Open Agenda

Health and Adult Social Care Scrutiny Sub-Committee

Tuesday 10 April 2012
7.00 pm
Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Date: 5 April 2012

Agenda Item 4 Open Agenda

HEALTH AND ADULT SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES of the Health and Adult Social Care Scrutiny Sub-Committee held on Wednesday 14 March 2012 at 6.30 pm at Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

PRESENT:

Councillor Mark Williams (Chair)
Councillor David Noakes
Councillor Denise Capstick
Councillor Patrick Diamond
Councillor Eliza Mann
Councillor the Right Revd Emmanuel Oyewole

PARTNERS:

Dr Jonathan Bindman, Mood Anxiety and Personality CAG
Zoë Reed Executive, Director of Strategy and Business Development SLaM
David Norman, Mental Health of Older Adults, SlaM
Tom White , Southwark Pensioners Action Group

OFFICER SUPPORT:

Jonathon Lillistone, Head of Commissioning Adult Social Care
Adrian Ward, Head of Performance
James Postgate, Principal Strategy Officer
Stephen Gaskell, Business and Partnership Manager
Julie Timbrell , Scrutiny project manager
Sarah Feasey, Principal Lawyer, Social Services
Shelley Burke , Head of scrutiny

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Norma Gibbes, and for lateness, due to work commitments, from Councillor Denise Capstick.

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

2.1 There were no urgent items.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the meeting held on 1 February 2012 were agreed as an accurate record.

5. SLAM CONSULTATION

5.1 The Chair explained that he would give senior SLaM managers, clinical staff and community representatives an opportunity to comment on the two consultations on service reorganisations under scrutiny tonight; Psychological Therapy Services and Mental Health for Older Adults and the possible impact on beds at Maudsely Hospital.

5.2 The chair invited senior mangers from SLaM to present on Psychological Therapy Services. Dr Jonathan Bindman from the Mood Anxiety and Personality CAG and Zoë Reed Executive; Director of Strategy and Business Development presented.

5.3 SLaM managers explained that they are proposing to develop a single integrated Psychological Therapy Service in Southwark to replace the existing three services; Maudsley Psychotherapy, Traumatic Stress Service and the Coordinated Psychological Therapy Service (CPTS). Officer said that this model creates confusion , but this is mainly with professionals rather than service users and SLaM wishes to develop a more cohesive service.

5.4 Managers reported that they did some early consultation with service users and took their advice in developing the model. Managers reported that they did not initially take the view that it was substantial variation; however they stated it is clear that the proposals have raised concerns. The Lambeth, Lewisham and Southwark Stakeholder Reference Group raised concerns and recommended greater consultation. Following this a meeting was held with Southwark LINks. As a result of this SLaM managers explained that rather than relying on the service user group they are creating a wider service user reference group. Managers stated that they are planning to have wider ongoing engagement on a three year cycle and have agreed quarterly meetings with LINks.

5.5 A staff proposal was issued recently and SLaM managers reported that they have started to interview staff. They went on to explain they that this regretful situation has caused destabilisation and resulted in the suspension of new treatments on a 9 month cycle , however they are hoping to restart these very soon.

5.6 The chair invited questions from members of the committee. A member commented that SLaM say that the service will be community based however it is not clear where it will be delivered from in trigger template, circulated with the papers. Managers responded that the service will be delivered form either Guys or Maudsley Hospital, however SLaM have not made a decision yet, but the location will need to accessible.

5.7 A member asked SLaM managers how confidant they are that the reorganisation would only result in a 10% cut to services. The managers responded that in their view it is not an efficient service and that currently people are referred many times or referred to the wrong service. Managers went on to explain that it will take time for the service to bed down and time to monitor the affects of the changes. The 10 % is more of an aspiration or target and if waiting lists do rise then SLaM will need to take mitigating action to remedy the situation. A member commented that the written evidence is more definitive. SLaM managers responded that specialist psychological therapies will take time to make efficiency changes.

5.8 A member noted that the clinical staff predict that the service changes will result in a reduction of between 40 to 45 per cent of service. SLaM managers responded that this is wrong and came from initial suggestions and discussions with Lambeth. Managers reported that this concern also came from band 8 cuts and they went on to explain that this has since been reviewed. Managers said that given the service reduction is going from 16 to 13 whole time staff they do not see how this could happen.

5.9 The chair raised the issue of the situation of honorariums .He said that his understanding was that full time staff need to manage honorariums so these cuts could have big impact. He also questioned the impact on the new generation of psychotherapists emerging through this process. SLaM managers acknowledged that the system is very dependant on the honorariums. Managers said that they have now modified the grade 8 cuts to take on board this risk. They went on to explain that they have chosen to select by grade rather than clinical specialism. A member commented that honorariums have raised concerns about continuity and managers said that while they can't guarantee clinical continuity for individual placements they are keeping the system so still providing continuity of the model.

5.10 A member asked what are the risks and managers explained that bedding down may take time so waiting lists may rise .Managers also explained that community mental health practitioners will need to provide support in the community, people often have to wait if not acute. However if they have to wait longer than a few months then this could be a worry.

5.11 A member asked if this is about cost reductions or improving efficiencies. Managers explained that there will be efficiencies savings, but we do have cost pressures in the current climate. Managers went on to explain that they are always looking to improve, for example by expanding peer support and seeking more equity from GP referrals. Managers explained that this proposal is our best prediction of an improved service, but they intend to closely monitor it to see if we need to adjust.

5.12 A member asked if the service was being cut to the bone and managers responded that no, this is a small cut in a range of services.

5.13 Attention was drawn to the letter circulated with the papers from UKIP. SLaM managers responded that UKIP are raising the concerns in the context of national fears about cuts to psychoanalytical in favour of cognitive therapy. They reported that SLaM have drafted a letter in response to the UKIP statement issued. The chair requested that this was circulated to the committee.

5.14 There was a question about the extent of consultation with service users using Psychological Therapy Services and managers responded that they thought it was an odd idea to consult with people in treatment because of psychological treatment boundaries and because this they did not contact them about future service delivery. However, SLaM managers went on to explain, that following feedback that people in treatment might be affected, and feedback from LINks SLaM have now widened consultation where psychologically appropriate.

5.15 A member noted that the reports states that the new team will be closely linked to the Community Mental Health Teams allowing people who may not require therapy to be diverted to a range of other community services, including primary care therapy (IAPT) . SLaM managers were asked if this means there will be increased access to IAPT. Managers responded that IAPT is increasing its range generally, however the IAPT and psychological overlap is small.

5.16 Members drew SLaM manager’s attention to the Equalities Impact Assessment and asked about the evidence base. SLaM managers said the Equalities Impact Assessment is a work in progress and said that different census information can be added once this is received. Managers went on to say there is an ongoing question if Psychological Therapy Services are accessible to BME and explained that BME clients are under represented in the service. Managers said that they hope these proposed changes and referral processes will make positive changes, however they said it is a complex situation.

5.17 A member noted that the papers say that you don’t monitor for sexual orientation and managers responded that Lambeth colleagues had fed back this was a sensitive question. The member pointed out that services are required by law to monitor for sexual orientation and transgender and went on to say that he hoped this situation with Lambeth was resolved very soon and that SLaM worked with the council to improve data collection around transgender.

5.18 It was noted by a member that Equalities law around disability means that services have to ensure that they do not discriminate against people with different types of impairment, for example, he asked if this service discriminate against people with particular conditions such as depression or schizophrenia. Managers responded that this service is geared towards people with enduring problems and in particular people with personality disorders. Reduction to services could lead to people not getting service with post traumatic stress disorder (PTSD) or personality disorder. The question is what is the right treatment given the evidence. Sometimes people with PTSD could be better treated by community services.

5.19 The member elaborated that this is a question about consultation and that the duty required that this is not just a passive consultation but about engaging services users in developing services and furthermore fulfilling the duty to meet the requirements of equalities law. Managers responded that we have consulted with service users and went on to say that while they did not initially think this was a substantial variation , now SlaM think it is and as such stakeholder involvement should have taken place from the outset .SLaM managers said that they accepted this point.

5.20 A member commented that managers from SLaM are obviously seeking to reassure us that the reduction in service will be nearer to 10% than 40% , however what about the quality of service? Managers responded that a shorter length of therapy will not make it more efficient so they do not intend to change this. Waiting times are 6 months to a year and if this not maintainable then we will need to adjust as clients tend to get worse .There is shift in service design to peer support.

5.21 The chair invited senior clinical staff from SlaM to present their evidence on the Psychological Therapy Service reorganisation. Senior clinical staff members began by stating that they are committed to the service. Clinical staff said that they support increasing referral efficiencies and accessibility. They stated that there principal concerns are that cuts are front loaded and that because of that service users will be seeing a bigger reduction in service and face cuts to a quarter of the service. Clinical staff explained that they are putting forward an alternative vision of 7 per cent as this would enable staff to make cuts in hours worked and take voluntary redundancies. Clinical staff complained that services users have not been asked if they would like slower cuts and they would like service users to have a say and be able to make choices. They also said that staff would like to be collaborated with.

5.22 A member asked clinical staff to clarify that this is not a problem with the model and staff responded that they like the model and that services are integrated. Staff went on to raise concerns about services being concentrated in the Maudsley. Clinical staff said that honorariums need to know rooms are available and they pointed out that this is a finely textured service and in danger of collapse.

5.23 Clinical staff were asked by a member if the frontloading is because of the way that government cuts are being made. Staff responded that some cuts may not be needed for two years. They also said that Lambeth residents are getting more of a service as Lambeth NHS are putting more in. Staff also pointed out that service users are not efficient as they often have chaotic lifestyles but clarified that the 9 month treatment cycles have not been postponed.

5.24 A member asked if there was any evidence that a particular group would be particularly disadvantaged and clinical staff responded that yes, there is a group of people who are very socially disadvantaged with complex needs and they may not fit easily into this new structure.

5.25 A member clarified that the clinical staff proposal was for slower change and for service users to be consulted and clinical staff agreed.

5.26 Clinical staff were asked for their thoughts on the impact on honorariums and staff were asked to clarify if the location is the main issue or the hours and posts. The response was that it is both; the clinical staff interviews are for generic interviews so there is concern that honorariums will be lost because of loss of specialism. Staff explained projections done twice by clinical staff both came up with a service loss of between 40 and 50 per cent. Clinicians explained that the projection would affect psychoanalytic and psychodynamic therapies in particular. An honorarium present said that he is very concerned about the impact and was not sure he will be able to continue.

5.27 The chair summed up the discussion by saying there are concerns over the equality impact assessment work done on sexual orientation and transgender, as well as the potential for this to adversely impact on people with different types of disability. The potential impact on honorariums and with the scale and speed of cuts is worrying. Concerns were also raised with the extent of engagement with service users.

5.28 The chair noted that the committee could escalate this to the secretary of state; however he cautioned this is a nuclear option and instead requested an immediate pause and recommended a longer time for consultation. The chair asked senior managers if they had done a twelve weeks consultation and senior managers said that they had done 5 weeks with staff and done cycles of consultation with service users earlier in the year with an iterative process to develop this model.

