

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

Monday 9 July 2012

7.00 pm

Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Membership

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

Reserves

Councillor Sunil Chopra
Councillor Neil Coyle
Councillor Rowenna Davis
Councillor Paul Kyriacou
Councillor Jonathan Mitchell

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Contact Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

Members of the committee are summoned to attend this meeting

Eleanor Kelly
Chief Executive
Date: 6 July 2012



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

Monday 9 July 2012

7.00 pm

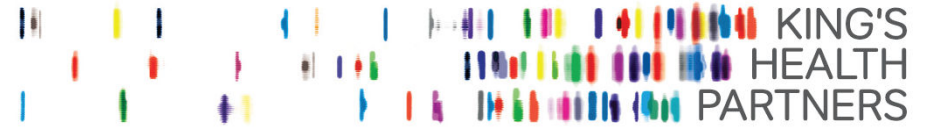
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

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	Public Health and Kings Health Partners (KHP): Professor Moxham, Director of Clinical Strategy	
8.	SOUTHWARK CLINICAL COMMISSIONING COMMITTEE (SCCC)	11 - 33
	There will be a report on SCCC implementation of the recommendations of the recent scrutiny report and a report on SCCC transition to full delegation.	
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Date: 6 July 2012

Public Health



An Academic Health Sciences Centre for London

Pioneering better health for all

John Moxham
Director of Clinical Strategy
King's Health Partners



King's Health Partners will:

- **Improve the health and well-being across our ethnically and socially diverse communities and work to reduce inequalities.**
- **Deliver a radical shift in healthcare by indentifying at risk groups, based on lifestyle and genotype, and helping them to avoid illness.**
- **Ensure our mental health services and physical health services work collaboratively to treat the entire individual.**
- **Constantly seek to reduce costs and improve quality for the benefit of patient care across the partnership and the wider health and social care system.**

KHP Strategic Framework 2009

KHP Public Health Strategy

- **Developed by: Charles Wolfe (KCL), Zoe Reed (SlAM), Graham Thornicroft (KCL/IOP – King’s Improvement Science), Matthew Hotopf (KCL/IOP), Anne-Marie Connolly (Southwark), Ruth Wallis (Lambeth), Danny Ruta (Lewisham), Ollie Smith (GSTT Charity).**

Discussed with:

- **Clinical Academic Group Leaders – in depth discussions with Diabetes, Addictions, Women’s Health, Oral Health and Medicine.**
- **Community groups (e.g. Citizens UK, Time Banking UK).**
- **Stakeholder Events: x 4 (Local Authorities, GPs, KCL academics, etc).**
- **Lambeth and Southwark Commissioners.**

Strategic Themes:

- **Developing the culture of CAGs.**
- **Public Health Collaborative for joint working.**
- **Community involvement to improve PH.**
- **Developing academic capacity.**
- **Deliver Public Health Interventions.**

Public Health Strategy	Themes for developing the strategy				
	<i>Developing Academic Capacity</i>	<i>Developing the CAG Public Health culture</i>	<i>Public Health Interventions</i>	<i>Community involvement</i>	<i>Public Health Collaborative</i>
<i>What is the vision and approach to working?</i>	School of PH, Develop tripartite mission for PH, Work collaboratively to identify innovative solutions	Embrace KHP vision	Innovate locally and to scale	Develop civic society and social cohesion	Synthesise KHP strategic framework, grand challenges etc Establish values for joint working
<i>What are the priorities?</i>	Identify drivers to inequalities and health and wellbeing, Increase capacity for evaluation, Improve data integration across sectors	Identify common themes across CAGs	Refer to JCNA but likely to include smoking, obesity, alcohol, drug misuse, exercise. Integrated Care Pilot	Refer to JSNAs Engage different community groups	Refer to JSNAs and developing priorities for the Boroughs Knowledge of what has already been tried
<i>What interventions will deliver these?</i>	Academics to work across themes	Link CAGs to PH community	Evidence on what works and what the gaps are	Highlight practical issues with what has been tried already Identify gaps in access and delivery	Knowledge of what has been tried and is known to work (or not) Highlight practical issues
<i>How will these interventions be delivered?</i>	Funding, environment	Training for CAGs to be a part of wider delivery system. Training in PH, Leadership, Employ Public Health Physician	Develop delivery model(s) Ensure fit with evaluation framework	Community as part of the solution, not being done to	Joint working, Offer of KHP skills to sector, Develop training opportunity for colleagues
<i>How will we know we have succeeded?</i>	Needs milestone objectives based on full Strategy development				

Alcohol

- **Alcohol is top priority of Public Health strategy.**
- **Acute Assessment Unit: rapid access to detoxification and treatment.**
- **CQUIN commissioned for screening hazardous/harmful drinking.**
- **Proposal by Addictions CAG, Medicine CAG at STH and LAS to create a facility to reduce burden of intoxicated individuals on ED (GSTTC)**

Smoking

- **Staff who do not smoke provide better care and are advocates of PH.**

Grant from NHSL to improve staff health – staff smoking cessation advisor, targeting heavy smoking groups.

- **Increasing referral of patients to SSS. Identify smokers, record information, refer to SSS (on EPR), feedback and follow-up (smoking as a chronic disease).**
- **Mandatory field on e-clerking.**

HIV

- **Promoting early, 100% diagnosis and treatment.**
- **Piloting opt-out HIV testing at KCH and GSTT (considering hepatitis B and C).**

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Integrated Mental and Physical Healthcare

- **Psychological Medicine CAG (KHP funded).**
- **Improving mental health of patients with chronic diseases.**
- **Identifying depression in clinics (e.g. Diabetes, Rheumatology) and delivering treatment.**
- **Programme is being expanded.**

Value-Based Health Care (VBHC) Integrated Care Pilot

- **KHP believes that the development of Value-Based Health Care can improve quality, efficiency and sustainability of care across our health and social care economy.**
- **“Value” defined as outcomes that matter to patients, divided by the costs of achieving those outcomes, over the full cycle of care.**
- **Development of VBHC Scorecards across primary, social, community, secondary, tertiary care. Increasing value is the common goal. Value will determine investment/disinvestment decisions. Work started in Stroke, MI, Hepatitis B&C and with the evaluation of the Integrated Care Pilot.**
- **Understanding and pursuing value will increase focus on Public Health.**



Southwark Clinical Commissioning Group

Response to HASC Scrutiny Committee's Recommendations on CCG Governance

5th July 2012

Update to Southwark Clinical Commissioning Committee's response to HASC recommendations

5th July 2012

1. Southwark Clinical Commissioning Committee (SCCC) has previously presented to the HASC Overview & Scrutiny in February 2012. This presentation outlined the SCCC's response to OSC's recommendations following presentation in November 2011 on SCCC governance.
2. This paper outlines the status of work completed to implement each of these recommendations. Further detail of progress in specific area will be presented to the OSC by Malcolm Hines, CCG CFO.
3. Southwark has sought to address the issues raised by the HASC OSC by developing its Conflict Of Interest Policy in light of the committee's recommendations. The CCG policy also incorporates national guidance provided by the NHSCB in respect of the management of Conflicts of Interest.
4. Ahead of CCG authorisation, the SCCC operates with a conflict of interest guardian who is a PCT non-Executive Director. The NED in this role acts to ensure all SCCC business is conducted in line with the CoI Policy.
5. The refreshed policy was approved by the QIPP Delivery sub-Group of the SCCC in June with a recommendation that it is formally ratified at the Southwark Clinical Commissioning Committee on 2 August 2012.
6. The CCG would be pleased to share the final draft of the Conflict of Interest Policy with the HASC Overview & Scrutiny Committee. We will publish this document once it is formally ratified.

