to the overall effectiveness of the service, and the IPTTs will therefore include staff of each of these three types. The types of therapy to be delivered in the new service will not be defined by professional background, and it will be for the Lead Psychological Therapist to deploy resources within the IPTT according to the individual skills of the staff appointed.

A Lead Psychological Therapist will be appointed to each borough IPTT, and may come from any professional background. A skills hierarchy will be developed that allows for senior clinical input into complex assessments, clinical leadership, primary care consultation and for supervision of junior staff.

All staff will have capacity / activity based job plans that will identify numbers of assessment and treatments to be undertaken in each period in addition to non patient facing activity such as GP consultation, supervision and co-working with care co-coordinators.

Consideration has been given to the ratio of staffing at different grades. Efficiency in mental health services usually requires that a pyramidal structure is adopted in which larger numbers of staff at lower bands deliver treatments to less complex cases.

However, in the case of psychological therapy services it is noted that between 45 and 85% of treatments in current services are delivered by honorary staff who are unpaid and who carry out their work in exchange for high quality supervision and training carried out by experienced staff. The proposed services will continue to use this model of service delivery, and the staffing structure therefore reflects the need for sufficient senior staff to provide supervision and training.

Central Functions

The current structure of services has the advantage that certain activities can be delivered efficiently from centralised services in ways which will be complicated by the move to three borough based IPTTs.

Considering all activities of the current services, those which can straightforwardly be devolved to local IPTTs include individual and group therapy, mentalisation (if offered), and family and couple therapy. CAT, currently only offered at St.Thomas's and CPTS, should be delivered by each IPTT.

Other functions will not be offered in each borough IPTT but can be hosted by one IPTT and made available to patients of other boroughs. These include the Young people's service, the CSA group, and the Vauxhall City Farm project. As described above, cost per case outpatient clinics can also be hosted by a local IPTT.

However, other functions would benefit from a single co-ordinating structure across all IPTTs. These include:

- co-ordination and delivery of medical teaching, which is structured around a Wednesday programme delivered at the Maudsley Hospital.
- A centrally co-ordinated Maudsley brand psychological therapies training drawing in staff from boroughs as necessary
- Services delivered by small numbers of staff to small numbers of patients which will be unhelpfully fragmented or undeliverable in three separate services, including perinatal treatment, mindfulness based cognitive therapy (MBCT), CBT for complex cases (Young's Schema Therapy)

It is proposed that these will be co-ordinated by the Trust Head of Psychotherapy, supported by other staff, who will be located within an IPTT but will have designated sessions within their job plans to deliver pan-borough services.

Risks and mitigations

Clinical risks arising from transition

Transition to new services may give rise to clinical risks. These relate to the need to contain staff distress and anxiety at the change in order that safe and effective therapy

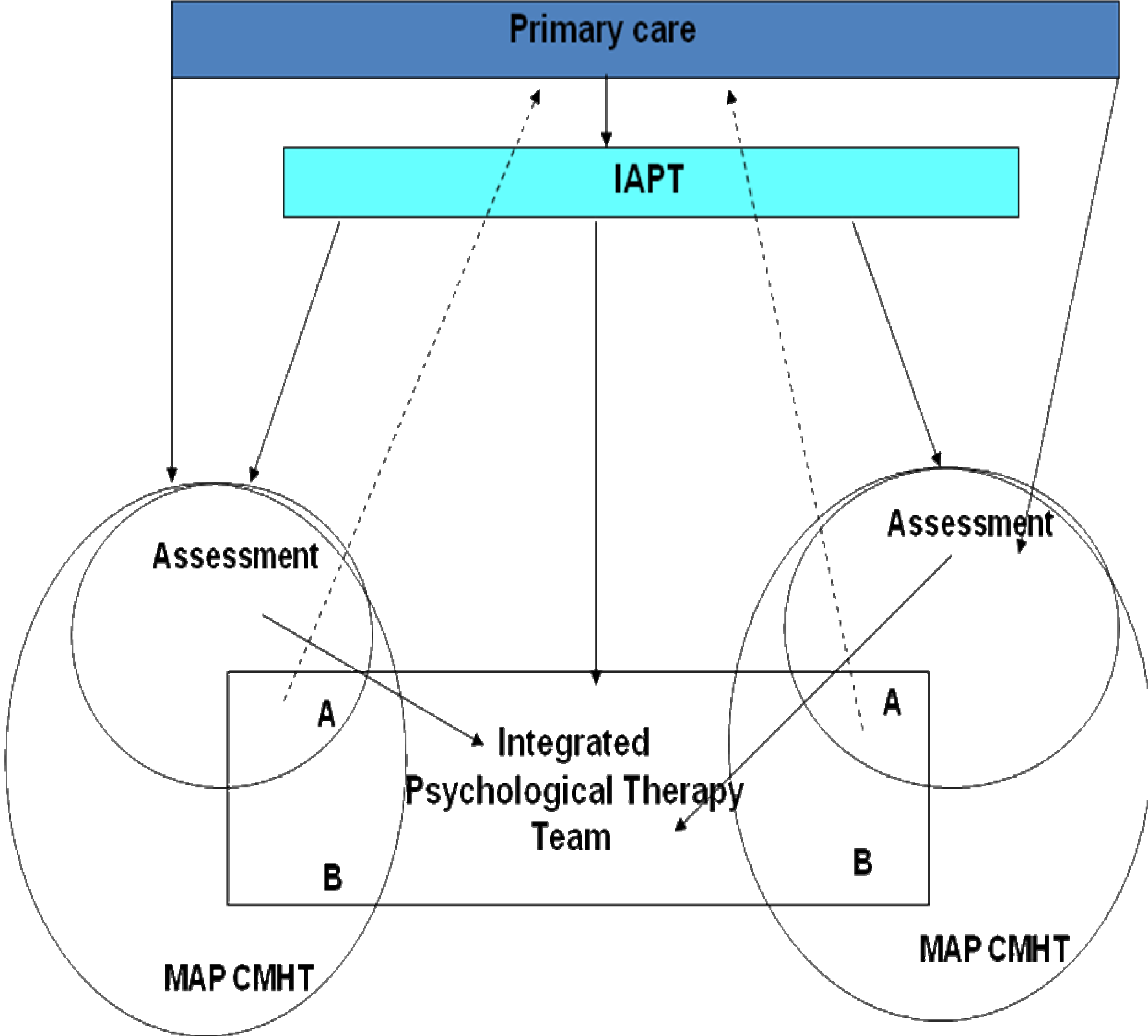
can be maintained, and also the risk of disruption to the therapeutic contract as a result of the change in staff roles.

Staff containment will be facilitated by clear communication about the changes, and support from the current leadership of services during the consultation period, followed by prompt appointment of clinical leaders within the new structures.

Patients of the current services have been offered periods of treatment which extend beyond the period of the restructure, raising the question of how therapy can be continued at a time when therapists may be at risk of displacement, redeployment or redundancy. Given that the new services will be delivering approximately 90% of the activity levels of the current services, it is unnecessary to suspend allocation for the period of transition, particularly as this would give rise to additional clinical and financial risks. Where staff are moved to new service structures or redeployed within the organisation, it should be possible to release individuals from their new roles over a transitional period to maintain the commitment to individuals in therapy that their therapy will be completed as planned. In the event that staff do not remain within the organisation, the impact will need to be considered on a case-by-case basis, with options including continuation of therapy by the staff member retaining an honorary contract, shortening the period of therapy by agreement, or the offer of an alternative therapy or therapist. Allocation of a care co-ordinator from a CMHT may maintain continuity and mitigate risk for some individuals.

Dr Jonathan Bindman
Consultant Psychiatrist Lambeth Assessment and Treatment Team (Brixton)
Clinical Director Mood Anxiety and Personality

Figure 1: Diagram of model showing overlaps



DOCUMENT C
Equality Impact Assessment

EQUALITY IMPACT ASSESSMENT
PART 1 – INITIAL SCREENING

1. Name of the policy / function / service development being assessed?

The re configuration of psychological therapies in Lambeth, Southwark and Lewisham.

2. Name of person responsible for carrying out the assessment?

Simon Rayner. Head of Pathway. Mood, Anxiety and Personality Clinical Academic Group.