5.29 The chair said that the committee would like you to take 12 weeks so you can consider the honorariums issues and the other concerns raised. He advised staff that SLaM could find itself open to a legal challenge.

5.30 Senior manager said that one of the impacts of taking longer to consult would be that it would be hard to place people on the 9 month therapy cycles as SlaM will not know the future structure and who the permanent staff will be. Senior managers said there is an intention is to go forward with LINk do ongoing work on implementing this structure and monitoring impacts. The chair responded that while he realised SlaM have a duty of care to people it was important that the proposed new structure would work and protect services.

ACTION

Recommend an immediate pause for 12 weeks consultation with staff and users.

Request an Equality Impact Assessment.

A letter will be written to SlaM

SLaM UKIP response will be circulated to the committee.

5.31 The chair invited Tom White from Southwark Pensioners Action Group (SPAG) to speak about the Mental Health of Older Adults service reorganisation. Tom began by explaining that the major concern is loss of beds at Maudsley Hospital and SPAG held a demonstration about this recently. He went on to raise concerns about the consultation process and said that, in his view, SlaM do not do consultation. Tom said that this is a reoccurring problem, and mentioned Felix Post and Marina House as examples. Tom said that he had a letter from his MP which stated that SlaM position was that they were not going to make cuts to wards, however this is part of the proposal. Tom said that SlaM made a press statement saying there would be pause but his understanding is that the beds are going now.

5.32 The chair asked Tom to clarify his statement about consultation and asked if there

was a pattern of poor or no consultation. Tom said that was his view and the Trigger Template focused on staff rather than service user consultation.

5.33 The chair asked Tom what he saw as the risk and Tom responded that he saw this in the context of ongoing cuts to services to older adults with mental health needs. Tom mentioned that the former Felix Post unit was good at rehabilitation, but this was closed. Managers said that services users could go to Holmhust, however this was then closed. Tom went on to talk about Greenhithe Care Home Becket Unit and said this was recently closed and a service user made a choice to go on home leave, but sadly she lit some matches and died of smoke inhalation. Tom said he knows of someone else who went on home leave and also died. He ended by saying he is very concerned with the risks of community care.

5.34 The chair mentioned that the committee is due to visit SlaM and will visit the ward and indicated that the committee would want a public consultation before this ward is closed.

5.35 The chair invited SlaM senior managers to present and David Norman and Zoe Reed were invited to talk about the proposal and their consultation process. Managers explained that SlaM have been thinking for sometime about making better links between community and hospital acute care. Managers explained that feedback from users is that the service is not available over the weekend and there are more admissions at the end of the week.

5.36 Mangers referred to Tom's comments and said that SlaM believes if we can provide support over the weekend we can make reductions to beds and this can help with providing the funds to expand the community team. Managers explained that there are no cuts to the wards at the moment and that the occupancy rates varies. Managers went on to explain that they are planning to set up a new team which will take referrals from people experiencing crisis. The proposal is to take money from beds to pay staff so the service can offer support in homes. Mangers clarified that this new service will be 7 days a week not 24 hours a day.

5.37 Managers said that they have listened to the risks associated with people going home and acknowledge this , however managers said that in patient provision is often not the best and that the service would like to encourage support at home and independence .

5.38 The chair asked SlaM managers if they consider this a substantial variation of service. The managers responded that when we model it out we think a community model is better. The chair commented that SlaM seem to be less good at recognising what is a substantial variation than other Foundation Trusts.

5.39 The chair asked for clarity on the proposed bed reduction and managers explained that there is a total of 81 beds and the plan is to reduce this by 19; however managers said that this is what we are looking at but the service is not set on figures.

5.40 A member commented that the proposal dose not mention costs or the scale of the cuts and there is a need to understand this to carry out a meaningful consultation. .

Mangers said they appreciated the points and that SlaM need to get better at this.

5.41 A member said he had concerns about risks. He went on to comment that while he could see that community health care literature recommends community care, he had concerns about bed capacity if there are spikes in demand . He noted that the loss of the ward is a significant loss of capacity and admissions maybe hard to manage. Managers said that SlaM can see if the service as a whole can flex better to make use of our overall capacity.

5.42 Members asked what can the service do to monitor the risks and in particular the one Tom has raised about people at risk at harm at home. Managers explained that this is not about eradication of acute and impatient care but trying to find a better balance between hospital and home and community care.

ACTION

The committee recommended that SlaM:

- Come back to the committee with more developed and budgeted proposals on the scale of the changes and how the service will manage the risks associated with the potential loss of ward capacity.

- Undertake a full 12 week public consultation.

6. REVIEW OF SOUTHERN CROSS

6.1 Jonathon Lillistone, Head of Commissioning Adult Social Care, presented the report on managing financial risks to care homes and contingency planning. He began by setting out the background to the exposure to Southern Cross. Heath Care One and Four Seasons took over these homes and care is purchased by spot contract. Southwark Council also have Anchor Trust and Abbey Health Care providing care on block contracts.

6.2 The Head of Commissioning explained that financial checks on contracts managed by spot contracting are focused on those the council have greatest exposure to and this is 5 out of 400 spot contractors.

6.3 The Head of Commissioning explained that some of the financial information that comes back is very complex and I and other colleagues struggle to understand it. He explained there has been some organisational learning since the demise of Southern Cross and a learning disability provider that faced insolvency. The council worked with a special legal company and officers did some specialist training.

6.4 A member asked how regularly financial checks are done and the Head of Commissioning responded that these were done at least annually and also if there are alerts.

6.5 A member referred to the role of central government and national co-ordination from organisations such ADASS if a provider was to fail. The member asked about local providers such as Anchor Trust and asked if these would be large enough to warrant national intervention. The Head of Commissioning responded that and Four Seasons and Home Care One are big enough to trigger a national response. Abbey is probably at the scale that there might be a London wide regional intervention.

6.6 The Head of Commissioning said that Anchor are a housing association and as such are better regulated and are obliged to have greater financial liquidity. Organisations such as these do not have the financial liabilities of bigger commercial providers. The Head of Commissioning added that they also provide line by line financial transparency in their statements. The Chair reported that NHP are the legal owners of Home Care One homes and their loan to value ration is 165, therefore the council is going back to a high level of risk.

6.7 The Head of Commissioning was asked if there are contingency plans for alternative beds and he responded that the council does have these plans but the focus is on continuity as the consequence of moving is not good. He explained that there is a high mortality rate if older people have to move from their homes.

6.8 A member asked if we still have an embargo on Tower Bridge. The Head of Commissioning confirmed that they did and with Camberwell Green. He reported that there has been some positive progress on both these homes but the council wants to be cautious. The officer added that the council have visited Burgess Park since the transfer of ownership and there have been some positive improvements. He reported that the number of people who eat communally has increased to double figures.

6.9 The Head of Commissioning was asked about the Lay Inspector reports and if they went back to the home owners. The officer responded that they did not, however the council do find them useful. He added that some extra training is being delivered to Lay Inspectors on recognising the importance of dignity in care delivery.

7. REVIEW OF ADULTS WITH COMPLEX NEEDS

7.1 Adrian Ward, Head of Performance, introduced the paper on the 'Impact of welfare reform on ageing adults with complex needs'. He reported that this is a complex position as some disabled people could be impacted on in a number of ways. He explained this is an initial look at some of the issues.

7.2 The Head of Performance explained that the modelling suggested a major impact on workless families, but less so on single people. He reported that those on disability living allowance are exempt from many of the changes, but tests for this

benefit will become more stringent so those with a lower level of needs could drop out and then become more in need of other services.

7.3 The Head of Performance said that another issue is that many of the people under occupying are disabled. The Carers Allowance is not exempt from cap. Council tax benefits are being devolved and reduced. He reported that this could lead to an overall impact of raising demand for more health and social care as people in need lose benefits. It is likely that more people claiming benefit will leave Southwark than move in.

7.4 The chair remarked that the 2,400 predicted disabled residents who could be forced to move out of their homes because of under occupancy is horrifying. He added that the more stringent test on disability benefits and the risk that this could leave people in genuine need without sufficient funds is also concerning.

7.5 A member commented that the impact of these changes will probably mean an increase in the need for advice and guidance to mount appeals, however there are also changes to legal aid which will restrict people's access to legal advice and support.

7.6 The Head of Performance said that there is a corporate work stream reporting on this in September.

ACTION

It was recommended this comes back to the new Health and Adult Social Care scrutiny committee next municipal year given the scale and impact of the welfare changes on disabled people.

8. ESTABLISHMENT OF A SHADOW HEALTH AND WELL BEING BOARD

8.1 James Postgate, Principal Strategy Officer and Stephen Gaskell, Business and Partnership Manager went through a presentation on the establishment of a shadow Health and Wellbeing Board (appended to the minutes).

8.2 Officers explained that the move of public health to the council is partly because of the 2010 *Marmot Review which* set out the limitations in tackling health inequalities in the current system in which "the perception among agencies is that responsibility for the delivery of health improvement lies with the NHS". The *Marmot Review* highlighted that local government and other public sector partners hold many of the levers that shape and can have an impact on health inequalities.

8.3 Officers reported that health outcomes in Southwark are improving, however there are significant health inequalities. Officers reported that as you move around Southwark you lose a couple of years life expectancy for every two miles shift in location.

8.4 Officers drew members attention to the diagramme in the power point which outlines the board's role and its relationships to other bodies. The Health and Adult Social Care scrutiny committee has a role in holding the Health and Wellbeing Board to account.

8.5 In developing the board officers reported that they had been referring to the Health and Social Care Bill passage through parliament and the 'Operating principles for health and wellbeing board'. These sets out what a board and strategy must do. Officers reported that there are some 'musts' but quite a lot of local flexibility. They explained that the membership is set by cabinet. Officers reported that the Board is an odd mix of officers and members and this is a new governance arrangement for the council to manage.

8.6 Officers explained that there was a cabinet decision in November 2010 that the Cabinet Member for Health and Adult Care would oversee a programme of work. In order to start work to establish a new Health and Wellbeing Board in September 2011 the Cabinet Member formed a Planning Group.

8.7 The planning group has been looking at parameters, the focus of the board and what should be its priorities. The Planning Group set out a number of initial areas to explore to help to understand the health and wellbeing challenges in Southwark. Focus groups and workshops with key stakeholders, including with community groups, have taken place in order to listen to other people's views on these and other areas.

8.8 Officers reported that these are the areas identified so far :

- Older People
- Early Intervention and Families
- Physical Activity/Healthy Weight and Exercise
- Alcohol
- Smoking
- Coping skills, resilience and mental wellbeing
- Housing and home
- Economy and jobs

8.9 The chair invited questions from the committee and a member asked if a lay person could be appointed, for example, a patient representative or someone such as Tom White from SPAG who will have a community perspective. A member said a youth representative might be useful. Officers responded that Healthwatch will get a place and there is local choice on the membership. A member expressed the view that there should be more than one councillor on the board or indeed a majority of councillors reflecting the political balance in order to tackle the health democratic deficit. A member reflected that we need to think about the balance of power and how we put the communities' voice in place.