Southwark Clinical Commissioning Committee response to HASC Scrutiny Recommendations

No.	HASC Recommendation	SCCC Response
1	<p>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.</p> <p><i>[SCCC, NHS SE London]</i></p>	<p>The SCCC welcomes this recommendation in full. This practice will be continued throughout 2011/12 and 2012/13.</p> <p>Committee structures revised under new governance arrangements for SCCC.</p>
2	<p>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:</p>	
2a	<p>All interests are declared at the beginning of each meeting (SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.</p>	<p>The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings</p>
2b	<p>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.</p>	<p>The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings</p>
2c	<p>Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.</p>	<p>The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings.</p>
2d	<p>Declarations of Interest are recorded at the beginning of meetings and recorded in sufficient detail in the minutes.</p>	<p>The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings.</p>
2e	<p>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 <i>declarations of interest</i> and <i>the register of interests</i>.</p>	<p>The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings.</p>

2f	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 the local press.	The SCCC welcomes this recommendation in full. Register of interest available for review.
2g	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.	The SCCC welcomes this recommendation. However our current process requires the member to absent themselves from the meeting only. Given that it is a public meeting we have agreed that they may sit with the public.
2h	Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.	The SCCC welcomes this recommendation in full. Incorporated within Col policy
2i	The SCCC ensures there is a non-executive non-GP 'Conflict of Interest Lead/Tsar' on its board and amends it's constitution accordingly.	The SCCC welcomes this recommendation in full. Applied to role of the Lay member and incorporated within Col policy.
2j	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".	The SCCC welcomes this recommendation in full. Incorporated within Col policy (10.1)
2k	The SCCC should develop a comprehensive policy for handling and discussing confidential information.	The SCCC welcomes this recommendation in full. Applied within Confidentiality Policy
2l	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.	The SCCC welcomes this recommendation in full Election process completed.
3	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. <i>[SCCC, NHS SE London and Southwark Council]</i>	The SCCC will implement this recommendation within the context of national procurement and contracting rules and procedures.
4	That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside	The SCCC welcomes this recommendation in full.

	the NHS on the long-term viability of public providers. <i>[SCCC, NHS SE London and Southwark Council]</i>	
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	The SCCC welcomes this recommendation in principle but would wish to work with the HASC committee to define the terms referred to and to ensure they can be applied adequately.
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'. <i>[DH, via HASC Ctte]</i>	The SCCC would welcome feedback from the Committee as and when detailed responses are received.
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. <i>[HWB and Monitor through HASC Ctte].</i>	The SCCC would welcome feedback from the Committee as and when detailed responses are received.
8	As a contractual obligation all providers should be subject to scrutiny by the HASC Ctte just as NHS ones currently are. <i>[SCCC, NHS SE London, Southwark OSC].</i>	The SCCC will implement this recommendation within the context of national procurement and contracting rules and procedures.
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. <i>[HASC Ctte].</i>	The SCCC would welcome this action and is happy to participate in any work as appropriate.
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). <i>[SCCC, NHS SE London, Southwark Council].</i>	The SCCC welcomes this recommendation in full.

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. <i>[SCCC, NHS SE London and Southwark Council]</i> .	The SCCC welcomes this recommendation in full.
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. <i>[HWB]</i> .	H&WB
13	Patient views and perceptions of the level of care they receive are vitally important to improve services. It is therefore recommended that the Acute Trusts continue to conduct patient surveys, and the SCCC drives patient surveys at GP practices across the borough to capture patients' views and perceptions of their care to help understand what can be improved. <i>[Acute Trusts x 3 and SCCC]</i>	The SCCC welcomes this recommendation in full.
14	It is recommended that the SCCC introduce and use as a matter of course standard clauses, in any contracts it signs with providers that ensure information is provided on the financial position of the provider on a quarterly basis. <i>[SCCC, NHS SE London]</i>	The SCCC will implement this recommendation within the context of national procurement and contracting rules and procedures. .
15	It is recommended that robust monitoring of satisfaction amongst patients placed with all providers take place as a matter of course.	The SCCC welcomes this recommendation in full.
16	In addition to clinical standards, set out by government, it is recommended that minimum levels of patient satisfaction are included in any contracts signed by the SCCC with financial penalties if these are not met, the exact levels, and how they are measured, should be a matter for the SCCC. <i>[SCCC, NHS SE London]</i>	The SCCC will implement this recommendation within the context of national procurement and contracting rules and procedures.
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. <i>[HASC]</i>	The SCCC welcomes this recommendation in full. Incorporated into Col policy.
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	The SCCC welcomes this recommendation in full. The SCCC and will take action to ensure that this training is established. Training has taken place on Col and a

	<p>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. <i>[NHS SE London, HASC]</i></p>	<p>development programme for GP clinical Leads completed, Induction programme for new clinical leads in place.</p>
19	<p>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.</p>	<p>The SCCC welcomes this recommendation in full. The SCCC has updated its development plan as part of the CCG authorisation</p>
20	<p>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.</p>	<p>The SCCC welcomes this recommendation in full. This reflects the current working practice and priorities of the SCCG and will continue into the future. It will also be a requirement of our Authorisation process in 2012/13.</p>
21	<p>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 financial penalties attached.</p>	<p>The SCCC welcomes this recommendation and will endeavour to comply with it provided actions do not fall outside of national contract requirements.</p>
22	<p>It is recommended that the SCCC appoints external auditors</p>	<p>At the current time (and until April 2013) the SCCC is a committee of the PCT Board with delegated responsibility for commissioning. The PCT Board has appointed external auditors. This requirement will be addressed, post April 2013, as part of the Authorisation process.</p>

Southwark CCG

Clinical Commissioning Group Authorisation

Southwark Council
Overview & Scrutiny Committee

9th July 2012

Summary: Key Facts

- NHS Southwark CCG will be a membership organisation of 47 GP practices
- It will have a Governing Body, which will include:
 - Clinical leads (including a Chair)
 - Nurse members
 - Lay members
 - An Accountable Officer and Chief Financial Officer
 - A patient representative
- The CCG must be authorised by NHS Commissioning Board before it can operate as a statutory body
- CCG authorisation is a rigorous process, which will involve a comprehensive review of the CCG's evidence against a detailed set of criteria and a survey of all major stakeholders
- NHS Southwark CCG will submit its portfolio of evidence in September and hear the outcome of its application in November 2012

CCGs – what are they?

- Health & Social Care Act 2012 gives responsibility for the majority of commissioning to primary care clinicians who will exercise this responsibility as a CCG
- Now the Bill has been passed the pace of change is rapid
- CCGs will be operational from April 2013 – when PCTs and SHAs close – and will take over responsibility for commissioning if successfully authorised
- CCGs are not yet statutory organisation and exist in shadow form at present
- Southwark CCG is operating in shadow form in 2012/13 with delegated responsibility from the PCT for a commissioning budget of approximately £450m
- CCGs will be a new type of organisation – a membership organisation – and Southwark CCG will be one formed of 47 GP member practices
- CCGs will have a Governing Body with a Chair, Accountable Officer, Chief Financial Officer, Lay Members, a Clinical leadership team and a nurse representative*
- CCGs will not have responsibility for performance managing primary care contracts

* full details on www.commissioningboard.nhs.uk/resources/resources-for-ccgs

CCGs – a new type of commissioning organisation

- The Health and Social Care Act stipulates that all CCGs must have a constitution and that all member practices must sign up to it
- The CCG constitution is legally binding and once signed indicates a practice's agreement to act as a participatory member of the organisation
- If practices do not join a CCG they will be allocated to one by the NHSCB
- The constitution sets out how the CCG will discharge its duties and functions including all aspects of governance
- Once signed, any future changes to a CCG constitution would need to be approved by the NHSCB
- Southwark is working with lawyers on its constitution. This will include:
 - arrangements to discharge CCG functions & those of its Governing Body
 - processes for decision making
 - duty for registers of interest and managing conflicts of interest
 - responsibilities of practices as members and what practices can expect from their CCG

CCG authorisation

- The CCG has recently concluded elections for eight clinical leads and one nurse representative.
- A national recruitment process for Accountable Officers, Chief Financial Officers and Chairs is underway as well as recruitment to Lay Member posts
- CCGs will only have licence to operate once they have been assessed & authorised by the NHSCB and to achieve authorisation CCGs will undergo a rigorous assessment process
- The ability to form and maintain strong relationships with stakeholders is seen as vital to the success of a CCG
- Results of a stakeholder survey is an important piece of evidence for authorisation. Ipsos MORI will run 360 degree surveys for Southwark in July
- Survey covers major stakeholders and partners (member practices, Southwark Health & Wellbeing Board, local providers, Southwark Council, LINKs, and others)

CCG Authorisation criteria is grouped into six domains



CCG authorisation time-table



Southwark Clinical Commissioning Group

Application group	Date for evidence submission	Total CCGs applying	SE London CCGs applying	NHS CB decision due
Wave 1	1 st July	35	None	End October
Wave 2	1 st September	70	Southwark Lambeth Lewisham Bromley	End November
Wave 3	1 st October	67	Greenwich	End December
Wave 4	1 st November	40	Bexley	End January

How will this affect GPs?

All GP practices will belong to a CCG, all CCGs will have a constitution and all practices will identify a practice representative

- All practices will identify a Practice Representative to sit on a Council of Members
- GP views will be fed into CCG Governing Body by practice representatives
- Member practices will be involved in the CCG through Locality Commissioning Groups and a Southwark CCG Council of Members
- Patients will continue to be involved through patient participation groups at practice and locality level and through the Engagement and Patient Experience sub-committee of the CCG Governing Body

BSU: Business Support Unit

CCG: Clinical Commissioning Group

NHSCB: NHS Commissioning Board (Authority)

SHA: Strategic Health Authority

Southwark CCG

Improving the quality of care for the people of Southwark

Southwark Council
Overview & Scrutiny Committee

9th July 2012

Our mission is to commission high quality services that improve the physical and mental health and wellbeing of Southwark residents and result in a reduction in health inequalities.