3. Describe the main aim, objective and intended outcomes of the policy / function / service development?

[A detailed description of the proposed service model accompanies this EIA]

Aim:

- To create borough based psychological therapy services that are well integrated with other borough mental health services and pathways. In particular with the Improving Access to Psychological Therapies [IAPT] services.
- To improve the efficiency of the service by moving delivery of treatment from several teams to one key team and through the creation of a single point of referral and assessment.
- Provision of a comprehensive assessment addressing the full range of client needs resulting in provision of client centered, support and recovery care plan - that addresses all service user needs – psychological, social and medical.
- To enable delivery of Trust cost efficiencies and commissioner Quality Innovation Productivity and Prevention targets.

Objective:
The reconfiguration of psychological therapy provision across Lambeth, Lewisham and Southwark, developed in collaboration with our commissioners, will allow improvements to be made to psychological therapy provision in each borough.

Psychological therapy provision in Lambeth, Southwark and Lewisham is complex and fragmented and does not offer clear referral pathways to GPs or other referrers. A number of services operate from different locations, having developed independently over time, as a product of history, rather than clinical best practice. The current arrangements often result in services being offered to people on the basis of where

they live in the borough rather than for good clinical reasons. Patients in Lewisham and Lambeth are required to travel to the Maudsley for some treatments.

While the fragmentation of services may not be apparent to patients who are referred directly from primary care to psychotherapy, they often become aware of the difficulties when assessed by one service and not accepted but another service is suggested. They may feel ‘passed around’ the services rather than having their needs meet within a clear care pathway within an integrated service/team of professionals.

Service users who work closely with the management team have highlighted the importance of reducing multiple or duplicate assessments as well as inconsistency in access to services.

The reconfiguration, which we plan to implement in April 2012, will lead to the creation of a single psychological therapy team within Lambeth, Southwark and Lewisham. Each team will bring together therapy provision previously delivered in the separate services. They will work alongside our existing community mental health teams (CMHTs) and will provide patients and GP referrers with a single point of access to a range of psychological therapies, according to assessed clinical need.

Intended Outcomes:

We intend that people requiring psychological therapy will continue to receive high quality evidenced based services. Provision of a central point of access and assessment will reduce the need for additional or duplicate assessments. A single assessment will allow the patient to access the correctly rather than on occasions needing to be transferred between teams. The single assessment will provide the service user with a tailored care plan that will address all their needs; medical, psychological and social.

The outcomes of the reconfiguration will be closely monitored to ensure that these outcomes are met and that access to the service remains as intended. Service user experience will be closely monitored.

The service configuration and capacity will be regularly reviewed with commissioners and adjustments made as required.

4. Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups?

Which equality groups may be disadvantaged / experience negative impact?

Race	No - Access will improve.
Disability	No
Gender	No
Age	No
Sexual orientation	No
Religion / belief	No

5. What evidence do you have and how has this been collected?

5.1 Race:

5.1.1 Demographics of Lambeth, Southwark and Lewisham (2001 census)

Lambeth.
Population census at 2001 Census indicated that 62.5% of Lambeth residents were white, although there are significant populations of ethnicities other than white British in this group. The white Irish population was 3.3% of the Lambeth population, and 'other white' (including Portuguese and Latin American) made up 9.6% of the Lambeth Population. In 2000 the estimated size of the Portuguese speaking community in north Lambeth, where most of the community lives, was between 9,400 and 14,100 people.

The largest other ethnic groups in Lambeth are black Caribbean (12.1%), black African (11.6%) and 'other black' (2.1%). Black groups total 25.8% in Lambeth, compared with 16.5% in Inner London and 10.9% in Greater London. Lambeth has a much smaller Asian population than London in general (Lambeth 4.6%, Inner London 10.6%, Greater London 12.1%). Mixed ethnic groups total 4.8% in Lambeth, compared with 4.0% in Inner London, and 3.2% in Greater London.

Ethnic group	Percentage
White	62.5
Black Caribbean	12.1
Black African	11.6
Other Black	2.1
Asian	4.6
Mixed ethnic groups	4.8

BME population – 37.5%
Non BME population – 62.5%

Southwark.
The population of Southwark is ethnically diverse, with around a third (35.2%) of the total population coming from the Black and Minority Ethnic community. This is a higher proportion than for London (31%) and England (11.8%). The largest ethnic minority groups in Southwark are those people who identify themselves as Black or Black British, making up around a fifth (20%) of the population. More than half of this group are Black African, representing at least 12% of the total Southwark population. The age profile of the BME groups is younger than that of the White groups, and 69% of school pupils in Southwark are from BME groups.

Ethnicity	Percentage
White	64.8
Mixed	3.9
Black Caribbean	6.4
Black African	12.2

Black Other	1.6
Asian	6.6
Chinese	2.9
Other	1.7

BME population – 35.2%
Non BME population – 64.8%

Lewisham.
Lewisham is the 15th most ethnically diverse local authority in England, and two out of every five residents are from a black and minority ethnic background. The largest BME groups are Black African and Black Caribbean: Black ethnic groups are estimated to comprise 30% of the total population of Lewisham.

Broad Ethnic Group	2010	Percentage
White	160655	59
Black African	30760	11
Black Caribbean	36064	13
Black Other	15466	6
Indian	5747	2
Pakistani	1506	1
Bangladeshi	1371	1
Chinese	3555	1
Other Asian	6807	3
Other	8618	3

BME population – 38%
Non BME population – 59%
Others – 3%

5.1.2 Ethnic breakdown of staff working within community mental health and psychological therapy services in Lambeth, Southwark and Lewisham.

	CMHT	Psychological Therapies
BME	42.62%	10.88%
Non-BME	47.54%	76.08%
other/not stated	9.84%	13.04%

5.1.3 Ethic breakdown of people currently using our services in Lambeth, Southwark and Lewisham (January 2012)

The following data, although not directly comparable to the census data, indicates that people from BME groups are more likely to access community mental health teams than psychological therapy services.

	% in CMHT	% in Psychological therapies
White	37.9	39
White Irish	2.4	2.3
White Other	14.3	19.5
White & Black Caribbean	1.3	1.7
White & Black African	0.4	0.7
White & Asian	0.1	0.4
Mixed Other	0.6	0.6
Indian/British Indian	0.5	0.2
Pakistani/British Pakistani	0.4	0.3
Bangladeshi/British Bangladeshi	0.5	0.3
Asian Other	2.0	1.4
Black Caribbean	4.7	2.5
Black African	8.2	2.6
Black Other	6.9	6.2
Chinese	0.6	0.6
Other Ethnic Groups	15.7	21
Not Stated	3.4	0.9

5.1.4 Improving access to psychological therapy for people from BME groups.

The group of service users accessing community mental health teams is more representative of the local population than those accessing secondary psychological therapy.

Community mental health teams sit within community networks that support and target improved access to services for people from BME groups. All teams have developed excellent links with local organisations who support and advocate for people from BME communities.

We anticipate that the new model of care will enable our services to be more accessible and acceptable to people who have not traditionally been referred to psychological therapy. This is particularly relevant for people from BME groups.

In particular, the single point of access for psychological therapies being within the community mental health team setting will facilitate this improvement.

A peer support / group coordinator will be established in each team to develop a range of groups and peer support systems that may be accessed as an alternative to formal treatment or used whilst an individual is waiting to see a therapist. The peer support system will involve service users who have had experience of using psychological therapy services. Access to the new support services will be planned with our local commissioners, 3rd sector and services provided by the local authority/social services.

The service will have a particular focus on improving accessibility to underrepresented groups. We intend to develop groups and peer work within community settings – linking in with established community groups, faith groups and BME groups. Within Lambeth these links will be made within the Lambeth Living Well Collaborative.

5.2 Gender:

The gender of people accessing psychological therapy and community mental health teams in Lambeth, Southwark and Lewisham is as follows;

	Female	Male
Psychological Therapies	65.8%	34.2%
CMHTs	57.6%	42.4%

We do not believe that the proposed change will have any significant impact on the gender of people accessing psychological therapy. We will monitor service activity against this baseline.

5.3 Age;

The service provides for people between the age of 18 and 65. The current breakdown of people accessing psychological therapy and community mental health teams in Lambeth, Southwark and Lewisham is as follows;

	16-18	19-35	36-65	65+	not recorded
Psychological Therapies	0.2%	35.1%	63.5%	1.2%	0.1%
CMHTs	1.3%	37.3%	60.6%	0.8%	0%

We do not believe that the proposed change will have any significant impact on the age range of people accessing psychological therapy. We will monitor service activity against this baseline.