8.10 Members asked officers if it was possible to be on the health and wellbeing board and on Health scrutiny. Officers said they would take advice on this.

8.11 A member commented that the board would need to think about how do you mitigate the power of clinicians. She went on to comment that General Practitioners can be very medical model and the council need to think about the Social Model's place and emphasise prevention. Another member agreed and referenced the success of the veterans model of public health.

8.12 Officers asked members for suggestions on topic and alcohol was strongly recommended by a member because of its overall impact on health and social wellbeing. Another member recommended obesity and went on to highlight the need to tackle the environmental cues and causes, such as the proliferation of chicken shops, and the need to work on prevention so that we create an environment that promotes health. Members asked officers for more information on the topics identified so far.

ACTION

The chair will write to the Leader with the scrutiny committee's recommendations

Officers will provide more information on the topics.

Clarification will be obtained on if a member can sit on the Health and Wellbeing Board and the Health and Adult Social Care scrutiny committee

9. SCCC CONFLICTS OF INTEREST REVIEW

9.1 The chair reported that the interim review report was presented to the last Southwark Clinical Commissioning Committee (SCCC) and the recommendations debated. He reported that there was a discussion about providers commissioned by the GP's, and it was noted that GPs are also providers, but they are commissioned though different arrangements.

9.2 The chair passed over to Andrew Bland, Managing Director of the Business Support Unit that supports the SCCC. The Managing Director thanked the committee and said that all the recommendations are accepted. He went on to explain that the ones the SCCC have highlighted are about wording and not material differences. The Managing Director said that the SCCC have now received national advice on managing conflicts of interest, however the review report recommendations went further.

9.3 The Managing Director assured the committee that there was an intention to stick to the timetable given and he reported that planning was in place now on carrying out an election ballot. He reported that Recommendation 22 to appoint external auditors was being carried out by the PCT but once it becomes SCCC's duty then we will do this. A member asked about the status of the SCCC and the Managing

Director explained that they are now accountable but will become the responsible body in 2013.

ACTION

A final meeting will be held between the chair and the Managing Director about the wording of some of the recommendations and then the final review report will come back to the committee.

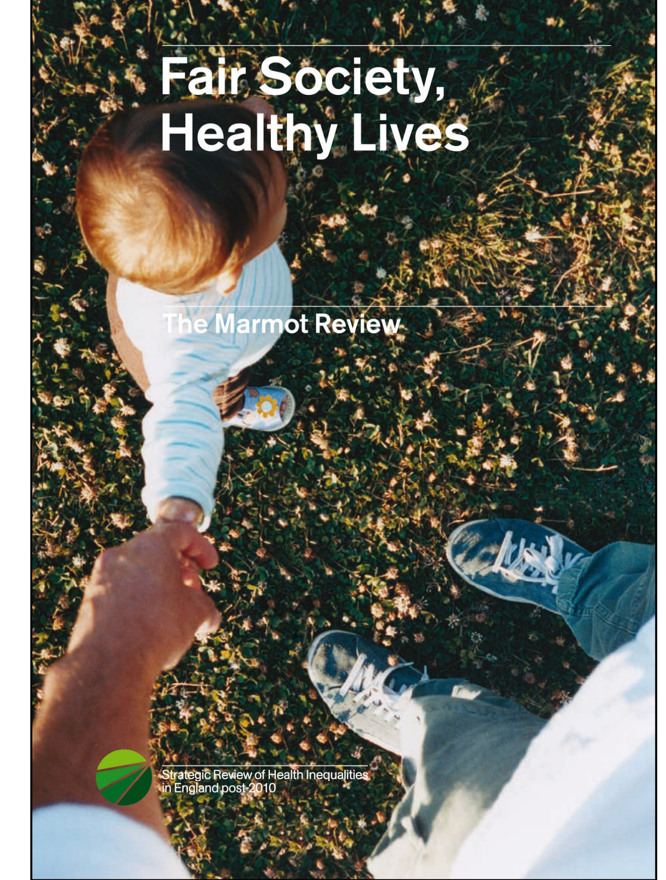
Health Overview and Scrutiny Committee

Establishment of a shadow Health and Wellbeing Board in Southwark

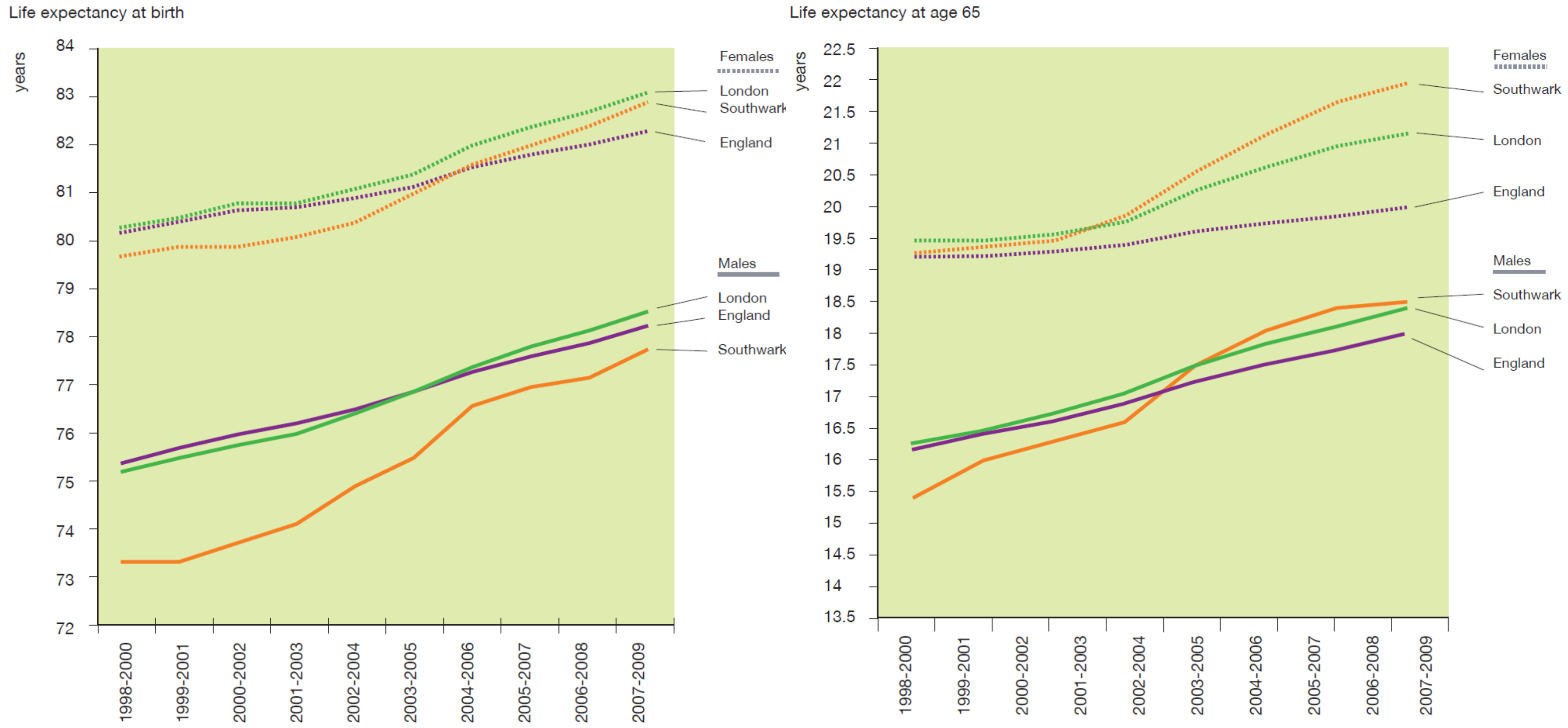
Stephen Gaskell and James Postgate
Corporate Strategy

Background – the Marmot Review

- The 2010 *Marmot Review* set out the limitations in tackling health inequalities in the current system in which "the perception among agencies is that responsibility for the delivery of health improvement lies with the NHS".
- The *Marmot Review* highlighted that local government and other public sector partners hold many of the levers that shape and can have an impact on health inequalities.
- The new role for local authorities, as encapsulated in the establishment of health and wellbeing boards, and the transition of public health accountabilities to councils, will be to lead work to tackle health inequalities across the system, and to champion improvements in terms of health and wellbeing outcomes for local populations.



Southwark – life expectancy



Slide three

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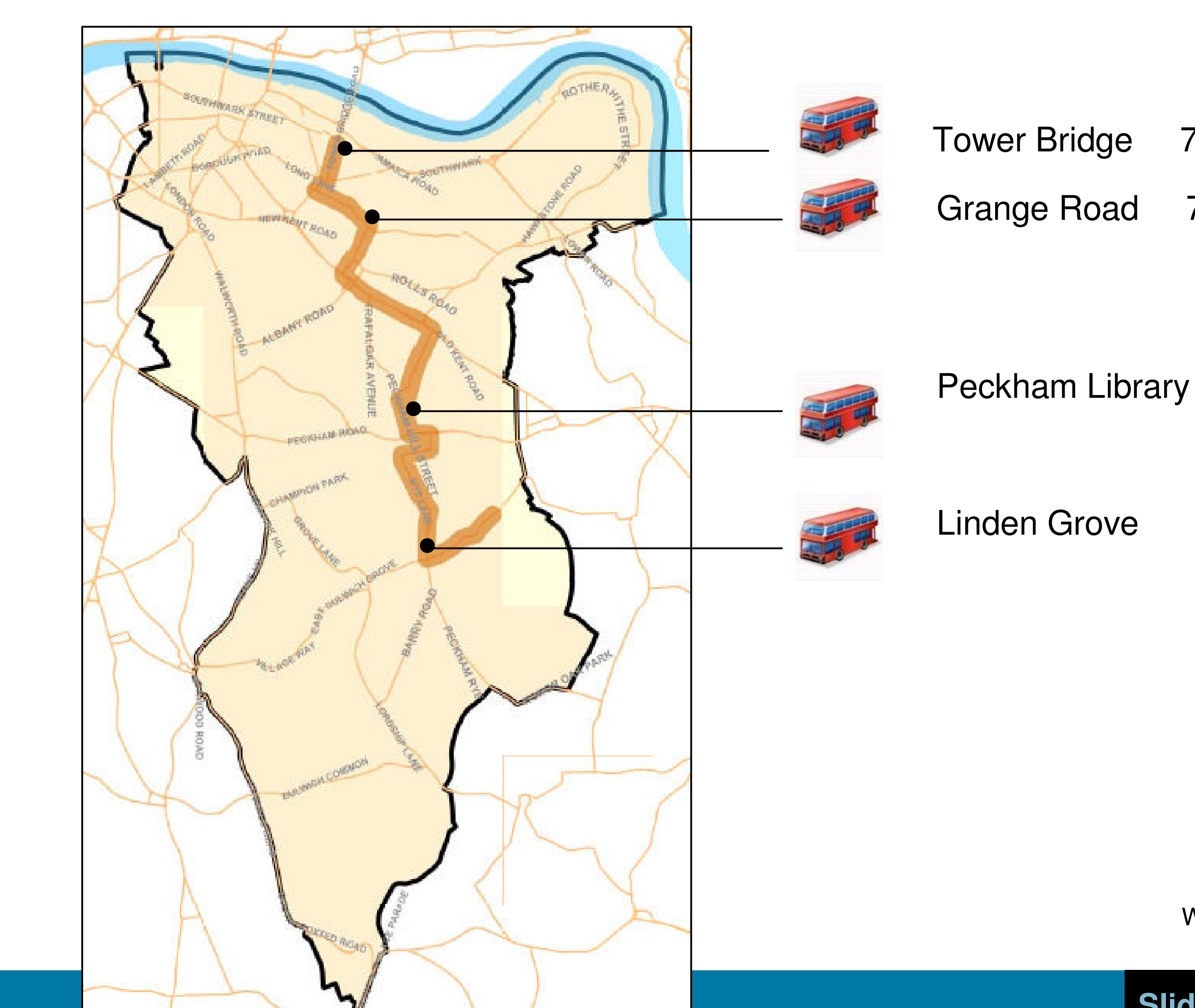
Southwark – health inequalities (Route 78)