Commissioning for our population will be:

- Evidence based
- Focused on clinical outcomes and high quality standards of care
- Led by local frontline healthcare professionals
- Determined by local need
- Informed by genuine patient and public engagement
- Result in more information and choice for patients.

Southwark
Clinical
Commissioning
Group:
**The best
possible health
outcomes for
Southwark
people**

The best possible health outcomes for the people of Southwark by ensuring that:

- People live longer, healthier, happier lives no matter what their situation in life
- The gap in life expectancy between the richest and the poorest in our population continues to narrow
- The care local people receive is high quality, safe and accessible
- The services we commission are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy
- We make effective use of the resources available to us and always act to secure the best deal for Southwark

Southwark
Clinical
Commissioning
Group:
**The best
possible health
outcomes for
Southwark
people**

- We continue to be guided by the founding principle of the NHS - that good healthcare should be available to all, free at the point of delivery.
- We place patients, health improvement and quality at the heart of everything we do
- We are honest and open about the actions and decisions we take
- We are accountable to the public and recognise our responsibility to act in the best interests of the population we serve
- Our decisions are evidence-based, fair and make best use of the resources we have available to us
- We act responsibly as a public sector organisation and are committed to working in partnership with local government, voluntary organisations and the wider community to ensure a united approach to tackling the wider determinants of poor health in Southwark.

Southwark
Clinical
Commissioning
Group:
**The best
possible health
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people**

Reflecting our Mission, Vision and Values the CCG leadership team – together with member practices, Southwark patients and partner organisations – has developed a *Strategic Commissioning Framework* as a guide for planning our work to enhance the quality of local services and improve patient outcomes

CCG Goals

1. To achieve a reduction in premature mortality
2. To achieve a reduction in health inequalities
3. To achieve a reduction in the variability of primary care outcomes and quality
4. To have all Southwark practices actively involved in commissioning
5. To have patients play a central role in clinically-led commissioning

Strategic Priorities

The *Strategic Commissioning Framework* sets out seven priority areas and for each includes a range of patient-focussed outcome indicators. These are quantitative and qualitative measures that will allow the CCG, our members, the public and partners to track our performance as we work to improve quality.

The Seven CCG Priority Areas

1. Better outcomes for people with **Long Term Conditions**, with a focus on people with respiratory disease, cardiovascular disease and diabetes
2. Support more people to **stay healthy and prevent ill-health** through targeted screening and early intervention working through the Southwark Health & Wellbeing Board
3. Commission **outpatient services** that enhance patient experience and are delivered in community settings in a way that is coordinated with local acute trusts
4. Improve rates of early diagnosis and **outcomes for people with cancer** and at the **end of life**
5. Improve outcomes for **people with mental health needs** by focusing on early intervention, improving dementia care and by improving care quality across primary care.
6. Develop a well-integrated and **high quality system of urgent care** supporting more people at home and in the community and so reducing the need for A&E attendance and hospital admission
7. Embed clinically- and cost-effective prescribing by reducing variation in prescribing behaviours in Southwark

Making a difference

Southwark clinicians – GPs and nurses – believe their leadership of commissioning in the borough will serve to incrementally enhance the quality of care patients receive.

Clinicians are well positioned to achieve this goal because:

- Clinical commissioning is not new in Southwark and local GPs and nurses have played a central role in commissioning activities as part of the PCT
- Front-line clinicians work with patients every day are best placed to understand their needs and shape local services and pathways of care to effectively support the range of need amongst our local population
- Their clinical expertise means doctors and nurses are best placed to identify quality issues in local services
- Clinicians can better engage and lead dialogue with secondary care providers, supporting a clinically-driven approach to the integration of services
- As members of the clinical community and as leaders of a membership organisation of colleagues, Southwark clinicians are suitably placed to support the development of primary care and work with local practices to reduce variability in care quality.

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Cllr Mark Williams
Chair, Southwark Council's Health, Adult Social Care,
Communities & Citizenship Scrutiny Sub Committee

Cllr Ed Davie
Chair, Health and Adult Services Scrutiny Sub Committee
London Borough of Lambeth

5th July 2012

Dear Cllr Williams and Cllr Davie

SLaM Consultation on changes to Psychological Therapy Services

Thank you for your letter 27th June 2012 and as requested I am replying by today on two of the issues that you thought it would be helpful to receive a progress report on at this stage. Our response is set out below.

A half day workshop was held with psychological therapy staff on 28th June 2012 to discuss the development of a service specification for the new teams. This work included identifying which therapies and modalities will be offered in the new teams. The workshop was attended by 30 staff and made some good progress. This work will continue.

Heads of Service have been identified for each of the three new teams (Lambeth, Southwark and Lewisham) who will lead the ongoing discussions with staff and ensure that clear communication is in place between therapy staff and the management team. The Heads of Service; who are senior therapists, as well as representatives from the service user advisory group, are members of the reconfiguration Project Board where decisions concerning the service model will be agreed.

Contact was made with the British Psychoanalytic Council and the UK Council for Psychotherapy on 23rd May 2012 requesting the opportunity to work with them on addressing concerns raised by some of our staff. Gary Fereday, Chief Executive of British Psychoanalytic Council replied on behalf of both organisations 25th June 2012, advising that they were meeting with a number of staff to discuss concerns and will contact us again very soon. We are keen to maintain good links with these and other professional organisations and to work closely with them in responding to staff concerns.

With reference to the second recommendation; we attach a document summarising the information we received during our additional period of stakeholder engagement in April and May 2012 (attached)

All stakeholders have asked for a reduction in the number of assessments and to for a less complicated journey through psychological therapy services. These improvements are central to the development of the new borough Therapy services as such, most stakeholders did not make any request for this model to be changed, but rather made suggestions about 'how' the service is delivered including how we communicate, how we engage and how therapists work collaboratively with patients in agreeing treatment and care.

These principals are being incorporated into the new service specifications and team operational policies, and will be central to the evaluation framework which we intend to develop between stakeholders and commissioners.

As also requested in your letter we will provide a progress report to the other areas of interest you raised in time for your September meeting.

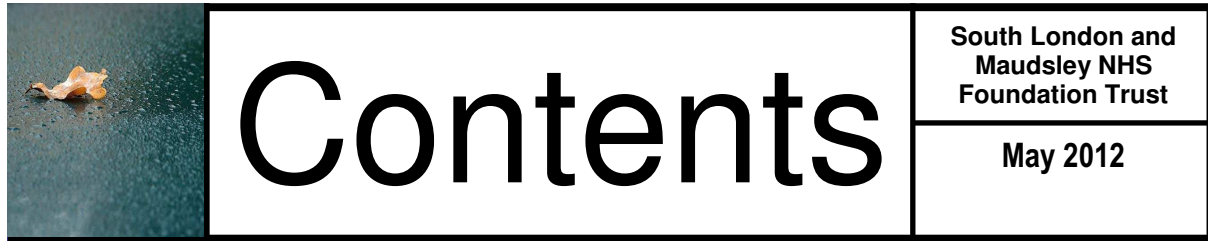
With best wishes

Yours sincerely

A handwritten signature in black ink, appearing to read 'Zoe Reed', with a long, sweeping underline that extends to the right.

Zoe Reed
Executive Director Strategy and Business Development





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Background

The purpose of this document is to report on and detail the feedback received about proposed changes to psychological therapy services provided by South London & Maudsley NHS Foundation trust in the boroughs of Lambeth, Southwark & Lewisham during April / May 2012. This feedback will inform the development of 'service specifications' which will define exactly how and what the new services will provide. The work is part of a wider involvement exercise and this document should be read with reference to the following documents:

- **Psychological Therapies - Overview of the proposed changes to psychological therapy services in Lambeth, Southwark and Lewisham.**
April/May 2012
- **'Involving stakeholders in the development of the proposed changes to psychological therapies services'**
April 2012
- **Find Out/Talk About – Involvement Report following stakeholder meeting**
November 2011

For copies of the above reports, please contact:
 Alice Glover—Patient & Public Involvement Lead

Building on specific involvement work carried out since November 2011 (see above), this additional work was overseen by the ***The Psychological Therapy Services Reconfiguration Communications & Involvement Working Group***. Membership included Lambeth, Southwark & Lewisham LINks, South London and Maudsley NHS Foundation Trust staff and members of the *Mood Anxiety & Personality Clinical Academic Group Service User Advisory Group* *

The work included:

- **Increasing availability of information about the proposed changes to wider stakeholders**
- **Approaching individual organizations and user groups in the boroughs to give information about and to seek views/ideas on the proposals.**
- **Running an event for stakeholders to present feedback to date & invite participants to share their views & ideas about the proposals**

* the *Mood Anxiety & Personality Clinical Academic Group Service User Advisory Group* is a group of people with experience of using mental health services who work with the senior management of the mood, anxiety & personality disorder services to keep the views of service users at the heart of all service developments and improvements.