5.4 Sexual orientation

We do not currently collect data concerning the sexual orientation of people using our services, however the new model will enable us to more easily link psychological therapy to LGBT organisations. We will also seek to develop links between these services and our service user LGBT group ‘four in ten’.

5.5 Religion/Belief

We collect data on the religion/ beliefs of people using our services however in common with sexual orientation this is information that many service users are

reluctant to share with us. The supervision of all therapists provides a focus for the delivery of therapy that is sensitive to religious beliefs. Clients are able to access the Trust multi-faith chaplaincy service.

6. Have you explained your policy / function / service development to people who might be affected by it?

Service users and staff have been involved in the development of the plans and have received information about the proposed changes

6.1 Service Users

The Mood, Anxiety and Personality Clinical Academic Group (CAG) management team who have developed this proposal, work closely with service users who either have an experience of, or interest in the delivery of care to people with mood, anxiety or personality problems. The CAG have a service user advisory group who meet regularly with CAG management to advise and consult on the development of CAG services.

As preparation for these service changes, the CAG held several care pathway development events which were attended by service users. These workshops were held 28th February, 28th March and 23rd May 2011. Within these workshops service users fed back to staff about components of care that were important to them. Repeated assessments were identified as a concern;

'We do not like unnecessary assessments. If we need to be assessed more than once, it is important that the clinician acknowledges that we may have already had an assessment & explains why a further assessment is necessary. It is essential that this process is dealt with in a sensitive manner and if we are to be subjected to repeated assessments we have control of our assessment and take it to each assessment, so that we don't find ourselves having to repeat the same things. We give a lot of ourselves in assessments and can feel violated by the process. We need to change the way the sessions are ended so that the therapist takes into consideration that we may also feel worse after an assessment; and incorporate some form of closure at the end.

In April 2011 members of service user advisory group identified one of their key priorities as;

'The need to address inconsistency in terms of access to services, level of services and quality of services across the CAGS and individual services'

In preparation for the service re design, data was collated from PEDIC; the Trust patient experience collation system and from a service quality session run with service users in July 2011. Within this event service users were asked to identify priority areas of need to inform the psychological therapy review work. They requested that the focus of care be more holistic in approach and identified the need for support when not formally engaged in treatment.

The service user advisory group received updates on the development of reconfiguration plans on 30th September, 28th October and 25th November 2011. The

advisory group discussed the final proposal in detail at the November meeting which was also attended by the CAG Clinical Director, Deputy Service Director and Head of Pathway.

The draft proposal was presented to service users at an event entitled 'Service users and carers - Find out / talk about changes to community Psychological Therapy Services' 21st November 2011.

The following groups received information about the meeting or how to feedback:

- Vital Link
- Cooltan Arts
- Southwark Mind
- Four In Ten – LGBT service user group
- Lewisham Users Forum
- Black Users Forum (Lewisham)

All who booked a place, or who otherwise showed interest were sent a copy of the draft proposal prior to the meeting and the draft proposal was sent to the Trust Service user involvement blog. Those interested, but unable to attend the meeting were invited to give feedback via phone, email or post. The session was chaired by a member of the advisory group and attended by the CAG Patient Public Involvement lead, Clinical Director and CAG managers.

The aim of the session was for;

- Participants to be more informed about the proposed changes to community psychological therapies services across Lewisham, Lambeth & Southwark
- Participants to have an opportunity to ask questions and give their views about the proposed changes.

10 people who use services and/or family or carers had booked to attend the session and 9 attended on the day.

Additional feedback was received by 2 people who did not attend the meeting, one via email and one through face to face meeting. This has been incorporated into the following themes from discussion;

Comment or question from participant/s	**Comment or response from staff**
About the impact of less money	
Will services or activities be stopped as a result of the proposal?	Whilst the services will be working with a reduction in funding, the reconfiguration will mean that the money available will be used more effectively with increased training for CMHT staff, clear pathways and activity targets. ? There will be a psychological therapies service in each borough and so people will still have access to the full range of

	treatments. Most of the treatments will be provided in the borough, but there may be some more specialised treatments that are provided in a single location.
Will the threshold for eligibility change, will waiting lists be longer?	Overall, there will be less staff providing the psychological therapies however by increasing the effectiveness of the assessment we hope to make sure that our resources are targeted the people who are most likely to benefit from the services offered . For example some people would benefit from the psychological therapies provided in primary care. [*text in table slightly amended for purposes of clarity]*
Will SLaM be able to signpost to other available therapy? **Suggestion:** partnerships with voluntary or private sector organisations	It is important for local teams to be aware of other services that might benefit people. We have also built in an element of peer support into the proposal
About the referral process	
Currently, it can take a long time to get to see a psychological therapist, will this model help? Individual feedback: *it seems that funding is now to be channelled towards a better referral and assessment process and that the therapies on offer will be only those detailed in the NICE guidelines which are applied nationally. My concern is that psychological and emotional health depends upon a holistic approach to the individual and their problem. The complete picture is often the only way to find out, treat and aid full recovery for an individual with psychological problems*.	With increased clarity about services on offer, referral into the new local psychological therapies teams may come directly from GP's. It will also be appropriate for some people to be referred via a CMHT. The role of the CMHT will be to offer immediate support to people in crisis or 'stabilisation' prior to referral for psychological therapies. The local psychological therapies teams will work very closely with CMHTS around referral & assessment.
About the assessment process	
Some people may not feel comfortable with the person doing the assessment, or with the outcome of the assessment. There would need to be processes in place for this eventuality. Sometimes people do not feel empowered at the point of	The usual systems would be in place for people if they feel unhappy with the outcome of the assessment People may be assessed in the CMHT, with increased clarity about what the local psychological therapies teams have to offer, GP's may also be able to refer directly.

assessment	
The assessment report should be written in plain English and accessible to the service user.	
About treatments available	
Participants asked about the availability of the following types of therapy: Mindfulness Based Cognitive Therapy (MCBT), Dialectical Behaviour Therapy (DBT),Cognitive Analytic Therapy (CAT),Transpersonal / holistic/ eclectic *There should be "holding therapies" designed to keep people afloat until appropriate "professional services" become available. These could include befriending, peer support, mentoring and pastoral care & be provided volunteers and/or by voluntary organisations.*	Current treatments on offer will continue, with an emphasis on treatments recommended by the NICE (National Institute for Health & Clinical Excellence) Guidelines. The main reason for including particular forms of therapy is that they appear in NICE guidelines and have an evidence base. From that point of view we would not be including all the forms of therapy referred to in the meeting as having been useful for some people, and the range of therapies available in the private sector or via low cost schemes will be wider than we can offer. However, we do regard mindfulness based cognitive therapy as having been a successful introduction and want it to continue. It is currently provided in Improving Access to Psychological Therapies (IAPT) as well as in the Maudsley- we will certainly continue it either in IAPT or the new IPTTs. DBT requires a team approach rather than being just an individual therapy and we are introducing it via our community teams who are being trained at the moment; some individuals in the IPTTs will also be skilled in it.
What about introducing new techniques and treatments? ***Suggestions:*** *life coaching, group work such as anger management* Individual feedback :*Nurturing /rediscovering interests and talents and developing creative outlets for people who have things to express is highly beneficial to their psychological and long-term health. They would also be providing their own worthwhile support by engaging in these processes and types of activities they feel they would enjoy. The range of activities could be seen as very wide and extremely vibrant, considering the complex mix of*	The priorities will be to embed the new services and to provide treatments that are recommended through national guidance and 'commissioned' by the boroughs. However, it is important to remain open to new treatments and opportunities for support. The arrangement of 'block funding' whereby borough gives a set amount of money for a certain number of treatments rather than 'cost per case' where individuals are funded for specific treatments may allow for more flexibility in what is provided.

culture and ethnicity across these boroughs.	
About choice	
Will there be more group work and less one to one therapy?	There will be some increase in the provision of group therapy over one – to – one, but not a dramatic shift as it is understood that whilst group therapy is appropriate in some cases, it is not a natural substitute for one-to-one therapy.
Feedback via email: *Importance of keeping group therapy e.g.: women's group at St. Thomas's – important part of recovery*	There are no plans to stop group work such as this
Will there be a choice of therapists and will we be able to change therapists if appropriate?	As is currently the case, there is a degree of choice, although this is limited. There are no plans to change existing practice around choice and there will be mechanisms to change clinicians. There was some discussion about the advantages & disadvantages of changing therapists.
About staffing	
If there are redundancies, is the proposal an opportunity to make sure that those staff retained are of the highest quality? This would help towards consistency of quality in terms of staff.	There are clear human resources policies which will be followed in the re-design of services
If staff use services, will there continue to be provision for them to use services not connected with where they work?	Yes, the same protocols that are currently used will be available.
About getting feedback about the services/therapists	
Sometimes questionnaires are too long	
Sometimes it is difficult to identify what is effective and good quality in a therapist. Existing outcome measures do not measure easily how people might value the input of one therapist over another	**Suggested & agreed action:** to develop a small working group of people with experience of using services to support staff to develop consistent patient experience questionnaires and relevant & useful outcome measures.
About planning ahead and trying new treatments	
It is important to be able to plan ahead, to try new treatments and to respond to ideas/suggestions.	Staff recognised this as important but confirmed that the initial priority will be to embed the new way of delivering the service, providing treatments recommended through national guidance.