Tower Bridge	79.5 years
Grange Road	77.8 years
Peckham Library	75.7 years
Linden Grove	71.2 years

Source: London Health Programme HNA:

Ward level male life expectancy 2005 - 2009

Health and Social Care Bill

- **Bill was launched in January, but was paused to undertake a "listening exercise" in July 2011 – now passed through Commons into Lords.**

- **Key changes**

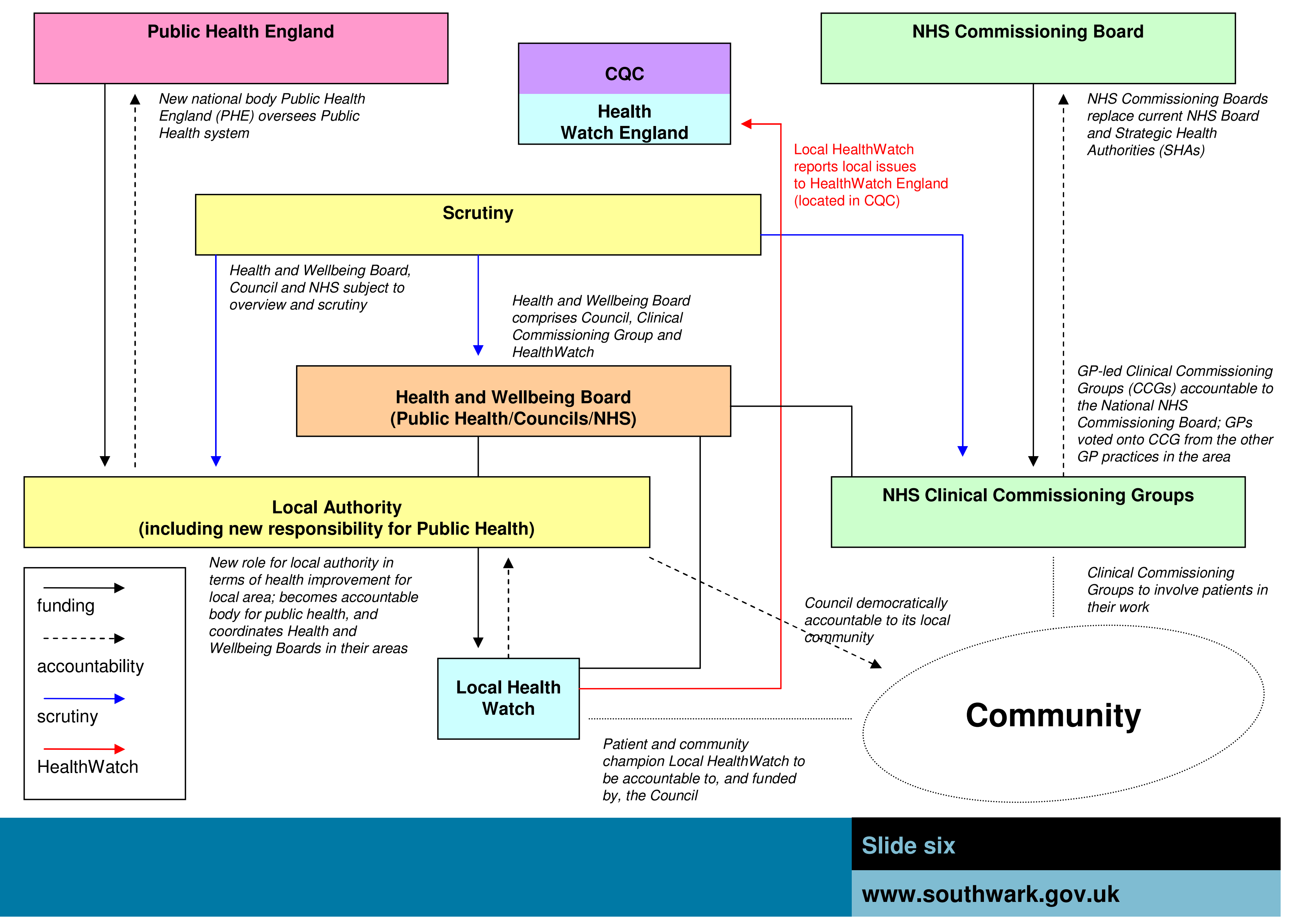
  - GP clinical commissioning groups to take over the majority of NHS commissioning as PCTs and Strategic Health Authorities abolished

  - Some Public Health function transfers from the NHS to the Council - with a "ring fenced" public health budget in the Council

  - Establishment of statutory Health and Wellbeing Strategies and Boards to encourage the integration of services across the NHS and Council

  - Establishment of HealthWatch – a new patient champion and advocacy agency to replace LINKs

  - New regulatory regime with HealthWatch England, the CQC and Monitor



Public Health England
New national body Public Health England (PHE) oversees Public Health system
CQC
Health Watch England
NHS Commissioning Board
NHS Commissioning Boards replace current NHS Board and Strategic Health Authorities (SHAs)
Local HealthWatch reports local issues to HealthWatch England (located in CQC)
Scrutiny
Health and Wellbeing Board, Council and NHS subject to overview and scrutiny
Health and Wellbeing Board comprises Council, Clinical Commissioning Group and HealthWatch
Health and Wellbeing Board (Public Health/Councils/NHS)
GP-led Clinical Commissioning Groups (CCGs) accountable to the National NHS Commissioning Board; GPs voted onto CCG from the other GP practices in the area
Local Authority (including new responsibility for Public Health)
NHS Clinical Commissioning Groups
funding
accountability
scrutiny
HealthWatch
New role for local authority in terms of health improvement for local area; becomes accountable body for public health, and coordinates Health and Wellbeing Boards in their areas
Council democratically accountable to its local community
Clinical Commissioning Groups to involve patients in their work
Local Health Watch
Community
Patient and community champion Local HealthWatch to be accountable to, and funded by, the Council
Slide six
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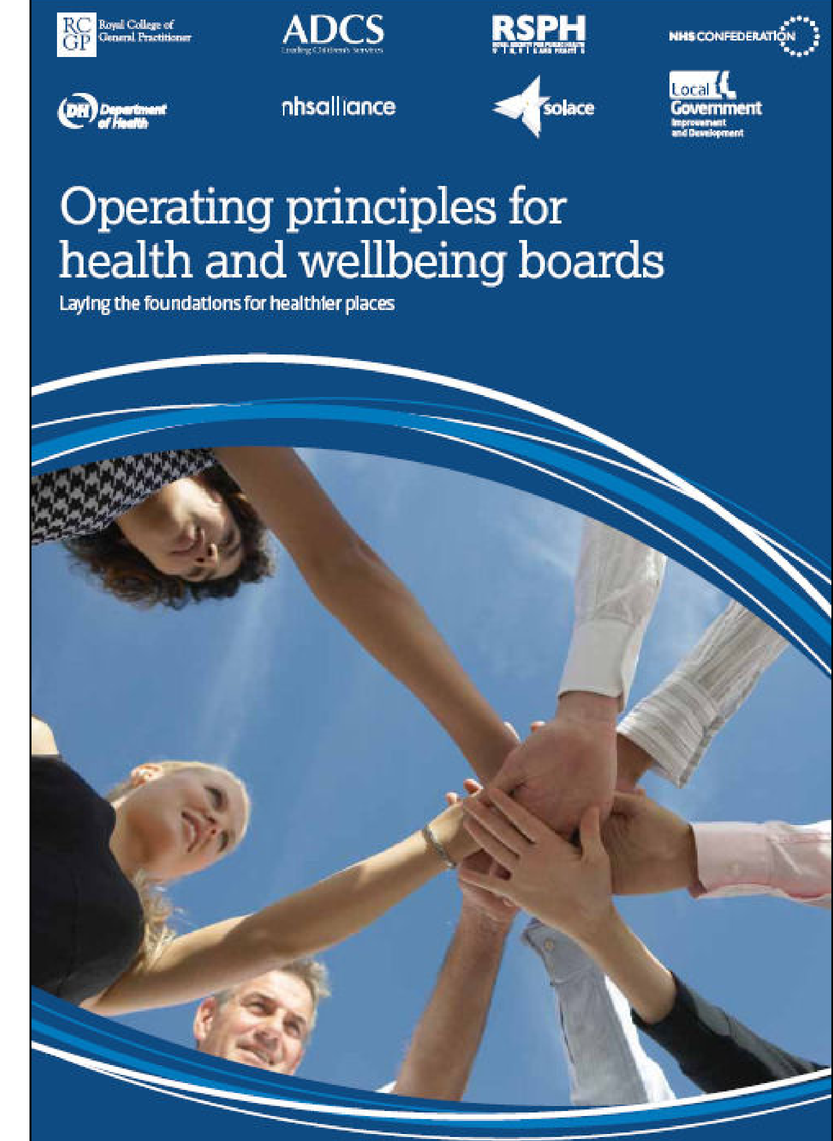
Health and Social Care Bill: Second reading, House of Lords

This briefing incorporates our response to the latest Government amendments of the Health and Social Care Bill published in September 2011, ahead of a second reading in the House of Lords. It does not aim to be a comprehensive summary of the Bill, but instead provides some evidence-based analysis of those sections (namely parts 1 and 3) that we believe might usefully be the subject of further debate and clarification by the House of Lords.

Key Points

- Many changes are already underway in the NHS in anticipation of the Health and Social Care Bill. There now needs to be a resolution to the Bill in the interests of providing the system with some much needed strategic certainty. Further protracted negotiations run the risk of alienating the many clinicians and other stakeholders across the NHS whose enthusiasm and energy will be vital to the effective implementation of what is still a complex reform programme.
- There remain many areas of the Bill that lack policy and implementation detail. Although it sets up the outlines and broad expectations of the new organisations, for example Monitor, clinical commissioning groups and the NHS Commissioning Board, much will depend on the culture and modus operandi of these bodies as they carry out their functions. We would encourage the House of Lords to use the time it has available to push for as much contextual detail about implementation as possible.