Content of the involvement

Increasing availability of information

- An overview document was produced to outline the proposed changes, to summarise the feedback received to date and to identify ways in which people could help shape the proposals.
- Previous documentation was collated and referenced in the overview document.
- All documents were made available on the Trust website and individuals / organizations were invited to request paper copies as appropriate.

Approaching individual organizations and user groups

The following local organizations & user groups were approached individually to explore how best to inform and involve their members:

- Cooltan Arts
- Vital Link
- Southwark MIND User Council
- Southwark MIND – Kindred Minds
- Lambeth MIND
- Lewisham Users Forum
- Four In Ten (LGBT service user peer support group)
- Metro Centre (LGBT support centre)
- Family Health Isis
- Black Users Forum (Lewisham)
- Amardeep
- Vietnamese Mental Health Services
- Fanon Resource Centre



Feedback from the above (and other) organizations and individuals were made available for participants to see at a wider stakeholder event

Running an event for stakeholders—May 16th 2012

- The purpose of the event was to share recent feedback and to generate ideas and discussion with a wide group of stakeholders, the results of which would inform the detail of the plans to reconfigure the psychological therapy services.
- The event and opportunities for involvement were advertised widely through local networks, including LINKs, South London and Maudsley NHS Foundation Trust membership, service user & carer networks, through community mental health teams & therapy services, voluntary sector & primary care.
- A range of information was available prior to the event and everyone who booked a place was asked about their information needs. On arrival at the event, people were given an overview document about the proposed changes and an information pack about the event.

Stakeholder Event 16th May 2012

Programme:

- Welcome & Introductions
- Presentation – Proposed Changes to psychological therapies
- Themed Table work
- Review, Reflections & Questions
- Close

Lewisham, Southwark & Lambeth LINks held information stalls, and South London and Maudsley NHS Foundation Trust (SLaM), provided information on wellbeing, psychological therapies, service user involvement, and a ‘talking wall’ was available for people to post & display their comments & feedback.

“Just to say thought yesterday afternoon’s session was very constructive. Impressed by the range of stakeholders present and the way it was structured. Hope it was helpful in finding a way through the current changes “ participant

Around 120 people attended the event. Participants had experience of using and/or providing SLaM mental health services or were interested through involvement with independent or voluntary sector, primary care or local authority organizations. We estimate that 30% of participants were mental health service users or carers. Members of the *Mood Anxiety & Personality Clinical Academic Group Service User Advisory Group* supported the event by meeting & greeting participants, opening the event, participating in the presentation and table work and being available for individuals to approach to discuss the proposals. Dr. Jonathan Bindman (clinical director) and Carmine De Rosa from the advisory group gave a presentation outlining the proposed changes, the rationale behind the changes, how stakeholders had been involved so far and the aims of the event .

Table work focused on 8 themes identified from previous involvement work with stakeholders and staff — Referral, Assessment, Waiting for treatment, Treatment, Peer Support , Voluntary Sector & Local Authority Partnerships, Does it work/What was it like

Feedback from targeted involvement work in the preceding 6 weeks was displayed on the tables. Participants were invited to discuss, respond to and feedback about themes on the tables, sharing ideas and raising questions where appropriate. Participants were invited to leave their own feedback on the tables or to raise issues through the facilitators.

Facilitators on the tables were asked to summarise key points and feedback to the whole group at the end of the session. At the end of the session, there was a brief opportunity for people to raise questions to the whole group and next steps were outlined. Participants were asked to complete a brief evaluation form which included the opportunity to give final comments about the proposed changes.

Themed feedback

‘I did really enjoy the day and want to thank you for organising the day. It was quite inspiring to see so many conversations taking place between all the various stake holders’

participant

Feedback from the table work including feedback gathered during the 6 weeks leading up to the event, was collated, themed and is summarized below in the following categories

- **The model**
- **Referral**
- **Assessment**
- **Waiting for Treatment**
- **Treatment & Support**
- **Measuring Outcomes & Understanding Patient Experience**
- **Communications & Involvement**
- **The Whole System**

The model:

We propose that: Each borough has an Integrated Psychological Therapies Team (IPTT) with a single point of access.

- There was positive feedback about the proposed single point of access

Comments included the need to:

- Maintain evidence-based treatments
- Offer a variety of and choice of therapeutic support -
- Evaluate new innovations
- View therapeutic support holistically - *“I see therapy as part of many services. It’s to do with how the person interacts and relates to you. There’s much more scope out there for therapeutic input without just using the label “psychotherapy.”*
- Offer services in a range of settings (eg GP practices, community organizations etc) – *“It is a really good idea to have ‘community outposts’ for BME clients services” “Go to where the people are, rather than where your office is”*
- Move away from 9 – 5 provision and be more responsive
- Work more seamlessly with primary care, & have good transitions between other mental health services
- Retain the good work that is already happening *“Lets not lose good work that is happening already – eg: Vauxhall City Farm”*
- Make sure the system works before implementing it
- Be clear about who is eligible for the service in terms of level of severity -

Concerns and questions raised:

- Volumes of referrals and capacity to respond in and across teams – particularly with the increased relationship with Community Mental Health Teams - *“Capacity of single point of entry, some need for more work.” “What about re-referrals? Is this an easy-in/ easy-out thing?”*
- Being able to understand the before & after scenario in terms of activity
- How does payment by results work with ongoing and long term mental health conditions?
- The relationship with the CMHT’s is pivotal in the new developing service

Referral

We propose that: Services such as GP's and Improving Access to Psychological Therapies (IAPT) refer to a 'single point of access' in the Integrated Psychological Therapies Team (IPTT). Referrals will be 'triaged' collaboratively by IPTT and community mental health teams to ensure the most appropriate assessment, signposting or treatment is offered.

Comments included the need for:

- Clear and consistent referral procedure – mutual understanding about what is expected – both between referrer & IPTT and service user & IPTT
- At the point of referral, to manage expectations further down the line, Be clear about what information is needed at referral
- Good preparatory work with service users prior to accessing psychological therapies
- Excellent information for referrers, Primary Care Trust, service users/carers and wider organisations about what is available, and how people could benefit and who can refer
- Consideration of under represented groups – eg Black & Minority Ethnic (BME), Homeless *“Why will the proposal improve access and use of talking therapies? Black, Asian and other minority groups (BAME) are not going to have better access the service any more than they do currently due the stigma associated with mental health care services; the fear of being detained under the Mental Health Act, and the history of the relation mental health services has had with BAME people to date?”*

Concerns and questions about:

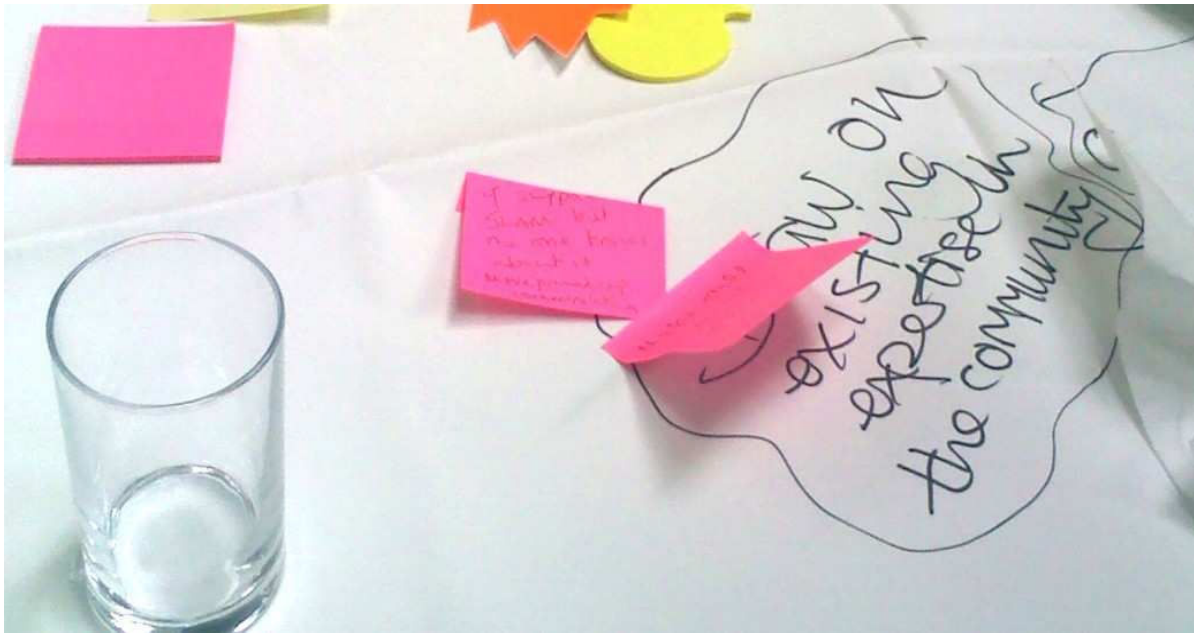
- The capacity of GP's to respond to mental health issues, and to be informed about what services are available
- The quality of work done by potential referrers being crucial – whether IAPT, GP or Community Mental Health Team (CMHT) as this may (or may not) result in referral to IPTT
- The time at which a diagnosis is made, is it part of the assessment process?