6 people filled out feedback forms about the meeting:

To what extent do you feel that we achieved what we set out to achieve?

fully ✔✔✔✔ **partly** ✔✔ **not at all**

Were you satisfied with the information that you received on and before the day?

fully ✔✔✔✔ **partly** ✔✔ **not at all**

To what extent did you feel that you could join in and give your views?

fully ✔✔✔✔✔ **partly** ✔ **not at all**

Final comments about the proposed changes:
Invest heavily in mentoring, peer support, life skills training, personalization, social inclusion & recover

Learning to take forward: Take steps to ensure that everyone feels heard during the session

A draft report with notes from the meeting was written & circulated to the participants for comment to ensure that they felt that their concerns/issues/comments had been accurately reflected. The final report was then circulated to staff and service users.

6.2 Staff:

As with the service users involvement, staff representatives from all services took part in the care pathway development workshops held February – May 2011. The outcome of this work was the development of detailed care pathways which have informed the psychological therapy reconfiguration proposal.

The proposed model was developed by a steering group chaired by the Clinical Director with a membership from key services and professions.

An involvement workshop was held 14th November 2011 attended by 70 staff. At this workshop staff were briefed on the proposal model of service and their views and observations sought. These informed the model finally proposed.

A staff consultation took place between 9th December 2011 and 16th January 2012. All staff had an opportunity to meet with a member of the management team and human resources.

7. If the policy / function / service development positively promotes equality please explain how?

The current fragmentation of services results in residents of different boroughs or areas with a borough receiving a different service with different waiting times (though it is not possible to say that one part has been consistently disadvantaged over time).

Within Lambeth residents in the South of the borough receive a psychotherapy service from the Maudsley whilst residents in the North receive a service from St Thomas's Hospital.

Residents in Lewisham can only receive psychotherapy treatment from the Maudsley in Southwark.

The proposed change will ensure that residents of each borough have clear access to the same therapy and assessment.

Developing a peer - support approach within psychological therapies teams will allow the involvement of service users in service provision and will enable promotion of their autonomy.

The network of peer led services, and related groups, will provide valuable support to people who require 'stabilisation' in mental health crises, or other short term interventions. These groups will help self management and enable service users to be less socially isolated. These groups can also be offered to service users waiting for other therapeutic treatments. This approach compliments existing partnership networks within boroughs; particularly the Lambeth Living Well Collaborative partnerships.

There will be no premature ending of any of the therapy that we currently offer. In addition we will have in place contingency plans to ensure that specialist supervision, group work and individual work will continue by having a group of staff who can continue this work.

We are aware of the potential impact on residents in each borough of the current economic down turn which may lead to a greater need for mental health support. We do not expect this to increase demand for the psychological therapies delivered by these teams to a significant degree as most people treated in these services have long standing difficulties with mood and relationships, commonly related to early traumatic experiences, rather than triggered by recent or short term social stressors. Demand for treatments related to short term anxiety and depression in response to stressors is provided largely by the Increased Access to Psychological Therapy teams (IAPT), which are well developed in Lambeth, Southwark and Lewisham.

The published Adult Psychiatric Morbidity Survey (APMS) 2009[i] makes the following comments about risk factors; 'Although poverty and unemployment tend to increase the duration of episodes of common mental disorders (CMD), it is not clear whether or not they cause the onset of an episode. Debt and financial strain are certainly associated with depression and anxiety, but the nature and direction of the association remains unclear. There are a wide range of other known associations, including: being female, work stress, social isolation, poor housing, negative life events, poor physical health, a family history of depression, poor interpersonal and family relationships, a partner in poor health, and problems with alcohol.'

The clear linkage between psychological therapy services and community mental health teams presents a framework where medical, psychological and social needs can

be addressed in an integrated approach. This will enable us to respond flexibly to a broader range of issues should they be presented.

8. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

The proposals will have a positive impact on access to psychological therapy services for people from black and minority ethnic groups. (5.13)

The proposal will have a positive impact on service user empowerment and involvement through the implementation of peer support models (7)

We assess that the proposal will have a neutral impact on other equality groups.

The impact of the change will be subject to regular review. Activity data for referrals and treatment against ethnic group, age and gender will be carefully monitored against current baseline. User experience data will be scrutinised to elicit further impact of change. The service user advisory group will remain central to the ongoing management and monitoring of the psychological therapy services.

Date completed: 2nd December 2011. Reviewed 24th January 2012

Signed Simon Rayner Print name: Simon Rayner

If the screening process has shown potential for a negative impact you will need to carry out a full equality impact assessment

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[i] Mc Manus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (Eds). ***Adult psychiatric morbidity in England, 2007 Results of a household survey***. A survey carried out for The NHS Information Centre for health and social care by the National Centre for Social Research and the Department of Health Sciences, University of Leicester. 2009, The Health & Social Care Information Centre, Social Care Statistics. www.ic.nhs.uk/pubs/

Psychoanalysts
Jungian Analysts
Psychoanalytic Psychotherapists
Child Psychotherapists

Devastating Cuts to Psychotherapy Services in South London

Joint Statement and Press/Media Release from United Kingdom Council for Psychotherapy and the British Psychoanalytic Council (1)

February 27th 2012

Up to 40% of psychodynamic psychotherapy services in South London will be cut if plans put forward by the South London and Maudsley Foundation Trust to reduce clinically trained staff posts are carried out. This will severely reduce the availability of 'talking therapies' across Lambeth, Lewisham, and Southwark. Hundreds of patients will lose the chance of obtaining such psychotherapy without a proper consultation taking place.

Originally, the plan was to cut 80% of these posts. However, after a campaign to fight against these drastic measures, the Trust has come forward with a new set of proposals which acknowledge the damage to patients and services if that level of staff cuts had been implemented.

However, the United Kingdom Council for Psychotherapy and the British Psychoanalytic Council believe that the new proposals will still have a major and damaging effect on the ability of services to provide psychodynamic (and other) psychotherapy. According to the plans we have seen, these cuts will continue to deprive many patients of treatment they both need and value.

Psychotherapy is a clinically proven and cost-effective form of treatment for people with complex emotional issues and mental illness. It is recommended by the National Institute for Health & Clinical Excellence. Cutting psychotherapy for these patient groups will put some of the most vulnerable lives at risk, and put further pressure on other services. Concessions made as a result of the earlier campaign do not alter this situation very much.

We are very concerned that the Trust has not adequately informed its patients about any of these plans. It has declined to hold meaningful public consultation, prohibited therapists from speaking about the plans with patients and even from discussing the proposals with those likely to be affected outside the Trust. 33 highly trained and fully qualified psychotherapists have been told their jobs are at risk. Even senior clinical staff describe being silenced by 'a climate of fear' in which they fear punishment for speaking out.

Despite agreeing to attend Lambeth and Southwark Oversight and Scrutiny Committee hearings in March, managers recently instructed staff to attend interviews for the reduced number of jobs they plan will remain in the service. These interviews are happening before the committees have even met. Although we wrote in January to the Chief Executive, Mr Stuart Bell, urging him to hold a public meeting, the Trust has declined to consult its patients and the public about these cuts. See Note (2) below, to read the text of this letter.

The services that would be cut have an international reputation. The loss would be irreplaceable. Other projects in the area in the mental health field are simply no substitute.

Professor Samuels (Chair of the United Kingdom Council for Psychotherapy) said: 'Everyone believes it's good to talk – except the South London and Maudsley Foundation Trust it seems. Psychotherapy is an economical treatment that really helps people with deep emotional issues and now we face the prospect of a huge area of London being deprived of it – at a stroke. God knows what the patients are supposed to do. Those losing out are ordinary people, not the rich. Psychotherapy helps them and their families with relationship problems, difficulties at work, and generally with living more productive and creative lives. And there is every chance that they will not need to come back for more.'