October 2011



Slide seven

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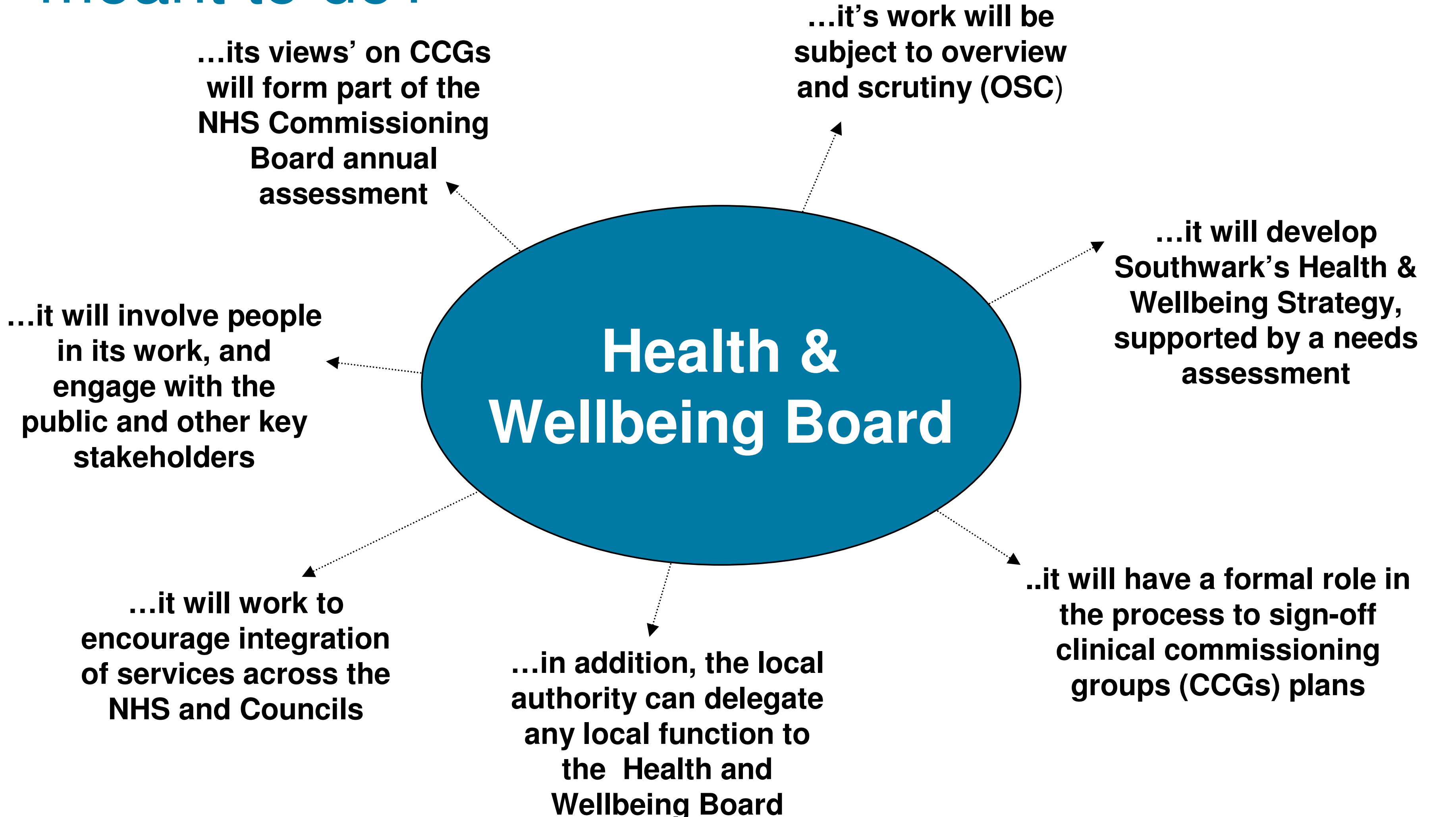
So what's the Health and Wellbeing Board meant to do?



What we know the Council/Health & Wellbeing Board must do…

193 Establishment of Health and Wellbeing Boards (pg 193)

- (1) A local authority *must* establish a Health and Wellbeing Board for its area.
- (9) At any time after a Health and Wellbeing Board is established, a local authority *must*, before appointing another person to be a member of the Board under subsection (2)(g), consult the Health and Wellbeing Board.

194 Duty to encourage integrated working (pg 194)

- (1) A Health and Wellbeing Board *must*, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.
- (2) A Health and Wellbeing Board *must*, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services. (pooled budgets)

195 Other functions of Health and Wellbeing Boards (pg 195)

- (1) The functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 ("the 2007 Act") *are to be exercised* by the Health and Wellbeing Board established by the local authority. (Preparation of a JSNA)

Health and Social Care Bill, Part 5 — Public involvement and local government, Chapter 2 — Local government

Joint Health and Wellbeing Strategies

116A Health and social care: joint health and wellbeing strategies

- (2) The responsible local authority and each of its partner clinical commissioning groups *must* prepare a strategy for meeting the needs included in the assessment by the exercise of functions of the authority, the National Health Service Commissioning Board or the clinical commissioning groups ("a joint health and wellbeing strategy").
- (3) In preparing a strategy under this section, the responsible local authority and each of its partner clinical commissioning groups *must*, in particular, consider the extent to which the needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (rather than in any other way).
- (4) In preparing a strategy under this section, the responsible local authority and each of its partner clinical commissioning groups *must* have regard to—
  - (b) any guidance issued by the Secretary of State.
- (5) In preparing a strategy under this section, the responsible local authority and each of its partner clinical commissioning groups *must*—
  - (a) involve the Local Healthwatch organisation for the area of the responsible local authority, and
  - (b) involve the people who live or work in that area.

  - (6) The responsible local authority *must* publish each strategy prepared by it under this section.

116B Duty to have regard to assessments and strategies

- (1) A responsible local authority and each of its partner clinical commissioning groups *must*, in exercising any functions, have regard to—
  - (a) any assessment of relevant needs prepared by the responsible local authority and each of its partner clinical commissioning groups under section 116 which is relevant to the exercise of the functions, and
  - (b) any joint health and wellbeing strategy prepared by them under section 116A which is so relevant.

Health and Social Care Bill, Part 5 — Public involvement and local government, Chapter 2 — Local government

Members of Health and Wellbeing Board

(2) The Health and Wellbeing Board is to consist of—

(a) subject to subsection (4)*, at least one councillor of the local authority, nominated in accordance with subsection (3),**
(b) the director of adult social services for the local authority,
(c) the director of children's services for the local authority,
(d) the director of public health for the local authority,
(e) a representative of the Local HealthWatch Organisation for the area of the local authority,
(f) a representative of each relevant clinical commissioning group, and
(g) such other persons, or representatives of such other persons, as the local authority thinks appropriate.

\- Health and Social Care Bill, section 191, 2

* In the case of a local authority operating executive arrangements, the elected Mayor or the executive leader of the local authority may, instead of or in addition to making a nomination under subsection (2)(a), be a member of the Board.

** A nomination for the purposes of subsection (2)(a) must be made— (a) in the case of a local authority operating executive arrangements, by the elected mayor or the executive leader of the local authority; (b) in any other case, by the local authority.

Health and Wellbeing Planning Group

- **Cabinet decision in November 2010 "that the Cabinet Member for Health and Adult Care will oversee a programme of work to implement the legislation that will follow the NHS White Paper" [ie Health and Social Care Bill]**
- **In order to start work to establish a new Health and Wellbeing Board, in September 2011 the Cabinet Member formed a Planning Group.**
- **The work of the group will be presented to Clinical Commissioning Group (CCG) and Cabinet for decisions on setting up a shadow Board. ("shadow" as the Board will not gain statutory powers until April 2013 – subject to the passage of the Health and Social Care Bill)**
- **The final Cabinet Decision will be on 17 April 2012.**

Principles and Behaviours

- **The Planning Group have explored initial ideas for what values and ways of working should be at the heart of the new partnership. A summary of key outcomes at this stage is set out below:**

- **The Southwark Health and Wellbeing Board should be:**

  - **proactive, promoting good health and promoting wellbeing**
  - **about spending public money wisely**
  - **open and transparent**
  - **focuses on residents and real life**
  - **a forum for debate, to tackle difficult complex issues**
  - **brings democratic legitimacy of the Council, and health expertise of NHS together**
  - **has engagement at the heart of what it does**
  - **is intrinsically Southwark; drawing on the borough's strengths, its diversity and history**
  - **takes on a 'broad' definition of wellbeing**
  - **its the way we come together to do things that we cannot do alone**

Priorities

- **The Planning Group have explored initial ideas for what criteria should be used to determine Southwark's health and wellbeing priorities. A summary of key outcomes at this stage is set out below:**

Partnership

- Working across partners can deliver outcomes that are otherwise unavailable
- Is a cross-cutting issue with broad impacts across different partners
- Achievable by local action

People

- Enables people to take greater control of outcomes for themselves and supports independence
- Based on residents' real aspirations

Health inequalities

- Has a significant impact on health inequalities

Strategic fit and drivers

- Local Political Priorities
- Aligns with, but does not replicate current strategies

Finance and sustainability

- Activities are feasible in the current fiscal environment
- Is shown to be cost effective, with a business case identifying future savings
- Has a long term, sustainable impact