Suggestions/ideas

- Referral form to indicate whether psychological therapies or engagement assessment & stabilisation (EAS) would be more appropriate
- Check list on referral form
- Training for GP's
- Contact person for referrals/GP contacts
- Information for service users – leaflet/website – on what to expect from referral to end of treatment
- Patients with lived experience of treatment to induct & navigate – service users can signpost to other organisations
- Link with community development workers in IAPT to increase access to BME communities
- Joint mental health promotion work between Assessment & Treatment and IPTT could assist with access BME communities for example.
- (Face to face) contact between IPTT and service user to explore expectations, assessing motivation and commitment.

Assessment

We propose that: by making sure that the appropriate 'level' of assessment is carried out people undergo fewer assessments before reaching the treatment or support that is most appropriate. The profession and grade of the assessor will depend on the complexity of the service users' presentation.



Comments included the need to:

- Minimize number of assessments for service users
- Approach the assessment more as a 'consultation' and less as a 'test' to be passed in order to access therapy
- Consider the option of face to face contact with service user to 'fill in the gaps' from referral & ensure correct treatment is assigned at single point of access Integrated Psychological Therapies Team (IPTT)
- Work with Assessment & Treatment in Community Mental Health Teams to discuss & log initial screening of referrals & take to weekly meeting
- Continue & extend work with BME groups currently working with Community Mental Health Teams (CMHT's) to promote access for BME service users
- Have a variety of professionals trained to undertake assessments
- Develop a transparent process, sharing assessments with service users/ external organizations where appropriate. Giving information about why someone is not seen as suitable.
- Be flexible in the way of assessing someone, to be decided with service user
 - eg: phone or face to face

Assessment - Contd

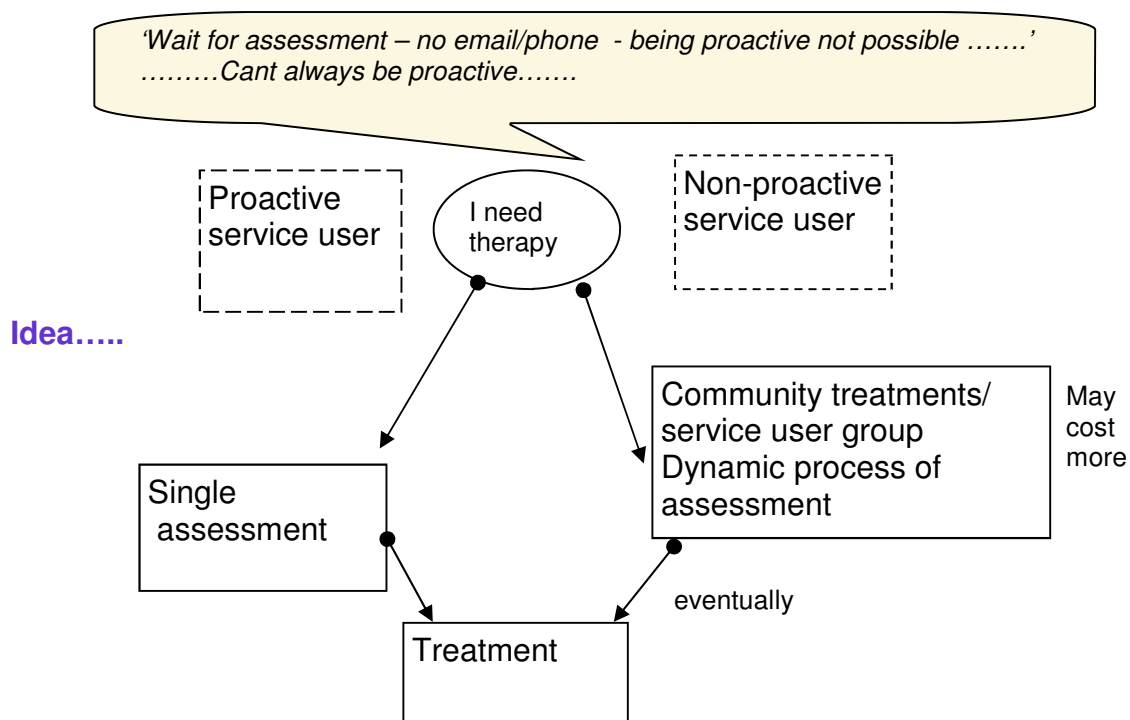
Questions and concerns:

- Who would be members of the assessment & formulation meeting (clinical & peer)?
- Feedback about assessment: need for culturally sensitive, understanding & respectful work, & 'language can be an issue rather than race or culture'
- "Service users do not care what colour/race/sex the assessors are – just want the help!"
- Would there be generic assessment and/or modality specific assessment?

Ideas

- Service users being more involved in the process – eg: carrying information that can be taken forward from one assessment or new appointment to the next
- Training for GP's
- Share formats with voluntary sector, to improve interface
- An objective assessment panel (clinicians, service user representative?) who assess and then decide what mode of therapy is best for each case
- Discussion about how to manage waiting times to be undertaken at the assessment stage, with realistic information about waits
- After the assessment people could be given information about: Big White Wall (not everyone has a computer) & other websites, Support Groups – there could be a list of options

"How can service users put their own assessment/story on the electronic patient journey system?"



Waiting for Treatment

Patient experience data tells us that we need to improve satisfaction rates around waiting times for psychological therapies.

We propose that: We monitor waiting times between assessment and the start of treatment and that we maintain a dialogue with commissioners around the capacity of the service to meet the demand.

Comments:

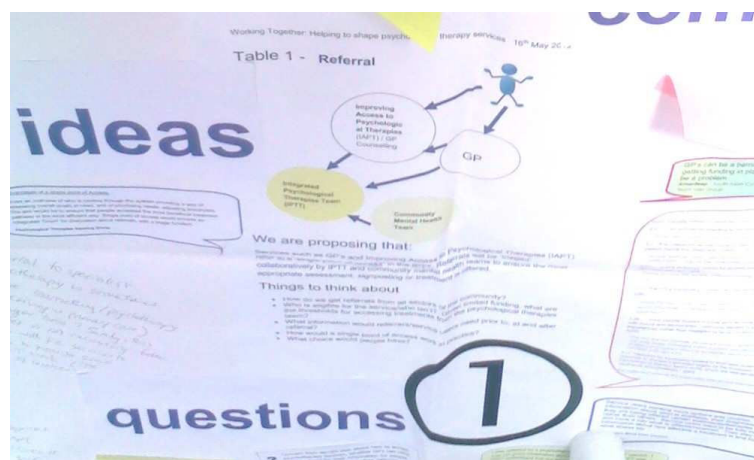
- We should try to make waiting an opportunity rather than a burden, using the time to support people to prepare for therapy
- Community Mental Health Teams need to be part of the solution to managing waiting lists
- The service user should not be a passive person waiting
- Staff should understand the anxiety that service users may experience during waiting
- It is important to acknowledge change in people during the waiting time

Questions and concerns:

- Inheriting a large waiting list in the new Integrated Psychological Therapy Teams (IPTT)
- Would like to see a before & after picture of waiting list number by modality

Ideas:

- Using a long wait trigger
- Checklist for people on waiting list – what to expect, when
- Provide information about the waiting times, regularly & systematically updating people on the waiting list using a variety of methods eg: email/text/letter/phone
- Groupwork during waiting time: peer support, therapeutic 'holding groups', internet groups, workshops on how therapies work, and what is involved



Treatment / Support

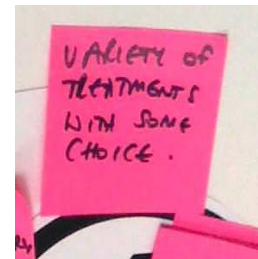
We propose that:

- A 'stabilisation and/or re-ablement pathway', within a therapeutic relationship will be offered to most service users initially. We develop new approaches and joined-up ways of working with the 3rd sector, the local authority and other agencies to ensure the most appropriate level of treatment is offered to service users
- The capacity of the service will need to be monitored closely to ensure it is able to accommodate as much psychological therapy as possible. There will need to be a systematic approach to working effectively & efficiently. The more skilled and experienced workers will assist others to run groups, to supervise and mentor other staff in being 'therapeutic' in their assessments and treatments
- We also need to do things differently – we have fewer resources and we want to maximise the therapy we offer.