Dr Lousada (Chair of the British Psychoanalytic Council) said: 'The proposed plans pay scant attention to the range and complexity of the users treated, many of whom are severely distressed and disturbed. The economics of these decisions are at best highly suspect. Without the containing psychological treatments the users now receive many will undoubtedly inevitably present in more costly ways elsewhere in the system , quite apart from 'damage' to those who live or work with them. Far too frequently this will mean their children. The cavalier manner in which cuts to services such this are carried out draws attention to how mental health remains the Cinderella service in spite of all the rhetoric.'

Dr Kingsley Norton (Consultant Psychiatrist in Psychotherapy, Clinical Personality Lead, West London Mental Health Trust wrote: Many patients with severe and enduring mental illness complain about the lack of 'talking therapies' (various DH documents confirm). Patients with moderate to severe personality disorder diagnosis (whether with co-existing mental illness diagnoses) require psychological therapies, including psychodynamic approaches, as the mainstay of their treatment (see NICE guidance). Patients with medically unexplained conditions are often amenable to psychodynamic input, enabling them to enjoy a significantly improved quality of life (Sattel et al (2012) *British Journal of Psychiatry*).

All of these severely ill and/or disordered patient groups are high users of NHS services, partly on account of their various difficulties in contributing adequately to a treatment partnership with professionals. Their low compliance with treatment and impaired capacity to engage actively and fully in the process of their own recovery generates considerable inefficiency, which produces additional costs. Such inefficiency and to an extent un-necessary expense are reduced as a consequence of talking therapies, especially psychodynamic psychotherapy, for which there is

abundant evidence (Leichsenring & Rabung (2011). Long-term psychodynamic psychotherapy in complex mental disorders: Update of a meta-analysis. *British Journal of Psychiatry*; Shedler (2010) The efficacy of psychodynamic psychotherapy. *American Psychologist*).

For further comment and information, call Professor Samuels on 07768 662 813 and/or Dr Lousada on 0208 938 2268 and 07958 563 729.

Professor Andrew Samuels, Chair UKCP

Dr Julian Lousada, Chair BPC

NOTE 1: These organisations are the two leading national voluntary regulators in the field of psychotherapy and both organisations have members working in South London & Maudsley NHS Foundation Trust Psychotherapy Services.

NOTE 2: This is the text of our letter:

Mr Stuart Bell CBE
Chief Executive
South London & Maudsley NHS Foundation Trust
Maudsley Hospital
Denmark Hill
London
SE5 8AZ

January 16th 2012

Dear Mr Bell,

PSYCHOTHERAPY SERVICES AT SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST

This letter is sent jointly from the United Kingdom Council for Psychotherapy (UKCP) and the British Psychoanalytic Council (BPC). Please enter it into the consultation you are carrying out.

These organisations are the two leading national voluntary regulators in the field of psychotherapy and both organisations have members working in South London & Maudsley NHS Foundation Trust Psychotherapy Services. We are gravely concerned about the Trust's proposals to restructure its psychotherapy services, and associated staff redundancies, which will lead to the effective closure of both the Maudsley Psychotherapy Service and the St Thomas Psychotherapy Service. The proposed changes would an irreparable loss to local mental health services, and would have serious consequences for the welfare of patients, both present and future.

We have four major concerns:

Firstly, the proposed “re-provision” and restructure of psychological therapies is a complete misnomer. The Trust’s recent internal consultation proposes to cut 81% adult psychotherapy posts and 57% of medical psychotherapy posts in Lambeth alone, placing 36 psychotherapist posts formally at risk. In particular, we note St Thomas psychotherapy service provides treatment to 300 patients every week through a well-established and clinically effective model of service delivery that is highly rated by service users[1]. The service hosts over 70 honorary (i.e. unsalaried) psychotherapists, providing specialist psychotherapy training, clinical placements and professional development for experienced mental health professionals, up to and including consultant grade. Yet the proposed restructure will leave just 1.5 (whole time equivalent) posts in the service, undermining this well-established model of service provision which, it is suggested, will reduce psychotherapy treatment provision by around 80%.

Secondly, the Trust’s consultation process does not appear to have followed transparent and standard procedures of consultation and decision making. It is perplexing that the Trust’ consultation process has apparently been restricted to a small internal consultation carried out in an extraordinarily rushed period of just five weeks over the Christmas period - while many potential respondents were of course on leave. We are gravely concerned that service users whose present and future wellbeing this ‘restructure’ will mostly affect appear to have been excluded from the consultation process. (Indeed, we understand psychotherapists were explicitly asked not to inform their patients of the proposed restructure and this consultation). This lack of transparent consultation and decision-making falls significantly short of standards of public service.

Thirdly, such severe cuts to psychotherapy provision will have repercussions both to other clinical services within the Trust, and to the wider mental health field. As part of the unique Clinical Academic Group for mood, anxiety and personality, SLaM psychotherapy services has a wider involvement within King’s Health Partners Academic Health Science Centre, making a distinctive contribution to the AHSC’s purpose of delivering high quality health care, world-leading research, as well as teaching and education. The Trust’s psychotherapy services have a prestigious and international reputation for excellence in the field, and St Thomas’ is notably the international centre of Cognitive Analytic Therapy, an evidence-based therapy pioneered by Dr Anthony Ryle in the 1980s. Indeed, the psychotherapy services provide what we understand to be a highly-regarded contribution to the AHSC’s wider organisational purpose, especially in supporting therapeutic environments in challenging settings - through clinical supervision, reflective practice groups and team consultation. We are concerned that the proposed ‘restructure’ takes no account of such present and future contributions.

Fourthly, while the consultation proposes reductions across the whole Clinical Academic Group, we have serious concerns that the burden of cuts is intended to be borne by psychotherapy services. We note that just 6 clinical psychology posts have been placed at risk, yet cognitive-behavioural therapy (CBT) provision is dominant mode of psychological therapy (indeed, there appears to be a 6:1 ratio of clinical psychologists to psychotherapists across the Trust). Whilst CBT is clearly an important mode of therapy, we seriously question whether tipping the balance even further in this direction is actually based on patient choice and clinical need. The plans we have studied will undoubtedly lead to a lack of choice for patients, the maintenance of which is a key feature of one of Andrew Lansley's 'four steps' consultation guidance. The provision of a choice of a range of psychological therapies is absolutely essential, and we can direct you to

[1] The recent PEDIC report on the St Thomas’ service shows a very high level of patient satisfaction. Outcomes Study funded by Guys & St Thomas’ Charity (summarised in the St Thomas Psychotherapy Service 2011 Annual Report and available on the SLAM Trust website) reports a high level of recovery over all treatment modes, with improvement continuing long after therapy has ended.

research demonstrating this to be the case.

To proceed with such ill-considered plans to effectively close these highly regarded psychotherapy services without proper and full consultation cannot conceivably be justified. We urge you to remedy this as a matter of urgency. NHS bodies have two separate legal duties to consult about the way that the NHS is operating and about proposed changes. The duties focus on consulting patients and the public, and consulting the local authority Overview and Scrutiny Committee.

Section 242(1B) of the National Health Service Act 2006 provides as follows:
“Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in:
(a) the planning of the provision of those services,
(b) the development and consideration of proposals for changes in the way those services are provided, and
(c) decisions to be made by that body affecting the operation of those services.
Subsections (b) and (c) need only be observed if the proposals would have an impact on:
(a) the manner in which the services are delivered to users of those services; or
(b) the range of health services available to those users.”

Regulation 4 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 provides that where a local NHS body has under consideration any proposal for a “substantial development of the health service” in the area of a local authority, or for a “substantial variation in the provision” of such service, it shall consult the overview and scrutiny committee of that authority.

These requirements apply before closing, or substantially restructuring or varying a service.

We therefore urge you to call a public meeting or series of meetings as soon as possible, to address both these serious failures of attention to patient welfare, and due process. In addition, we fully endorse the Rt Hon Tessa Jowell’s advice to you in her letter dated 10th January, asking you to carry out a full Equalities Impact Assessment and Health and Wellbeing Impact Assessment.

This letter will be widely circulated and we look forward to your early reply.