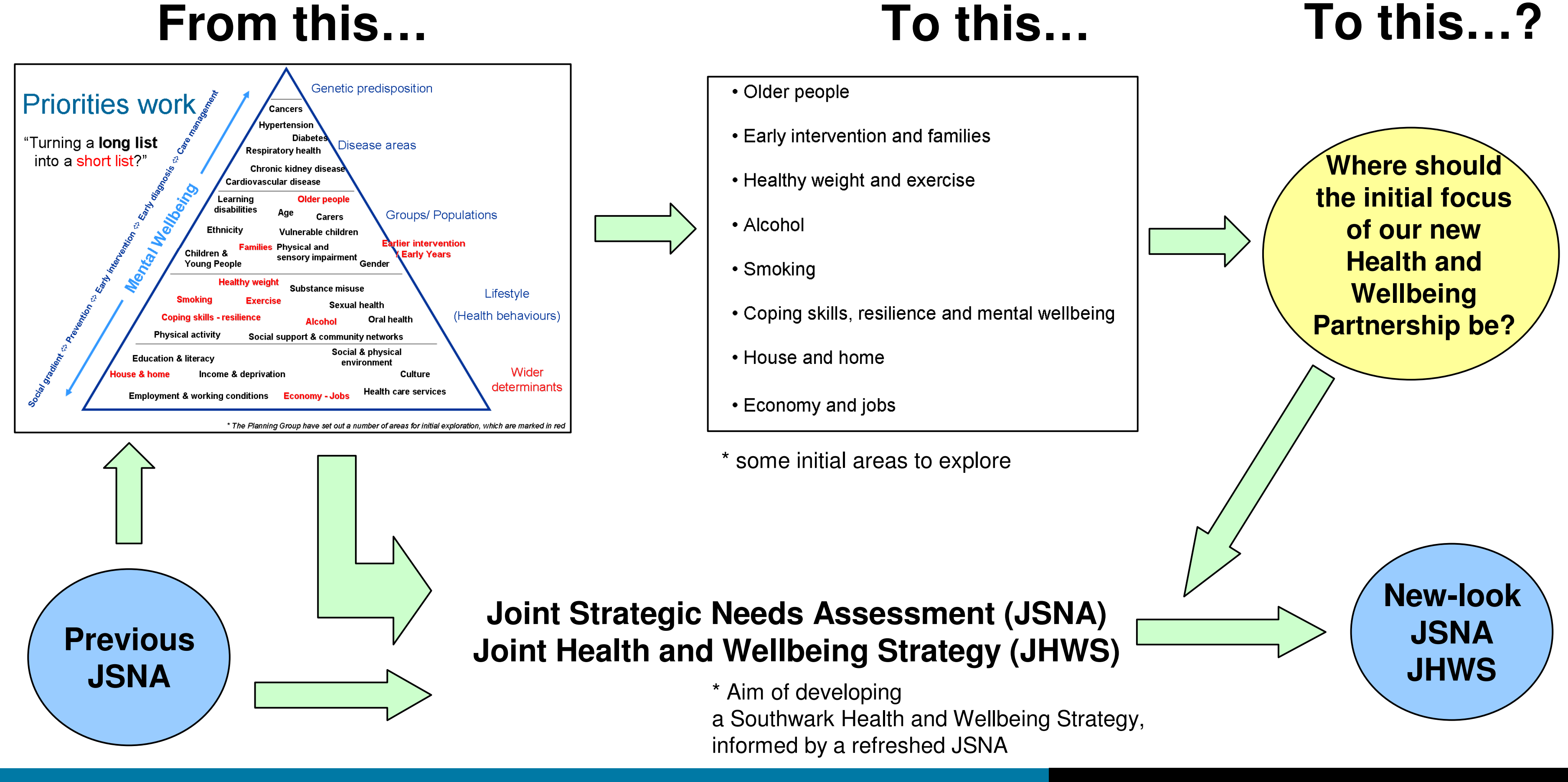
Evidence and need

- Is based on evidence, performance and trends
- Focused on a measurable outcome
- Addresses the wider determinants of health and wellbeing
- There are successful levers which have a proven impact

We know that there are many health and wellbeing challenges in Southwark…

What we've discussed in the work of Planning Group so far is: where should the focus of the Southwark Health and Wellbeing Board be?

Where should our focus be?



Initial areas to explore - where should our focus be?

- The Planning Group set out a number of initial areas to explore to help to understand the health and wellbeing challenges in Southwark. Focus groups and workshops with key stakeholders, including with community groups, have taken place – to listen to other people's views on these and other areas.

- Older People
- Early Intervention and Families
- Physical Activity/Healthy Weight and Exercise
- Alcohol
- Smoking
- Coping skills, resilience and mental wellbeing
- Housing and home
- Economy and jobs

Governance

- **Constitutional Issues – including relationship with scrutiny**
- **Configuration of Board as a "committee of the local authority"**
- **Partnership Implications**
- **Governance to support Health and Wellbeing priorities and engagement, including membership**
- **What we can learn from other areas**

Questions for health scrutiny

- **What are the key health and wellbeing challenges in Southwark, and where should our focus be?**
- **How can the Council work with the NHS and other partners, with Health and Wellbeing Board, to help improve the health and wellbeing of people in Southwark?**
- **Planning Group have said that "the Health and Wellbeing Board cannot do everything". Bearing this in mind, what does the Health and Wellbeing Board need to look like, and how does this relate to the rest of the system?**

Next steps

- **14th March – Fourth Planning Group**
- **14th March – Health Scrutiny**
- **7th April – CCG Meeting**
- **17th April – Cabinet decision on establishing a shadow Health and Wellbeing Board**

- **April 2013 – statutory Health and Wellbeing Board established**

From	Title
Norman Coombe ;Principal Lawyer	Legal advice on Health and Wellbeing Board and Scrutiny members ability to sit on both committees
Date	**To**
5.4.2012	Health and Adult Social Care Scrutiny meeting

Is it possible for Scrutiny members to both serve on the Health and Wellbeing Board and be part of Overview and Scrutiny, which will hold the board to account , or would this be seen as a conflict of interest.

This is a difficult question to answer as the standards regime is changing

Currently a member would have a **prejudicial interest** in any business before an overview and scrutiny committee or sub-committee meeting where both of the following requirements are met:

• That business relates to a decision made (whether implemented or not) or action taken by your authority’s executive or another of your authority’s committees [**such as the Board**], sub-committees, joint committees or joint sub-committees.

• You were a member of that decision-making body at that time and you were present at the time the decision was made or action taken.

Until we see the new regulations it is not possible to be definite , however it looks unlikely.

Agenda Item 5

From **Susanna White** **Strategic Director of Health and Community Services**	Title **Age UK (Formerly Age Concern)** **Lay Inspectors Briefing**
Date **3.4.2012**	To **Health and Adult Social Care Scrutiny meeting**

Background to briefing

The Chair of Health and Adult Social Care Scrutiny has requested that the Strategic Director of Health and Community Services provides clarification on how the reports provided by Lay Inspectors are acted on, and in particular how issues of concern are picked up and acted upon, and specifically how these are addressed with care home management.

Description of lay inspector's scheme.

- The lay inspector's scheme has been running for almost five years, at a cost to the Council of £10,000 p.a.

- The lay Inspectors are older people themselves, with training and co-ordination by Age UK Southwark. Regular liaison meetings are now being held with the Lay Inspectors, Age UK and officers from the Council, to build upon the current arrangements.

How reports from the lay inspectors are acted upon.

- The Lay Inspectors discuss with the Registered Manager on the day of their inspection their initial observations. Often this helps to clarify issues or ensure an immediate response if required.

- If the Lay Inspectors observe any safeguarding concerns, these are reported immediately under the Council's safeguarding procedures.

- For non safeguarding issues, the Lay Inspectors discuss their initial observations with both their peers and staff at Age UK. Following this, the Lay Inspector would then finalise the written report.

- A copy of the final report is then sent concurrently to the Contract Monitoring Manager within the Council and the Registered Manager of the home in question.

- The report is assessed by the Contract Monitoring Team, and where necessary further information /clarifications are sought from the Lay Inspectors.

- Any specific issues identified can be followed up as appropriate by the Council's contract monitoring staff. This can either be through the planned and routine monitoring visits / meetings with the Registered Manager, or if necessary through unplanned visits to the home. Through either approach the Registered Manager of the Home would be asked to respond to the issue identified in the report, and provide details of any remedial action that they are planning to take.

- The Lay Inspectors also provide more general pointers for the Council in relation to the overall user experience and ambience to be found in a particular home. Again these observations, although not necessarily relating to poor performance are addressed with Registered Care Managers by council officers through scheduled contract management meetings and visits.

- Officers from the Council will provide feed back on the response of the Registered Manager /Home Owner to the Lay Inspectors, via Age UK as appropriate

- Similarly the Registered Managers respond directly to the Lay Inspectors report, and any specific issues to have risen within the report.

Building upon the existing arrangements

- Discussions are currently taking place between the Lay Inspectors and the Contract Monitoring Team to strengthen the existing partnership arrangements. The parameters of which is focusing upon :

    - Advance notification by the Lay Inspectors of a planned visit, so that any specific issues can be shared with the Inspector prior to the inspection. It is also useful for the Council to be aware of which homes either have been or are planned to be visited.

    - For the Lay Inspectors to send reports through to the Council as soon as possible after the visit, so actions required by the Contract Monitoring Team can be taken in a more timely manner.

    - Co-ordinate more joint visits as required.

Andy Loxton
Lead Commissioning Manager – Older People

Care home questionnaire

RESULTS

Survey of residents and families affected by the ending of Southern Cross and the move to new care home ownership.

Introduction

Southwark Council's Health and Adult Social Care scrutiny committee contacted 200 relatives of residents in three care homes ; Tower Bridge, Burgess Park and Camberwell Green and asked them to fill in a survey looking into the ending of Southern Cross and its impact on affected residents and their families. The aim was to particularly understand how the care homes, Council and NHS Southwark communicated with residents and families.

Question 1 Are you a resident of family member?

Care home resident	1
Relative	21

Question 2 Are you aware that Southern Cross used to own this care home and now it is run by HC-One / Four Seasons?

Yes	22
No	0

Question 3 If so, how did you first become aware?

Care home staff	10
Social worker	1
A relative	0
Resident	0
Media	12

Any other? Please give details: ....

Question 4 Who has kept you informed through out the changes?

Please tick all that apple :

Care home staff	15
Social worker	0
A relative	0
Resident	0
Media	10

Any other ? Please give details: ....

Question 5 How well do you feel you were kept informed and supported throughout the changes to the Care Home's ownership?

1 to 10 (where 10 is very satisfied and 1 very unsatisfied)

1	2	3	4	5	6	7	8	9	10
3	1	1	0	4	2	1	2	1	6

Overall average 6.29

Question 6 **What was good about the communication and support you received as Southern Cross ended and the care home's ownership changed?**

Apart from the media communication regards the ownership change over was notified once or maybe twice by Southern Cross to let me know that the care home would be taken over on the 24/10/2011 by Four Season's and will be notified by letter.

Things only improved when our new home manager took charge with Four Season's Health Care. The manager has made so many improvements for everyone.

I was apologised to for any inconveniences we must have suffered. Then I was reassured that it will not happen again ever.

Well informed of any changes.

No communication from Southern Cross. A letter from HC. After takeover.

The media gave cause for concern but management at the care home assured residents relatives that Tower Bridge Centre would not be closing.

Four Seasons sent us many letters and we had meetings with their staff. We also had lots of helpful information from Southern Cross staff who still look after mum.

The staff keep me informed at all times about what was happening.

Writing.

Reassuring letter from HC One about the changes and their smooth transition.

Everything is done well.

The same of communication, through all very good.

The staff were hopeful the new owners would make changes to benefit all staff and residents.

The staff were very helpful and kept us fully informed.

HC-One are very much more organised.

Nothing, had no communication from Southern Cross or Southwark.

Apart from the media communication regards the ownership change over was notified once or maybe twice by Southern Cross to let me know that the care home would be taken over on the 24/10/2011 by Four Season's and will be notified by letter.

Question 7 **What could have been done better?**

It had become a shock to know that the information I received by Southern Cross about the changeover was not very informative, and not much was said about the company 4 season's who were going to takeover Burgess Park Home.

One letter posted in the lift of the home about Southern Cross, all on Sky News and the Sun newspaper. Morale was low and not knowing what the outcome would be. (Better Communication).

Better physical care, looking after residents wounds. Answering calls to residents when they call for attention. Giving afro-Caribbean food.