Suggestions that the service should include:

• Variety of therapies - *"Service users want more options and choices. Want information about what is available, their diagnosis, why they are being offered certain treatments/therapies – rather than others."*

- Evidence based treatments
- Opportunities for long term therapy
- Real time information & signposting.
- Psychoeducation, peer support, staying in touch, recovery college
- Co-production written into the pathways
- Procedures for service users to change workers if they are not happy
- Opportunities to offer patients some choice over where they are treated - (e.g. voluntary sector agency). 'Go to where the people are, rather than where your office is' to promote access for BME & other underrepresented groups



In developing the service the need to:

- Consider how we treat conditions for which there are no NICE (national institute for clinical excellence) guidelines?
- How much time & money can be allocated for introducing and researching new modalities?
- Consider what is meant by peer support, how does it differentiate from user run groups, how good is it, what is the evidence around its benefits?
- Differentiate between peer support, friendship & peer advocacy
- Develop greater collaboration with voluntary sector in both provision of formal therapies and promotion of therapeutic work or therapeutic ideas
- Consider how partnerships and relationships with external organizations can be developed to enhance the pathway for service users, and how this can be funded, how to overcome practical issues such as information sharing etc
- Draw on the expertise in the community, developing networks and communication systems – the voluntary sector can have better representation

Treatment/Support Contd:

The need to:

- Consider the implications for existing service users going through the changes to service
- Consider the support needs of staff
- Understand that most patients prefer to access services locally,

Concerns and questions

- Are there modalities that are currently provided that are at risk of not being provided in the new service?
- The honorary/trainee system - what are the implications on this in the proposed changes? *"Trainees are the future"*
- Concern about how peer support will be used – it should not be used to replace statutory services. Need to have strategies for addressing negative as well as positive aspects of peer support group work
- Peer support - the vast majority of the people that would benefit from such a project are the last to seek such support?
- How will peer support for BME communities be developed?
- How will payment for peer supporters work? How will peer supporters be supported & supervised? How about Criminal Record Bureau checks for peer supporters?
- How will funding for peer support be maintained?
- Voluntary sector & user led services are reducing due to budget cuts
- Staff who are happy to go out in community are not given the incentives such as unsocial hours/toil without bureaucracy of management
- How can therapy services be made accessible to people who are homeless or in insecure or temporary accommodation?
- Services need to be made more acceptable to BME groups
- How do the IPTT work closer with Community Mental Health Teams – as they need to
- What can people do when they are in a crisis

"Community Mental Health Teams (CMHT's) have been good at delivering short term interventions such as workshops on anxiety & depression or mini CBT courses on sleep or anger management. CMHT's have also given me one off social work support around a housing problem, and offered me a 6 week healthy lifestyle course with a social worker, which did not completely meet my needs. I found that the worker was able to remember the things she had said more than the things I had said. I have thought for some time that the workers would benefit from more training in listening skills. I don't go to the CMHT when I'm in crisis – as I come out feeling worse. They only want to assess me in terms of risk and whether I am safe to go home. I want support and space. Our agendas are too different. I only go when I feel well enough."

Treatment/Support Contd:

Comments about therapy:

- Group work – people learn by hearing from others in the group, can help people feel more connected, working with peers can make more difference
- Individual therapy - too didactic. *“It feels like “clinician knows best.”, “you can have too much therapy”.*
- A collaborative relationship is the key
- Cultural barriers: therapists may not understand the cultural context

“Its not just about race with psychotherapy – class is an issue too”

“the therapist did not understand my background”, Language is a problem in accessing psychotherapy as interpreters can impact on the relationship between therapist & client. Some therapists can speak other languages, but only offer therapy in English, Difficulties of therapies via interpreters. Lack of Vietnamese speaking therapists.

Comments about peer support

- People can gain expertise in recovery – from other service users as opposed to from training
- You can be given hope via peers. *“If someone else says, look, this is how I coped with the situation it can give real hope rather than a professional just saying what to do.”*
- Peer support – people can talk in their own languages, a neutral space, dispelling the myth of professional superiority, less hierarchy, non directive/ authoritarian
- Example of peer support – Amardeep & group for older people
- In peer support groups those who are more experienced in using services can support others who are new to things – but we need to keep aware of the difference between advocating and befriending
- Peer support needs consistency, leadership & structure

Comments about partnership working with external organizations:

- Recognize the strength in each group - its not just about money
- A clearer understanding from service users and professionals about other community outreach 3rd sector groups that are out there.
- Main issue at our table was need for clear pathways from Voluntary Sector to SlaM/NHS/GPs and vice-versa.

Ideas and suggestions

- To promote attendance at appointments – how about a system of deposits?
- Types of therapy – mentalisation therapy, Rogerian Therapy
- Build in systematic and regular feedback
- Advocacy services in psychological therapy services
- Link with researchers to look at conditions that are ‘difficult to treat’ & develop new treatments
- Staff training to include: Lesbian Gay Bisexual Transgender (LGBT) awareness training, recovery training
- Work with the local MINDs

Treatment/Support Contd:

Ideas and suggestions about peer support:

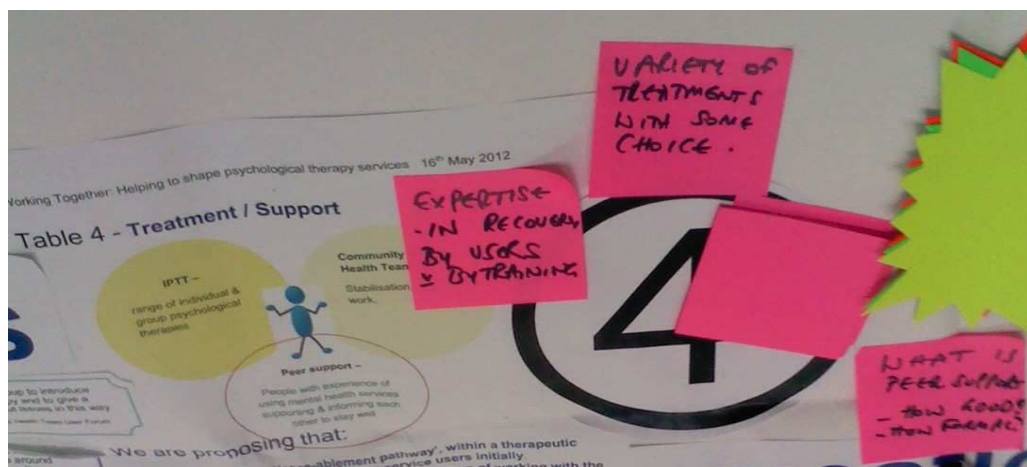
Peer support could offer:

- Support to people to navigate the IPTT system—induction, through assessment etc
- Signposting to relevant support/information whilst waiting for therapy
- Informal support after a formal intervention
- Ways for people to give feedback about how they have experienced the service
- Life skills, self advocacy & therapy skills
- The trust that exists within a peer support relationship could easily be compromised if it was seen to be simply an extension of statutory services. It might be a good idea for there to be an ongoing user only group established to discuss issues that arise from peer support.

“Teach peers counseling skills. Basic counseling is not hard to learn, is effective & gives peers a tool to use.”

Specific suggestions:

- Tree of Life & Kindred Minds—to work with SLaM on this model together & promote on the wards in Southwark
- Cognitive Behavioural Therapy (CBT) M.O.T ‘This idea came out of my telling my CBT therapist that in an ideal world I’d like to have a top-up of a few weeks of CBT every year.’ Annual top-up available of a 4 week peer-supported course run twice a year for people who have done CBT and want re-motivation. Co-designed by trained professional & experienced ex-CBT service user .5 or 6 members per group, self referral and with a commitment to attend all sessions.
- From Four in Ten : - “User run & user led organizations, talk to us, we would love your support & you might need us”
- Peer support for families? – dispelling myths. Home visits, training, money?
- Training service users to be peer support mentors



Treatment/Support Contd:

Ideas and suggestions contd:

- Directories for each borough with local support opportunities, a newsletter - A HUB for this service to include a LIST/directory of relevant/appropriate Voluntary sector deliverers.
- Map the current services in the local area. Think innovatively to provide a range of support. Think prevention, look at work with young people & children
- Improve links between voluntary sector & SLaM by having a named person as champion, phone numbers, office space to go to, team contacts, agreed response times - could we get a formal link between voluntary organizations and the hospitals
- 'Talking therapy' groups for BME groups to introduce people to the idea of talking therapies
- Care co-ordinators (with greater cultural understanding of service user) could share maybe 10 mins of the therapy session to liaise around practical issues such as housing & to offer a cultural bridge where needed
- Trained volunteers to access isolated people
- Low level care co-ordination with recovery, support & crisis plans for clients with occasional needs, 6 -monthly appointment ? plus rare specific-need appointments
- Community Mental Health Team workers could ask clients on a regular basis, how the treatment is going and if there are any problems or issues
- Clear information and/or workshops for service users about the different types of therapy, how they work, what the evidence is about their effectiveness etc

"It would be good to have a 'talking therapies forum' for networking between SLaM & voluntary sector organizations, have a system for representatives from different groups to come together – elected members, safe in a group "



Measuring outcomes & understanding patient experience:

We propose that: Staff & people with direct experience of using services work together to develop a framework for measuring patient experience across all the IPTT's. We develop a consistent approach to measuring outcomes across the psychological therapies services.