Yours sincerely,

Professor Andrew Samuels, Chair UKCP

Dr Julian Lousada, Chair BPC

Agenda Item 6

From **Jonathan Lillistone – Head of Commissioning Health and Community Services**	Title **Contingency Planning For Care Homes / Nursing Homes**
Date **5.03.2012**	To **Health and Adult Social Care scrutiny meeting**

1. Summary

In response to the Scrutiny Committees themed review of events surrounding the collapse of Southern Cross and the transfer of the Care and Nursing Homes it operated to other providers this report provides further information in response to the following questions raised by the committee.

1. What procedures are in place to measure the financial health and risk of care home providers?
2. Does the council regularly check the financial viability of parent companies?
3. How are these procedures applied to care home places purchased under block contract and spot purchase.
4. What, if any, contingency plans does the council have in place to manage the risk of future financial collapse of care homes.

2. Background

As reported to previous scrutiny meetings, at the time the transfer of Southern Cross Homes to other providers and winding up of Southern Cross as a company was taking place; it was responsible for the management and delivery of services in 3 homes within Southwark as follows:

- Tower Bridge – 66 nursing beds and 28 residential bed spaces
- Camberwell Green – 55 nursing beds
- Burgess Park – 60 beds

In addition, the Council had 4 placements in other Southern Cross homes outside of the borough.

Southern Cross was therefore the major supplier of nursing provision within Southwark. Working closely with the national process and following the principals of engagement issued to Local Authorities by ADASS in May 2011 council officers worked actively to manage potential risks and put in place contingency plans to ensure service continuity for residents of these homes in the event that national processes failed to secure the transfer of homes to other providers.

3. Current position – provider profile

The transfer of Southern Cross homes took place as follows; Tower Bridge and Camberwell Green transferred to Health Care One on 31st October 2012 and Burgess Park transferred to Four Seasons on 30th September 2011.

The effect of these transfers has been that provision within the borough is now spread across more providers and the following is a summary of the current supplier profile within the borough.

- **Health Care One** – two homes providing 111 nursing beds and 28 residential bed spaces
- **Four Seasons** – one home providing 60 bed spaces
- **Anchor Trust** – providing 242 residential care bed spaces
- **Abbey Health Care** – providing 52

4. Response to questions raised.

1. What procedures are in place to measure the financial health and risk of care home providers?

The Council undertakes regular financial checks of key providers. This is typically an Experian financial health check assessment that considers a range of assessments to provide a risk profile. Further director's searches are done where necessary, in particular to understand changes in company directors or ownership that may have occurred and any issues this may give rise to. Also this allows the Council to gain some understanding of links to other companies that may assist with anticipating potential issues.

Regular and ongoing supplier management is carried out in the form of contract performance and quality monitoring. There is also regular information exchange with other boroughs through the work of the Brokerage Team who are responsible for sourcing and negotiating placements. In addition there is regular strategic dialogue with directors to ensure that the Council remains aware of any key organisational changes and pressures that may impact on service quality, delivery and continuity of care. These discussion also serve to ensure that suppliers are kept fully informed of the Councils strategic direction of travel around reducing its reliance on residential care so that providers and plan for and respond to this and ensure that their business and operating models remain sustainable into the future.

2. Does the council regularly check the financial viability of parent companies?

As indicated above, a range of financial checks are undertaken including director checks to establish links to other companies and is so far as is possible, to establish company structures that may inform the type and level of risk that exists.

3. How are these procedures applied to care home places purchased under block contract and spot purchase?

As described in response to question 1. a range of financial checks are undertaken.

Spot Contract - Given the number of placements the council has – across all client groups this totals some 1100, and that these placements are made with

just over 450 different providers, the councils approach is to prioritise regular checks on providers who are our majority suppliers. Consistent with reporting to corporate contract review boards on care placement activity and spot contracting, the focus is generally on providers with 5 or more placements. As at February 2012 there were 11 providers where the Council had more than five placements with a given organisation. It is important to note that the Councils placements are with a range of different types of organisation and of these 11 providers 4 are private businesses, Health Care One, Bupa, Four Seasons and Abbey Health Care, with the remainder of the 11 being charitable or voluntary sector organisations.

Block Contracts - The Council holds one block contract for residential care with Anchor Trust. This contract is subject to regular financial scrutiny including a requirement that Anchor Trust provide the Council with annual trading accounts for the four home under this contract. In addition a detail Best Value review was undertaken on this contract in 2010/11 which has been refreshed in February of 2012 as part of the Councils wider work on setting its approach to fees for 2012/13.

4. ***What, if any, contingency plans does the council have in place to manage the risk of future financial collapse of care homes.***

As noted above a range of checks are undertaken to assess and anticipate financial risks and the likelihood of provider failure as well as an approach to supplier engagement and management that ensure there is a constant dialogue that allows early identification of potential issues.

Risk of provider failure is a key risk identified in the departmental risk register and corporately and in event of major failure as in the case of Southern Cross it is anticipated that there would be national co-ordination from ADASS, NHS and central government departments to work collectively to ensure continuity of care.

Building on the Councils experience of the events associated with the winding up of Southern Cross and experience of having to manage the potential insolvency of a provider of care homes for people with learning disabilities training sessions have been held with senior managers across the council on how to manage provider failure, the councils role in provider insolvency situations and technical and legal aspects of working with administrators where provider failure / insolvency occurs.

This training was provided by Nabarro, specialist insolvency lawyers who are on the Councils Framework. Nabarro supported the Council in dealing with and resolving the potential insolvency and eventual transfer of service delivery to another provider, that ensured continuity of care, of the services at the care homes referred to above. The training drew out learning points from their involvement in this work for the Council and expertise and experience in a range of other insolvency, service transfer and takeover scenarios in the public sector.

LAY INSPECTORS REPORT

DATE: 26TH JULY 2011. TIME: 11.45 AM.

NORMA LAWRENCE AND DAVE CLARK.

the above date Dave and I visited Camberwell Green Care Home.

were introduced to the new Activities Organizer who came from another Local Home.

our inspection, the was nothing to report but a situation was brought to our attention by the nager.

re was a 93 year old lady who had arrived at the Care Home, and they did not know how she got re. But they knew that her brother who is 89 years old was a resident.

problem was that none would take responsibility for her because she was a Lewisham resident.

Care Home Manager said she was told by a social Worker to put her in a Taxi and send her to visham.

the Manager, with good sense decided that she could not do that and as LAY INSPECTORS we eed.

e Clark and I decided that this was unusual circumstance and therefore consulted with Tom by ne.

ı told us he contacted Ray Boyse at Southwark Social Service who assured us the matter was under trol and they would take over the situation.

Age Concern Lewisham and Southwark

Lay Inspector's Report

Name of Home: Burgess Park, Picton Street, SE5 **Date of Visits:** 28/10/11 and 30/10/11

The home has recently been taken over by Four Seasons Care which has changed the Senior Management. This visit was undertaken to meet the new management and to compare standards with those found at the last visit.
In fact there were two visits by Les Alden and Tom White.
On Friday 28th we visited from 2.15pm to 4.30pm. We met the Manger Fred Okine.
On Sunday 30th we visited from 8pm to 9pm. We met the senior nurse on duty.

Although a 58 bed home there were only 34 residents. Fred said there was no embargo and this results from current LA policy to reduce admissions. Some placements are by LB Lambeth.

The Dining Room
On a previous visit the dining room was only laid for 11 places although only 3 actually dined. We observed that it is now laid for 24. There are still a lot of residents eating in their room, although one resident said he used the dining room and there was no pressure either way.

Pets
We were pleased to see a cage of lively finches and were told there is a house cat. Pets are important.

Catering
Unlike the previous visit the catering now seems to be well organised. There is a choice of two main dishes and other things are available on request.. There is a light supper at 5pm which includes a hot dish. In the evening visit we saw the trolley serving refreshments visiting all rooms.

Decoration
It was explained that a programme of redecoration was in progress. New paint could be smelt. Overall the decorative order is satisfactory.

The Incontinence Smell
We were very disappointed in the prevalence of the incontinence smell which most homes have now conquered with modern chemicals and a little effort. In particular:
Ground Floor: Reception OK but corridor with rooms 1-8 dreadful.
First Floor: Patchy
Second Floor: Terrible.
We feel this cannot be blamed on a small number of residents alone. Major attention is required, including staff training in managing continence.

Smoking
Residents are not allowed to smoke indoors and there is a covered area outside where we met one resident and her visitor. We feel this could be unfairly restrictive on residents particularly in cold weather.

Alcohol Policy
Residents may purchase their own alcohol and this is kept at the nursing station (soi-disant) and dispensed. We were told that beer is also provided by the home – an interesting innovation.