Everything, we were told nothing.

Some more communication.

Earlier notification would have been nice to avoid worry when the rumours started to spread. You knew something was going on but no-one was being honest about it.

Being contacted by Southwark Council.

More information.

Let us know what is happening.

Receiving a letter sooner. The news about Southern Cross had been in the media several months before we were informed of the outcome.

The dentist that they deal with.

I don't think anything could have been done better.

None it doesn't really affect me.

Letters to relatives who were concerned about there mother was she to be moved or what would happen a very unsettling time.

Question 8 **Have you noticed or felt any changes since Tower Bridge Care Home changed its ownership?**

Yes	14
No	8

Question 9 **What, if anything has changed?**

There is more going on now. The place is getting a face lift. Living quarters have been freshly painted top digital boxes have been installed in all residents rooms for the changeover 04/04/2012. The staff are more motivated.

More staff, and the home has undergone a complete makeover, i.e. painting, carpets, curtains new items for the residents, towels, bedding etc. I was very pleased with all the new furniture and all the new improvements to the home.

No one can walk into the home as they like anymore. You have to put on the visitor's badge. My dad's wounds are not dressed & bandaged.

Care home is being redecorated; also new TV fitted which is lovely for the residents, many thanks to the new owners.

Nothing at present, given time hope things changes.

The lounge and dining room have been decorated. New TV in the lounge. A complaints book was introduced at reception and I complained about old, grubby toaster in dining room which has now been replaced. However, communication is still a problem due to poor English skills of staff. Sometimes it is quite obvious that they haven't understood what you are saying which can be a big problem when dealing with these vulnerable residents. Also there was a period where trainees were engaged who didn't have a clue about caring skills & were receiving "on the job training" from other staff who were already stretched due to extra paperwork. Efficiency is sometimes a problem, e.g. I have been trying to arrange for a chiropodist to visit my mum since November last year. They eventually booked on in February 2012 but failed to include my mum's name on the list. I have to be constantly chasing and pity other residents who may not have relatives to constantly chase.

Mum still has the very best care, and now has palliative care, staff are so kind to her and the room she is in is lovely. The home has been redecorated and the atmosphere is lovely.

Cleaner, one and the same. Better.

The home is cleaner and staff are very approachable and helpful. It appears to be better organised and staffed.

General cleaning of carpets, paintwork being done throughout.

The home is now a more inviting place to visit owing to the great improvements and décor it is bright and homely.

The staff continues to be good to me and some walls have been painted.
The whole management is much better and caring.

We have noticed the internal decoration, but no difference in the welfare of residents. There is no hairdresser, staff do not wear name badges and often talk to one another not in English so the old people feel insecure.

Staff attitude seems more confident and on the ball.

Question 10 How did you feel about the care you or your family member received when it was owned by Southern Cross?

1 to 10 (where 10 is very satisfied and 1 very unsatisfied)

1	2	3	4	5	6	7	8	9	10
3	0	0	3	3	3	3	0	2	5

Overall average	**6.23**

Question 11

How did you feel about the care you or your family member receive now it is owned by HC-ONE?

1 to 10 (where 10 is very satisfied and 1 very unsatisfied)

1	2	3	4	5	6	7	8	9	10
0	1	0	2	2	0	1	4	3	9

Overall average	**8**

Question 12

Please comment on anything you feel important; this could include relationships with staff, activities, relationships in the home, visiting, meals, your routine care, medical care etc

Staff at Burgess Park Care Home are doing an excellent job. I feel the care for my sister is very good and above all responsive to her needs, this includes her care and medical needs.

I have been coming to the home since 09.03.2009 on a daily basis to see father, I have a good relationship with all the staff and also residents. I am pleased with the care he receives from all the staff and also his medical care.

My dad is still neglected with fixes? on the floor by his bed. The same clothes on for 2 weeks. Left in his room unattended for too long. Staff are friendly and relaxed.

All staff are kind, caring and very helpful.

Not enough English speaking staff, very few activities. Mum's personal hygiene. Not enough linen. Clothes always shrinking. Food ok but some is much better than other's. Chef is very helpful though.

My mother went missing after a hospital visit and there was an inquiry but we went, not informed of this and I think something as important as this, we should have had more information about.

Not happy with GP visits. Doesn't appear to be great deal of input in this area. Some staff are not as gentle as others when dealing with the residents. Larger staff should remember that they are dealing with extremely vulnerable people & act accordingly.

Mum has the very best care, now that she has palliative care, when you visit the home everything is just the same. Mum still has the same staff and they always involve us in everything they do.

Satisfied overall.

Satisfactory

Meals are better.

Quality of food is excellent.

Staff are very gentle and professional considering the very difficult changing environment they work in i.e. the care of dementia/elderly patients.

Everything is good.

Anytime I visit staff make me welcome i.e. offer cups of tea.

The communication with staff is excellent the activities are good, medical care is excellent.

I would feel sad if two of the staff goes as their visas expires. I am hoping that the new company can support them to be retained here at Camberwell. These two go beyond their duties they are very good to me even on their days off they do things for me. All staff are good to me.

The floor manager 3rd floor, has always kept everything running smoothly. Thank god she's been there through the time my stepmother has been there. She's an Angel.

Staff are quite abrupt with the old people, my mother has clothes but sometimes is dressed not to an acceptable standard. Food is not always nutritious and curried goat is not always what someone would choose to eat.

Lot clearer about who does what.

Question 13

Do you have any other comments on the ending of Southern Cross and the recent change of ownership?

I am hoping that 4 Season's who are now the operator's of all Southern Cross care homes will carry on the good work, keep relatives informed on any changes which may arise now and in the future.

I am now so pleased that Four Season's Health Care have taken over the business from Southern Cross. Everyone can see the improvements.

Thank god Southern Cross is gone. I think they should refund some of the money back to residents.

Southern Cross could not do their accounts and that's why now there are hundreds of people like myself who are hounded for monies that they say we owe from as far back as when Southern Cross took over. Lets just hope HC one can do a better job with their accounts.

We had one letter after the changeover which said they hoped to improve on the running of the home, I hope they do.

The food has not improved at all and there is a lot of waste. Communication needs attention urgently. A good command of the English language should be essential when recruiting. Also communication between managers/team/carers/nurses needs to be improved to ensure proper care of residents.

We went to a meeting regarding the changeover and we didn't notice very much difference, except that the home décor has been changed and looks very clean and fresh.

Southern Cross were awful at their financial matters, they waited over a year before sending me a bill!

Better.

One and the same.

Could have done better.

No, they were good.

No.

Basically the care has not really changed but because of the décor it is a more comfortable place to visit.

Keep up the good work HC-One.

Southern Cross we found unacceptable with care my mother was given, she had a fall and broke her wrist but no ambulance was called until 12 hours after the event. My mothers toe nails were growing into the back of her toes and she was in pain. She broke her teeth and needed to see a dentist and was not until we made a fuss was anything done on each occasion.

Question 14

Is there any other comment you would like to make?

My sister has been a resident at Burgess Park care home since September 2009 and in all that time as been bedridden, and no attempt has been made to sit her in a chair and join other residents in any care home activities.
Well done Four Season's Health Care, with many thanks to the Home Manager.

The home should learn to implement family rules, e.g. we told the home only children should be allowed to visit my dad, but they allowed anyone. Residents clothes are always going missing.

The home is far too big, the new owners will struggle unless better staff more qualified people are brought in. That means from top to bottom.

Mum is always happy and well fed, but we have had to complain that on a few occasions she has been looking un-kept. E.g. odd shoes on and her teeth missing, dirty clothes.

Things have improved slightly under the new management but there are still issues that need to be addressed.

We have always been very happy with the care that mum has been given, and never had any complaints, mum has been in Burgess Park for over five years.

At no time did Southwark council inform me to tell me of the financial troubles with Southern Cross! I only found out by reading of it in the Evening Standard!

I find staff helpful.

I was sorry to see it end like this.

They have done a good job for all the years.

Not really we are very satisfied with the whole package.

I hope the care from staff will be better with the new owners and that nothing will be repeated as with Southern Cross.

Agenda Item 6

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4th April 2012

Cllr Mark Williams
Chair, Health and Adult Social Care
Scrutiny Committee
160 Tooley Street
London SE1 2TZ

Dear Cllr Williams,

SLaM: Consultation on the reorganisation of Mental Health of Older Adults Service

I am writing in response to your letter of 21st March 2012 to Stuart Bell in respect of the proposal by the Mental Health of Older Adults service to create a home treatment service in respect of the specific questions raised in that letter.

As the discussions with commissioners on whether to plan to adopt the model are still ongoing, I am afraid that it is not possible to provide detailed information on budgetary implications to SLaM on any change. I would anticipate that when these discussions have been concluded then I will be in a position to provide this level of information at a future committee.

I can confirm however, that the Mental Health of Older Adults Service will engage with stakeholders on the merits of the proposal. This will include working with the LINK and Older Adults Partnership Board; organisations such as Age UK, the Alzheimers Society and Southwark Pensioners, and also our own service users and their carers.

As the SLaM proposition has not been agreed by commissioners it is not possible to provide detailed information on the impact of any change on bed capacity. This is again, detail that will be available should commissioners support the model and we then provide more detail for scrutiny at a date to be agreed.

Yours sincerely,

David Norman
Service Director
Mental Health of Older Adults
Clinical Academic Group

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Professor Andrew Samuels
Chair
United Kingdom Council for Psychotherapy (UKCP)

Dr Julian Lousada
Chair
British Psychoanalytic Council (BCP)

4th April 2012

Dear Professor Samuels and Dr Lousada,

I am writing in response to your letter dated 16 January 2012 about the changes we are planning to make to our psychological therapy services across the Trust.

The reconfiguration, involving psychological therapy provision delivered in Lambeth, Southwark and Lewisham, will result in the development of integrated psychological therapy services for each of these boroughs.

The services provided by the Maudsley Psychotherapy Service and St Thomas' Psychotherapy service will not be lost but will be integrated with other therapy provision to provide local integrated psychological therapy teams (IPTT's). These teams will provide a single point of entry rather than several, as with the current configuration, and deliver care on the basis of assessed need rather than historic patterns of referral, and will be fully integrated with other local community based services. The proposals have the full support of our commissioners, one of whom gave notice to us some months ago that they no longer wished to commission the Maudsley Psychotherapy Service.

In response to your four major concerns:

Impact of the changes

The figures you quote in your letter concerning staffing levels date from the initial staff consultation and are selective, relating only to some staff groups at the St Thomas' service. They do not reflect the original level of changes proposed in psychotherapy as a whole. In any case, following staff feedback during the consultation and a review of the saving levels required by one of our commissioners, changes have been made to the proposed staffing structure. The overall change in whole time equivalent (wte) posts across Lambeth, Southwark and Lewisham will

change from 49 to 39 wte. In Lambeth, the service will reduce from 18 wte to 14 wte and for psychotherapy specifically, from 7.8 to 6 wte posts.