Comments about outcomes:

- Treatments/interventions should be shown to be effective, and that there should be standard way of doing this whatever the modality/approach used. The proposal has not however said how effectiveness is to be determined and how will you ensure that funding only goes to those who can adequately monitor and show effectiveness over time?
- Demonstrating effectiveness is not yet an exact science: means of such demonstration are more straightforward for some modalities than others
- How will you measure the outcomes such as hope/belief?
- Translated measures – difficulty of interpreting
- We need to become more aware of the ways in which the information we provide can be useful to and used by service users (this said by a psychiatrist). We need something beyond the basic stats approach of the CORE OM.
"I have had several treatments, interventions etc over the years. I have NEVER been asked how I felt about it"

Ideas & Suggestions about outcomes

- Different styles of monitoring/assessing treatments & interventions to suit individual needs
- After 4 treatments, service users are invited for a chat to see how treatment is going
- Ask people about outcomes much later after therapy
- A discussion about outcome measures
- Consistent monitoring of outcomes for benchmarking – keep commissioners happy Sharing outcome measures

"It would be good if we could be looking at aspirations rather than targets."

Measuring outcomes & understanding patient experience contd:

Comments about understanding patient experience:

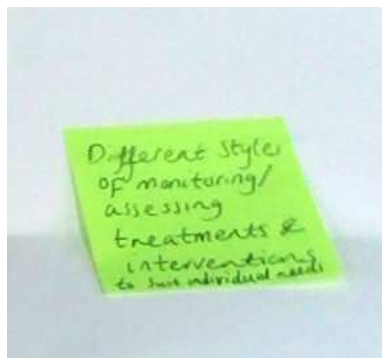
- Clear commitment on patient feedback from SLaM, clearly communicated to patients, patients can see how their experience has an influence, on their care, but also on the service as a whole
- Continuing (throughout and post therapy) feedback and dialogue about what is happening – not just an assessment form at entry to the service then another one at the end. You need to feel you are being listened to and valued as a human being. Not just tick box experience
- Patient Experience Data Intelligence Centre (PEDIC) (the SLaM system for analyzing user satisfaction questionnaires) is useful and important, and has been adapted and developed in the light of user feedback . It is one way to collect patient experience data.
- Need a variety of methods to collect feedback
- Need to consider how to get feedback from people who do not speak English
- Need to consider how to get feedback from people who do not finish therapy
- Carers & family members need to have opportunities to feedback about their experience of services
- Need more qualitative data to back up the statistics so we don't lose what real individuals are experiencing

Ideas and suggestions about patient experience:

- Use peer support groups to express experiences/feelings
- Services users call, return phone call. Other means of feedback – phone call, groups, questionnaire
- Idea of being asked after treatment & assessment – what it was like being able to feedback

PALS (Patient Advice & Liaison Service) & complaints:

- It is helpful to be able to discuss difficulties locally (with a team manager?) without making a formal complaint - *"Sometimes all I'm looking for is an apology when something has gone wrong – I don't want to be lumbered with a complicated complaints procedure."* *"PALS has been disappointing"*



Communications & Involvement

We propose that:

- The service user advisory group continues to support the development of the new services
- People with experience of using services participate in the steering group that leads the development of the new services
- People with experience of using services work alongside staff to develop a framework for understanding 'patient experience' and for exploring options around 'outcome measures'
- Each IPTT holds regular service user forums to explore themes raised in patient experience feedback

Comments about keeping people informed:

- Need for accurate, clear, honest communication & dialogue, being open about the parameters of scope for change or influence
- "Good to know in advance about the meeting on the 16th, better than the meeting in March."
- Information designed with service users & staff that people can understand
- Information disseminated through a variety of routes
- Continue to use other groups, organizations to get information out to the 'grass roots', BME communities etc.

"Our main concern as a group is that most of our members are isolated and don't receive any information about changes affecting their lives."

Ideas & Suggestions about keeping people informed

- Information about changes written from the perspective of a service user illustrating how things would change
- Use SLaM website to give updates
- Newsletter

Comments about Involvement

- Service users need to be involved and included 'along the way' of the consultation, outcome & implementation and on management bodies
- Groups need to have an 'equal playing field' not be SLaM staff dominated
- Service users want to be more involved in the developments of services – need to offer clear ways of how people can become involved
- "We need to promote grass roots involvement"
- Working Together (not us and them, but we)
- Continue work with LINKs
- "Need to listen, not talk at people" "Ideas around collaboration and consultation very well received". "It is a matter of record that several parties felt that this consultation had taken place without some due considerations. In particular, feedback from staff and LINKs recorded concerns at inadequate consultation with service users."

Communications & Involvement contd:

Suggestions/ideas about involvement –

- Broaden the MAP Clinical Academic Group Service User Advisory group – what it is and how we use it – to include wider stakeholders – or the advisory group could link to other groups
- Use the Trustwide Involvement Group to oversee and comment on consultations – getting together with other groups to agree a way forward - Trustwide Involvement Group needs a website
- Set up an advisory group with external stakeholders and service users to develop a framework for evaluating the success of the new service
- A group owned by the community to develop recommendations to give to an internal group, or a central body representing community organizations to discuss issues
- Offer better support to service users to attend steering groups
- Attend GP patient participation groups
- Use a variety of routes to get information/ feedback about proposed changes to services, having discussions locally, peers talking to each other, showing the actual comments that people make
- Get feedback & respond
- Share the learning about the involvement process across SLaM

“Comments & suggestions are fine – Action is the name of the game”



The Whole System

In addition to feedback about the proposed model, people gave their views and ideas about the whole system:

About commissioning:

- How much resource will go into commissioning & bidding? Do the right people have the right skills?
- Joint working / consortium projects need support of commissioners and a sustainability plan – learn from experience of consortium work in older adults. Market day for GP's to find out about services
- Commissioners could be creative 'spread the pot' not just purchase from the same areas
- "Don't forget the on-costs when commissioning services"
- Range of services, "need more social support & less talking therapy"
- "Need SLaM to see 3rd sector as partners not competition" " Looking to work with SLaM under contract, so can provide services free at the point of access"
 "We need to change how we work, costs, marketing to attract personal budgets"

Reduction in funding

- Concern about the impact of less funding—"It's a tough situation – there will be misery & casualties. Maybe invest more in prevention & counselling – this cuts costs in the long run & is more effective"
- Acknowledgement that due to lowering of budget this is very difficult.
- "Despite assurances that our group would continue and our therapy would not be disrupted our therapist has made a decision to leave SLAM and accept a job at another Trust. This obviously has big implications for our group who will spend the next months trying to come to terms with this and build up a relationship with a new therapist I fully back the concerns expressed by the St Thomas's team at the Lambeth scrutiny committee which I did attend. It would be no exaggeration to say that the therapy I have received has been life changing and I am deeply saddened that cuts to the service would unable others to benefit "
- "I would like to re-iterate my concern about losing the most experienced psychotherapy staff, in terms of retaining the honoraries who require high level supervision and also in terms of the reduction in highly qualified therapy hours available to clients. I strongly believe removing these lynch pins positions holding the structure together would degrade the entire service provision quality, rather than solely being a reduction in provision. Eg St. Thomases Psychotherapy Dept. uses their most experienced staff to assess referred clients.(psychological therapies service user) **IDEA:** Make cuts elsewhere – take money from IAPT services (?) to keep the higher level staffing - in order to aid recovery for those with deeper, more complex mental health needs and thus avoid increased costs from the fall out of not adequately providing for these needs."
- "What evidence is available to demonstrate that IAPT and similar interventions are reducing demand for the psychological therapy services this proposal is considering? "

Response & Next Steps

Communications & Involvement

The feedback about communications & involvement received prior to and at the event on 16th May was reviewed by:

- *The Mood Anxiety & Personality Clinical Academic Group Service User Advisory Group*
- *The Psychological Therapy Services Reconfiguration Communications & Involvement Working Group* (Membership of this group included the local LINKs, members of the service user advisory group and SLAM staff)

From these discussions, the following recommendations were developed :

- 1) *Time is set aside, in forums overseeing the implementation of the project to review the feedback generated in the recent involvement activity alongside feedback received in preceding months. Discussion about the feedback is documented and changes to the proposals as a result of feedback are identified and communicated to stakeholders.*
- 2) *The implementation plan that is developed includes opportunities for small time limited group work that includes people with experience of using services and where appropriate other stakeholders to inform the detail of the new service. This group work may also include specific topics discussed in existing user forums rather than people coming to SLAM working groups.*
- 3) *The implementation board develops a workplan with a timescale that means that stakeholders can be included*
- 4) *The Mood Anxiety & Personality Clinical Academic Group Service User Advisory Group representatives should sit on the project implementation board and will ensure that the advisory group is kept informed and involved in the work. The advisory group will develop user-friendly briefings which will be disseminated widely to user/carer groups, LINKs & other interested bodies*
- 5) *A working group is set up (to include LINKs, advisory group members, service users with experience of psychological therapy services and staff in psychological therapy services) to develop a framework for measuring outcomes of the new service to include activity, patient experience, clinical outcomes & patient reported outcomes*
- 6) *Lessons learned from the involvement in this service reconfiguration is shared within the Trust*
- 7) *A report detailing the recent involvement activity, is disseminated widely to those who participated in recent involvement, local organisations/ LINKs & on Trust website & service user blog.*

On June 16th, these recommendations were discussed and agreed at the strategic group responsible for overseeing the changes—the Project Implementation Board. Membership of this board includes senior clinical and management staff and representatives from the MAP CAG service user advisory group.