Digital TV Switchover April 2012
The Manager was not sure of the position with residents TV sets.
We suggest there is an audit of all sets and the communal aerial system is confirmed as working in all rooms. We saw good quality TV pictures in the lounges.

Laundry
The home still relies on individual labelling of clothes and mass washing. We informed the Manager that some homes avoid institutional labelling by using individual laundry baskets or else open weave sacks each containing a single resident's clothes. He was not prepared to accept these suggestions.

Visits to residents Rooms
We made unaccompanied visits to the floors and took the opportunity to speak to residents when they invited us into their room. In all 6 residents were spoken to. Also one set of relatives. Apart from the issue below no other issues arose.

Activities
There is an organiser who works five days a week and we saw the programme of activities. We saw the programmed activity taking place in the afternoon.
Brunswick Park primary school is opposite and relations with the school we were told are good and children visit.
Sacred Heart Church visit fortnightly but no other churches. Other churches need to be invited.

Bed Times and Respect
One resident we spoke to said there was no pressure to go to bed early. However another had been upset by being told to get into bed at 9.30pm. This resident also spoke of a lack of respect from the same care assistant and a serious incident. The resident was reluctant to be identified.
This issue seems to be related to one member of night staff and we referred this to Brenda Bond at ACLS to consider raising an alert.

End of Life Care
The home uses the Gold Standard in conjunction with St. Christopher's Hospice. The Manager confirmed that the home will undertake end of life palliative care so residents may die in the home.

Personal Relationships
The home and owners do not have any policy on intimate or personal relationships between residents.
We think this should be developed, coupled with staff training. On the one hand there is a right to these relationships without teasing or adverse comment. On the other hand there is the duty to protect residents from unwanted attention.

Conclusions
There are a number of issues mentioned above which we are not happy with. We hope they can be addressed. The home is certainly better than the previous visit. We would like to visit again shortly.

Signed:

Les Alden

Les Alden also pp Tom White

Age Concern Lewisham and Southwark

Lay Inspector's Report

Name of Home: Tower Bridge **Date of Visit:** 09/02/2012 1.35pm – 3.30pm

I visited this home with fellow Inspector Tom White. Over the previous couple of years we had expressed some dissatisfaction with this home due to standards and turnover of senior staff. The home has however been steadily improving.

The home is now run by HC One who are a large care home operator. We had previously met with the owner and area manager and were impressed with their plans for the homes they have taken over. The home is currently embargoed for new admissions and the owner said he does not want this removed until the home is up to his company standard.

We noticed a major improvement in the attitude of staff and residents who feel the new management is a good thing. We met the new manager Linda.
Due to a scheduled staff meeting we were not able to spend long with Linda at the end of the visit.

The home is on 4 floors but we were informed that the ground floor is now closed (except for the dedicated smoker's lounge).

Third Floor. This is generally for EMI residents. There were 6 staff present for 20 residents. We were impressed by the very clear notices (on all floors) about activities and events. We noted there is a Manger's Surgery for staff and relatives weekly. We have not seen this openness in any other home.
There is a new TV and stereo. The carpet is looking shabby but it is expected to be replaced soon.

Second Floor This Floor is registered for Nursing EMI residents. There were 18 residents with 6 staff.
We think this floor has a big problem with a persistent bad odour worse than urine – more like fermented urine. It cannot be explained by reference to a few residents who have hygiene problems. There have been attempts to clean the carpet but surely it needs a fresh start. The manager recognised this problem and hopes to deal with it soon. From our point of view it is **completely unacceptable** for residents, visitors and staff.

First Floor This floor is a general residential floor. There are 28 residents with 7 staff.
We had a long talk with a new resident (93yo) who was very pleased to move to the home and was amazed at the meals, laundry and other services provided.

The Ground Floor This floor is closed except for the Smoking Lounge and offices.

Due to the staff meeting we were able to explore only a limited number of other issues.

Activity Organisers We were told there are now 5 staff. They are part time but the number of staff should give a wide range of ideas. 5 residents had gone to the maritime museum at the time of our visit. The monthly budget for activity expenses is £341 which in our experience is low - £600 being typical.

Doctors Visits. The doctor comes every day and is available on call 24/7, SELDOC not being used, we were told. This seems very good. We suggested that residents consulting a doctor were positively offered the opportunity to not have a care assistant present so their consultation could be confidential. The manager accepted this idea and agreed to discuss in the staff meeting.

Personalisation The home does not use any commercial methodology but we were shown a 'Life Story' book which is being developed for each resident. There is also a pro forma to record preferences. This seems a good start and it would be interesting to see some anonymised results of this process. We think that Adult Services should lay down a minimum standard and timescale for the personalisation process in all homes it monitors.

Laundry The home labels all clothes and they are washed in large commercial machines. One senior carer said she would like to change to the individual net laundry bags which avoid labelling of clothes which is institutional. We strongly suggest that all homes with commercial size machines should change to this system.

The Embargo We understand that Southwark and Lambeth currently have an embargo on placing new residents. One staff member mentioned this as demotivating. There is clearly some improvement and the new Manager is motivated to increase standards. Physical improvements are required such as decoration and carpets.
Staffing generally is good and have high hopes for the new management.

Conclusions
The home is functioning well. However until physical improvements we do not think the embargo should be lifted.

Signed:

Les Alden
Tom White

Age Concern Lewisham and Southwark

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Signed:

Les Alden
Tom White

Agenda Item 7

Item No.	Classification: Open	Date: 14th March 2012	Meeting Name: Health and Social Care Scrutiny Committee
Report title:		Impact of welfare reform on ageing adults with complex needs	

1 Background

1.1 At the Health and Social Care Scrutiny meeting on 1st February a short report was requested on:

How ageing adults with complex needs, and the council, could be affected by:

- *rising rents*
- *cuts to housing benefits*
- *and how this could affect other London boroughs and any knock on affect to Southwark*

1.2 This is a complex question that is currently being covered by a corporate workstream looking at the totality of the impact of the Welfare Reform Bill. The detailed outcome of this work with respect to health and social care issues can be reported to Scrutiny when this work has been progressed further.

1.3 Assessing possible impacts of welfare reforms is challenging and complex as:

- a range of reforms will be introduced at different times; affecting households at different times.
- It is not possible to predict how individuals, both in and out of the borough, will respond to the welfare reforms
- Some may experience one change, others multiple changes.
- The implications of reforms are not always clear and some aspects are still to be finalised e.g. Council Tax Benefit localisation, Social Fund reform, impacts for temporary and supported accommodation, etc.

2 Impact of welfare reform

2.1 The Welfare Reform Bill is currently in the House of Lords at the third reading stage and is expected to receive Royal Assent by April 2012.

2.2 The bill will potentially have a high impact for many Southwark residents and will impact significantly on council services in a number of ways. A corporate workstream including Health & Community Services looking at the totality of the impact of welfare reform is in place and the impact on Adult Social Care clients and services will be explicitly covered in this.

2.3 Specific areas that could impact on adults with complex needs will be looked at with a view to understanding the likely impact, including:

2.4 **Introduction of Universal Credit:** this is a simplified benefit designed to replace most benefits for working age people, including housing benefits, to be introduced from October 2013. It is capped at £350 per week for single people and £500 per week for families. This is a national flat rate which does not reflect higher accommodation costs in London. This is expected to have the greatest impact on families with children for whom it has been estimated that up to 30% may not be able to afford their current home in London. Clearly rising rents will exacerbate the issue of affordable housing if not covered within the Universal Credit cap.

2.5 **Changes to Disability Living Allowance:** this will be replaced from April 2013 by a more stringently assessed Personal Independence Payment. This could impact on the estimated 13,290 Southwark residents in receipt of DLA, especially the estimated 5,000 on the lower level DLA care and Mobility allowances who it is expected may lose benefits. It is anticipated that this change should generally not have such an impact on those with higher levels of needs, but this requires further analysis to confirm the overall impact. The payments will be exempt from the Universal Credit cap.

2.6 **Local Housing Allowances (LHA):** these concern the maximum Housing Benefit payable for private rented properties and caps have already been introduced, although the majority of properties in Southwark are within the cap. However from April 2011 the maximum amount of LHA payable is being tightened, moving from the 50th to the 30th percentile of properties. 882 households have 9 month's transitional protection from losing benefit as a result of this change in Southwark, of whom a proportion will have social care needs. Officers are investigating how best to target Southwark's Discretionary Housing Payment allocation from DWP, to allow such households a period of grace in order to find cheaper accommodation on expiry of their transitional protection. Analysis will be undertaken on the proportion within this cohort who have social care needs.