Meeting the complex needs of the local population is a clear priority for us as well as for our commissioners who, in particular, have asked us to review the delivery of psychological therapy to ensure that it works more closely with other local services and pathways. In Lambeth for example, this will be planned as part of the ongoing Living Well Collaborative. We will monitor the impact of this change very carefully including consideration of temporarily flexing the workforce if necessary. However, we are aware, through a recent panelling process instigated by one of our commissioners, that some patients referred for psychotherapy may appropriately be diverted to other services or may be better served through new local community mental health team models. This, alongside efficiencies realised though having clearer referral pathways and single teams, will assist the service in mitigating the impact of the changes.

Consultation

Staff and service users have been involved from the outset in the development of this proposal. One of the benefits of the Clinical Academic Group (CAG) model is the ability to take an overview of all services delivering treatment to patients with similar needs across a number of services. The Mood, Anxiety and Personality (MAP) CAG developed this proposal through a systematic review of care pathways across the Trust. Staff and CAG service users were involved in this process throughout, starting with a series of workshops in spring 2011 (28 February, 28 March and 23 May). This work identified inconsistencies in the pathway, as well as concerns from service users about uneven access and multiple assessments.

The final proposal, developed by a steering group comprising senior psychological therapy practitioners from all disciplines and professions, built upon this work. An outline of this model was presented at a workshop on 14 November 2011 attended by 70 staff. The subsequent formal staff consultation, which ran from 9 December 2011 to 16 January 2012, elicited 84 responses which were subsequently used to review the model. There have been a number of opportunities for ongoing staff involvement including the offer of individual interviews, as well as team discussions concerning the proposal.

Involvement of service users in developing the proposal has been via the CAG service user advisory group, which consists of patients with an expertise or personal experience of services delivered for people experiencing mood, anxiety or personality problems. We did have concerns about the manner in which this proposal was being discussed with patients currently in treatment and have now provided written information for therapists; using their clinical discretion, to share with patients. We have recently engaged patients through the Lambeth, Southwark and Lewisham LINks who are all committed to helping us to develop and monitor the new model.

Contribution of psychotherapy to the mental health community

The proposal will not impact upon the opportunities for psychotherapy to make a contribution to the Kings Health Partners' Clinical Academic Agenda. We are committed to maintaining all modalities where possible and maintaining and expanding our training and supervision profile.

Balance of impact between psychology and psychotherapy

The configuration of professions within the new model was made with reference to a reduction to psychology staffing as part of reconfigurations to Lambeth and Southwark community services last year. We do not believe that the proposed service configuration will affect the choice in the treatment of complex patients.

We are working closely with our Local Authority overview and scrutiny committees in ensuring that the impact of these changes on local people are well understood and have effective mitigation. You will also be aware that NHS Foundation Trusts are not subject to the same duty to consult with health overview and scrutiny committees in respect of substantial developments or variations in service provision as other NHS bodies. As set out in the Health and Social Care (Community Health Standards) Act 2003 (Supplementary and Consequential Provision)(NHS Foundation Trusts) Order 2004 the duty upon NHS Foundation Trusts to consult health overview and scrutiny committees does not arise over every proposal for a substantial development of the service provided, but only where

a) the NHS Foundation Trust proposes to make an application to the Independent Regulator ["the regulator"] of NHS Foundation Trusts to vary the terms of its authorisation; and
b) that application if successful would result in a substantial variation of the provision by the NHS Foundation Trust of protected goods or services in the area of the local authority.

We do not intend to make such application to the regulator for any of our proposed changes in our Forward Plan 2012-2015.

Equality Impact assessments are available for Lambeth, Southwark and Lewisham. These do not indicate any adverse impact. Indeed, we expect to be able to improve access to people from BME communities through these changes.

I hope this addresses the concerns raised in your letter. I would like to reassure you that we remain committed to the provision of high quality psychological therapy. We are holding an involvement event on 16 May 2012 which you are very welcome to attend, alternatively Steve Davidson, Service Director, or Dr Jonathan Bindman, Clinical Director, would be happy to discuss any further questions you may have

Yours sincerely

Stuart Bell CBE
Chief Executive

Agenda Item 7

Southwark Health and Adult Social Care Scrutiny sub-Committee – November 2011

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 HASC committee members 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 this 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 Committee members is the provision of high quality healthcare provision that meets the needs of Southwark's population and continual improves

Importance (COMPLETE)
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 SE 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 29th June and 5th October 2011, in addition the HASC Chair attended a SCCC public meeting in July and the NHS Southwark AGM September The HASC 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 committee to explain the transition to the consortia, the impact of cost savings (QIPP) on patient care and at the committee's request the SCCC provided further clarification of it's 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 believe 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 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 is made to highlight potential problems that could develop in the future and to try and mitigate against these. It is understood that Southwark Health Commissioning has co-opted members onto its board which is a welcome step. The 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 committee urges that a culture of listening and consultation with patients is developed and built upon to ensure that they remain 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 taxpayer’s 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 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 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 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 where by 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 occuring.

e) Southwark's HASC 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 none 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 5th October 2011 the 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 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 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. Committee members have concerns that the introduction of private providers into this system through 'Any Qualified Provider' could have a detrimental impact to 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 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

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 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 committee, as it would be unacceptable for the specialism's 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 committee recommends to the SCCC that they:

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 (HASSC) for consideration and should be deemed a 'substantial variation' and be submitted to the HASC Ctte for scrutiny, including outsourcing
c) The 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 Ctte 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 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 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 committee therefore recommends SHC and it's 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 contracts up 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 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 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 committee's recommendations are listed below, the body which the committee is seeking to adopt the recommendation are italicised in square-brackets at the end of each one.

Recommendation 1
The committee recommends 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 the 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 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 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 alert 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 it's 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 none 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
The committee recommends that the SCCC's tendering process for any service includes standard clauses in the contract to ensure collaborative working and demonstrate that

integration will 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 Committee for scrutiny, including outsourcing . This process will consist of a brief monthly update setting out the proposed changes with a summary of the anticipated change , including its scale, impact and any community sensitivities. The committee will then consider if any of these warrant a 'Trigger Template' being filled out .

Recommendation 6
The 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 Ctte]*

Recommendation 7
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 Ctte].*

Recommendation 8
As a contractual obligation all providers should be subject to scrutiny by the HASC Ctte 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, it is recommended that the HASC committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health. *[HASC Ctte].*

Recommendation 10
The committee recommends SCCC and it's 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
The 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 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 as 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 primary and community care 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
It is recommended that the SCCC introduce and use as a matter of course standard clauses, in any locally determined 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
It is recommended 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, it is recommended that minimum levels of patient satisfaction are included in any locally determined 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]*

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
It is recommended 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.

Recommendation 20
It is recommended 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.

Recommendation 21

It is recommended 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 service penalties , such as suspensions of contract , attached.

Recommendation 22
It is recommended that the SCCC appoints external auditors

Appendix 1 - timetable for delegation to SCCC

2011/12 Budget Delegation

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

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

Notes:

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

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

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

Appendix 2 - SHC's current conflict of interest policy

SCCC approach to Conflicts of Interest

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

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

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

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

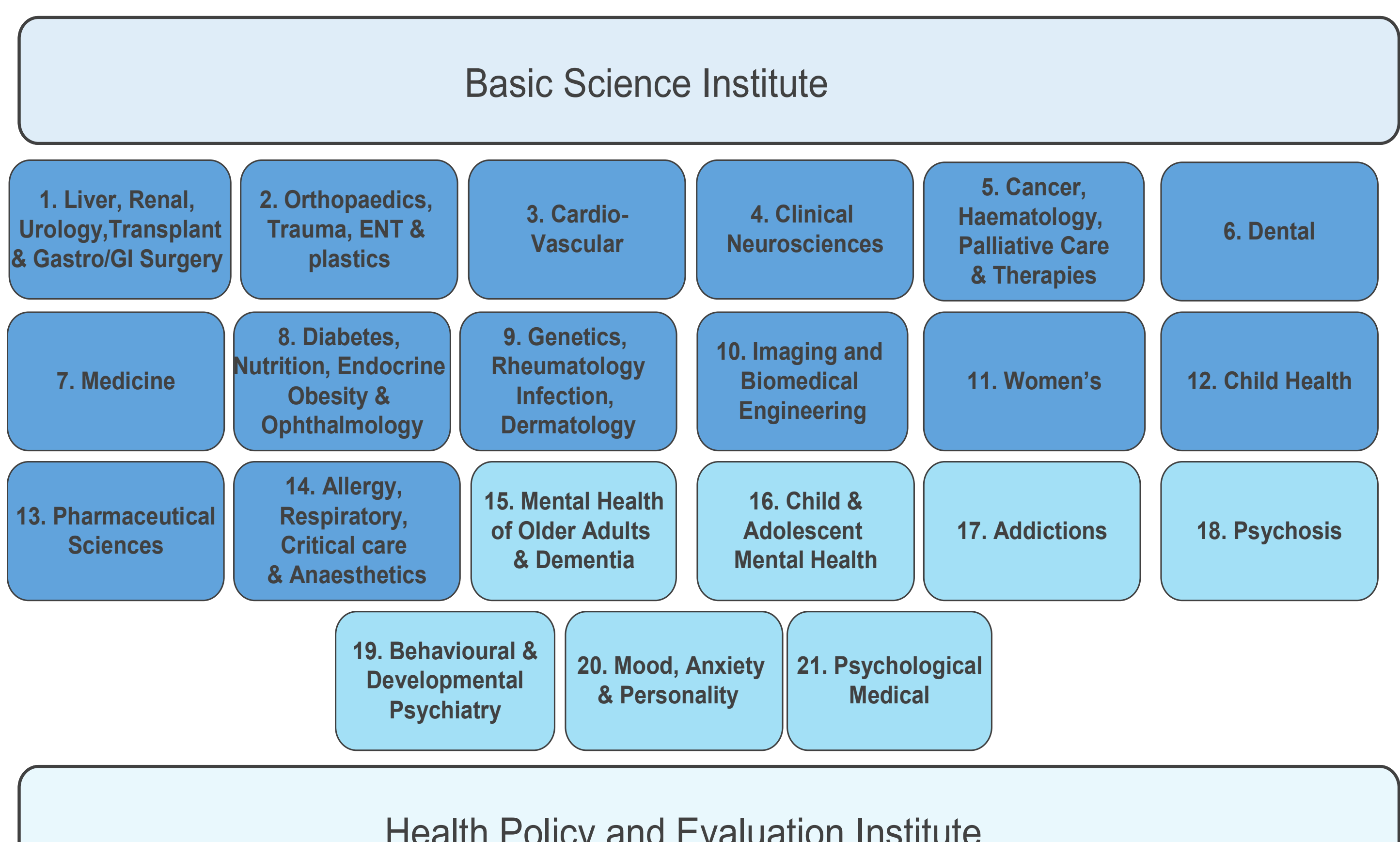
1.5. The Evaluation Panel, when called upon, will provide neutrality in the evaluation process and will have the following membership:

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

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

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

CAG and Research Group Structure



<u>Appendix 4</u> – 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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