Integrating feedback & suggestions into the plans

'The initial proposal was developed using themes that service users had raised in previous work on care pathways. The basic premise of the model is to reduce assessments and to offer a less complicated journey into and through psychological therapy services. Service users felt very strongly about these two things. For this reason, it is not surprising that service user and wider stakeholder feedback has on the whole been supportive of the borough based integrated service and we have therefore not made any major changes to the overall model. However, a lot of the suggestions relate to 'how' rather than 'what', and there were good ideas about the approach we should take:- how we communicate, how we engage and inform people and how we work collaboratively were strong themes from the recent work'

Steve Davidson—Service Director

'The feedback we have received has definitely influenced our thinking - for example we understood from the feedback how much people valued the existing range of evidence based therapies but acknowledged the need to include a wider range of psychological approaches for people who have high levels of need but for whom long term therapy is not necessarily helpful. We also heard that some people did not get referred to psychological therapy until after long periods of care from community mental health teams, for reasons that were not clear to them; we need to take a much more systematic approach to considering the full range of treatment options as soon as possible after people have come into contact with mental health services.'

Dr Jonathan Bindman—Clinical Director

Working with the feedback—The Project Implementation Board

All feedback/comments/suggestions as documented in this report, have been circulated & read by members of the *Project Implementation Board*. The board noted the breadth, detail and quality of the feedback. It also noted that whilst there were some themes, some of the feedback was contradictory or there were good reasons why suggestions could not be taken forward. The following was agreed:

- to integrate appropriate ideas and suggestions into the detailed plans as they were developed over the coming months.
- to be clear to stakeholders that the service would have to take a view on whether and how to integrate suggestions into the service.
- to identify areas which have been informed by the recent involvement activity and to communicate this to stakeholders
- to produce and disseminate widely a report about the recent involvement activity

Working with the feedback—making plans a reality

The Project Implementation Board, supported by an Operational Group will build on the feedback & ideas to develop a 'service specification'. When agreed with the commissioners, this will outline the level and type of activity that the new borough based services will provide.

As agreed at the Project Implementation Board a draft service specification has been developed and circulated to staff in the new borough teams for consideration. Ideas and suggestions from the feedback have been incorporated as appropriate into this document and all the feedback has been made available for the new teams to see.

Working with the feedback— considering specific themes

Specific sections of the feedback have already been digested and reviewed by existing groups for example:

- Feedback & ideas focussing on communications & involvement were reviewed by the *The Mood Anxiety & Personality Clinical Academic Group Service User Advisory Group* and the *The Psychological Therapy Services Reconfiguration Communications & Involvement Working Group*). From this the recommendations adopted by the *Project Implementation Board* were developed.
- Feedback and ideas focusing on peer support, has been circulated to a *Trustwide Peer Support Working Group* for consideration

We anticipate that as specific work is done on particular aspects of the pathway, for example, assessment or referral, the detailed feedback will be re-visited.



Opportunities for involvement as the plans develop

At the second meeting of the *Project Implementation Board*, the recommendations on communications & involvement were agreed and the following actions identified:

- wider stakeholder involvement will be considered in all workstreams.
- to develop a small working group which will develop an evaluation framework for the new services—to include outcomes, patient experience, levels of activity etc. Membership of this group will include people with experience of using & providing psychological therapies as well representatives from local LINKs.
- where wider or extended involvement is not practical due to unavoidable timescales, SLaM will be open about this

It was noted that a number of individuals have expressed interest in being involved, and that the service user advisory group will continue to support the process.

Representatives from the service user advisory group who attended the Steering Group in March & April are now members of the *Project Implementation Board* and the Operational Group. They report back to the Service User Advisory Group which has now begun to produce a monthly briefing sheet which has been widely disseminated.

The reconfiguration of psychological therapies services is a regular agenda item at the monthly service user advisory group meetings and updates are given by the representatives.

This report will be disseminated to those who have participated in the work and within wider networks.

Involvement Action Plan

Objective	Actions	Time frame
Keep people informed and updated about progress	<ul style="list-style-type: none"> • Produce and disseminate report about involvement • Produce and disseminate briefings from service users advisory group • Identify areas where feedback has influenced, informed or changed plans & feedback to stakeholders • Attend meeting at Lambeth/other LINKs as agreed at March Meeting 	<p><i>June/July 2012</i></p> <p><i>Monthly from May 2012</i></p> <p><i>August 2012</i></p> <p><i>September/October 2012</i></p>
Ensure stakeholders are involved in small working groups as appropriate	<ul style="list-style-type: none"> • Contact people who have expressed interest in further involvement to discuss particular areas of interest • From the developing operational plan, identify areas for future or continued involvement 	<p><i>June/July 2012</i></p> <p><i>July 2012</i></p>
Develop framework for measuring outcomes and patient experience	<ul style="list-style-type: none"> • Set up small working group to include people with experience of using and delivering services as well as representatives from local LINKs 	<p><i>July—September 2012</i></p>
Obtain more detail about how the service can be more accessible for BME communities	<ul style="list-style-type: none"> • From existing feedback produce ideas to discuss in small service user-led focus groups in bme organisations 	<p><i>July—September 2012</i></p>
New teams up and running		<p><i>September 2012</i></p>
To give people systematic opportunities for involvement & feedback	<ul style="list-style-type: none"> • Each IPTT to establish service user forum for people using the service to give feedback & be involved in service improvements • Offer systematic opportunities for service users to feedback on patient experience via questionnaires 	<p><i>Quarterly from December 2012</i></p> <p><i>Ongoing from November 2012</i></p>

Lessons learned from the involvement process:

The Psychological Therapy Services Reconfiguration Communications & Involvement working group reviewed the involvement activity and the following learning points were identified:

- To involve service users at all stages of planned changes
- To plan well in advance for service change to enable meaningful involvement to be undertaken
- To be clear about the parameters of the involvement – what is given, what can be changed and what cannot. Where there are restraints – be honest.
- To ensure that the advisory group is supported & informed enough to co-lead the involvement process.
- To undertake a range of involvement activities – small focus groups, large wider stakeholder groups, working with user/carer organisations
- To provide information in a range of ways eg: verbal, written & with varied detail according to need
- To demonstrate and communicate changes made as a result of involvement/feedback

These lessons will be highlighted through Trust Patient & Public Involvement Networks

Final Thoughts....

"It is great that service users are fully involved in the review and implementation of the proposals with senior management and that their voice is heard at all levels within the MAP CAG"

Graham Hadley Mood Anxiety & Personality Service User Advisory Group

"The stake holder consultation has provided the MAP CAG executive with excellent information and ideas which will inform the development of the service specification. As the reconfiguration develops there will be opportunities to broaden the scope and range of user involvement. Thank you all for making such a valuable contribution to the improvement of the services the MAP CAG provide."

Carmine De Rosa Mood Anxiety & Personality Service User Advisory Group

"This process has not only strengthened the relationship between the senior management team and the service user advisory group, but has also given us opportunities to engage a much wider range of people in the development of the new services. I believe that the quality of the new Integrated Psychological Therapies Teams will be better for it."

Alice Glover—Patient & Public Involvement Lead—Mood, Anxiety & Personality Clinical Academic Group

Contact Information

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**HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP
SCRUTINY SUB-COMMITTEE**

MUNICIPAL YEAR 2012-13

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Jo Kent, SLAM, Locality Manager, SLaM	1	Total:	
Marian Ridley, Guy's & St Thomas' NHS FT	1	51	
Professor Sir George Alberti, Chair, KCH Hospital NHS Trust	1	Dated: July 2012	
Phil Boorman, Stakeholder Relations Manager, KCH	1		
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