2.7 **Changes to under occupancy rules for housing related benefits:** working age social housing tenants in properties deemed to be under occupied will receive reduced benefits, meaning they may need to move to a smaller residence. National analysis suggests this could impact upon disabled people disproportionately, with estimates that two thirds of under occupied dwellings are occupied by registered disabled, which would equate to 2,400 disabled residents in Southwark. This may result in people moving out of homes that have been adapted to their needs.

2.8 **Impact on carers:** reductions in Disability Living Allowance and other benefits may indirectly impact on the ability of carers to support people. Also, unlike some other benefits, the Carers Allowance is not exempted from the Universal Credit cap so may in effect be lost for some carers who are at the cap level. The position of households relying on young carers also needs to be understood.

2.9 **Social Fund changes:** this is to be reduced and devolved to local authorities to administer on a non-ringfenced basis. 2009/10 data suggests there were around 15,000 applications for crisis loans with a value of £1.8m. The extent to which current beneficiaries are adult social care clients who could lose out with the changes is to be assessed.

2.10 Council Tax Benefit changes: this will be devolved to local authorities with a reduced budget, and a requirement to ensure that over 65s are protected from reductions. How these reductions impact on working age people with social care needs is to be mapped out.

2.11 Potential impact on supported housing costs: there is longer term uncertainty on the housing benefit contribution to supported housing costs, which could impact on the economics of supported living schemes over residential care options.

2.12 Knock on impact on demand: This could take a number of forms:

a) **Population changes:** There is the potential for people whose current accommodation has become unaffordable to leave Southwark, and (probably to a lesser extent) to move to Southwark. The potential impact of this is to be explored.
b) **More people entering the health and social care system and those within the system having increased needs:** some people with reduced benefits and consequent problems such as homelessness, overcrowding, reduced independence, stress etc will be likely to develop more intensive needs for social care and health support.
c) **Pressure on adult social care budgets:** apart from the impact of increased demand, if the contribution service users can make to their total personal budget needs is reduced then potentially the Council contribution will increase. This is not currently expected to be a high risk as it is expected that most adult care service users are at the higher levels of disability and will receive Personal Independent Payments that are exempt from the Universal credit cap, however further analysis is needed.

3. Reporting back

A further report will be presented on the impact of welfare reform on adults complex needs as the analysis is progressed with an update in September.

Report Author	Adrian Ward, Head of Performance, Health and Social Care
Version	Final
Dated	8/3/2012
Background documents	Adrian Ward, Health and Social Care ext. 53345

Agenda Item 9

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

Interim Report into Southwark Clinical Commissioning Consortia

Part 1: Introduction

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

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

Importance

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

Scope of the Review

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

The review will focus on:

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

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

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

Part 2: Scrutiny of Establishment of Southwark Clinical Commissioning Consortia

Southwark Clinical Commissioning Consortia (SCCC)

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

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

Consortia Background

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

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

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

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

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

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

Conflict of Interest

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

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

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

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

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

King's Health Partners

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

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

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

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

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

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

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

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

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

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

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

Impact of Cost Savings on Patient Care

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

NHS Southwark Performance

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

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

Contract Management

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

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

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

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

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

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

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

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

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

Part 3: Conclusions and Recommendations

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

Recommendation 1

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

Recommendation 2

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

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

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

Recommendation 3

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

Recommendation 4

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

Recommendation 5

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

Recommendation 6

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

Recommendation 7

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

Recommendation 8

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

Recommendation 9

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

Recommendation 10

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

Recommendation 11

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

Recommendation 12

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

Recommendation 13

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

Recommendation 14

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

Recommendation 15

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

Recommendation 16

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

Recommendation 17

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

Recommendation 18

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

Recommendation 19

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

Recommendation 20

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

Recommendation 21

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

Recommendation 22

That the SCCC appoints external auditors *[SCCC]*

Appendix 1 - timetable for delegation to SCCC

2011/12 Budget Delegation

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

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

Notes:

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

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

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

Appendix 2 - SHC's current conflict of interest policy

SCCC approach to Conflicts of Interest

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

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

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

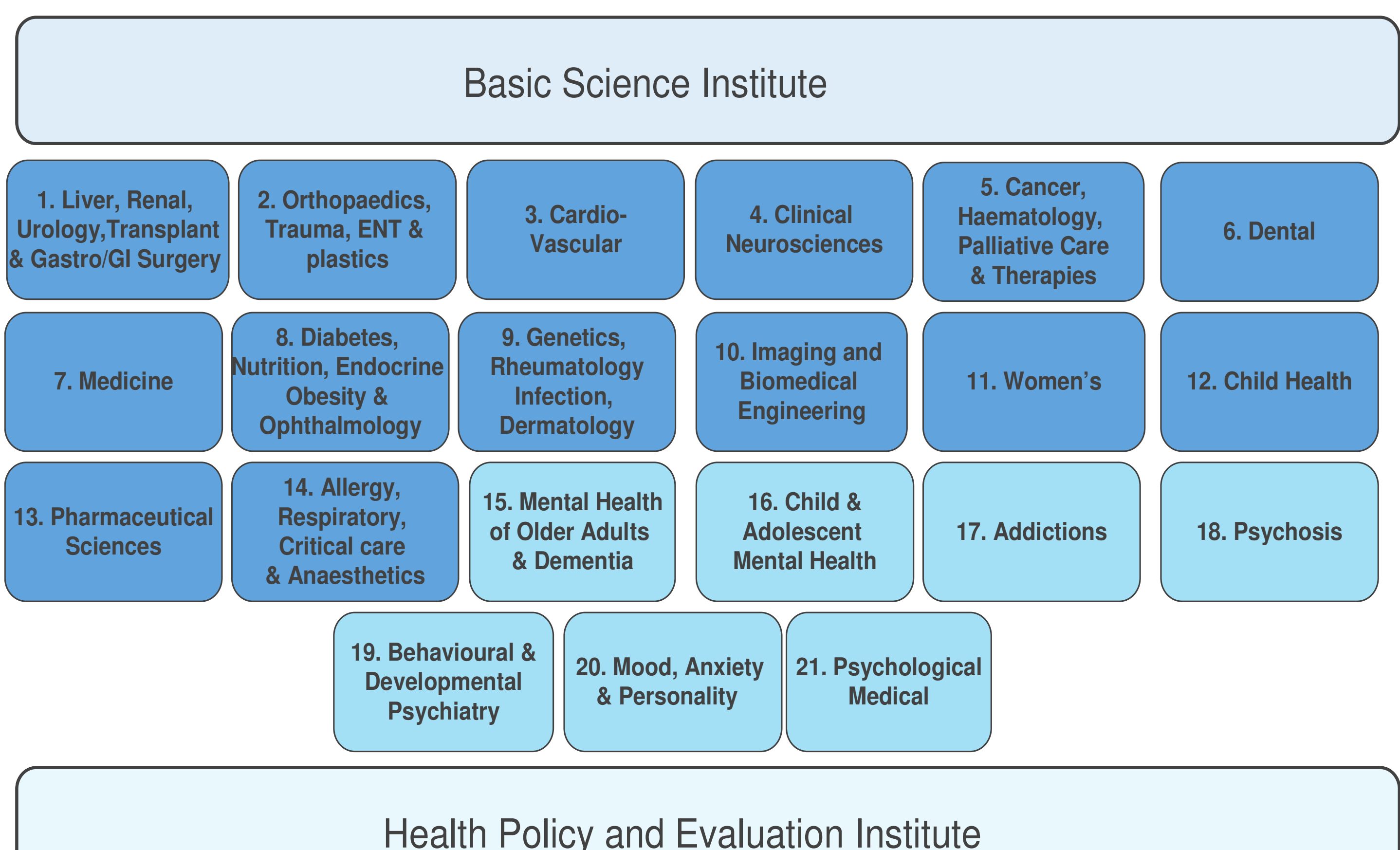
1.4. Where more than two GP leads holds a significant conflict of interest the committee will require consideration of the proposal / issue to be made by a separate evaluation panel. The evaluation panel would evaluate the proposal for quality and cost-effectiveness and if satisfied it would then make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

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

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

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

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



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

Performance data

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

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

Table Performance on Vital Signs National Priorities: 2010/11

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

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

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

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