Open Agenda

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

Wednesday 1 May 2013
7.00 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

List of Contents

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Date: 29 April 2013

Agenda Item 4 Open Agenda

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

MINUTES of the OPEN section of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Monday 25 March 2013 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Mark Williams (Chair)
Councillor David Noakes
Councillor Norma Gibbes
Councillor Rebecca Lury
Councillor Eliza Mann
Councillor The Right Revd Emmanuel Oyewole
Councillor Mitchell

OTHER MEMBERS PRESENT:

OFFICER SUPPORT: Julie Timbrell, Scrutiny Project Manager

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Capstick; Councillor Mitchell attended as a substitute. Councillors Gibbes and Mitchell gave apologies for lateness.

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

2.1 The chair stated that although this item has not been deemed urgent, he has been alerted to reports in the media that King's College Hospital has performed liver transplants on 19 patents from the European Union and other countries, and concerns have been raised that patients might have been given organs that could have gone to British NHS recipients. The chair commented that it is very worrying if there has been queue jumping. The chair indicated that he would ask questions of delegates from King's later on in the meeting.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The chair explained that the minutes of the meeting held on 6 March are not ready as there had been an unusually short gap between meetings; these will be circulated with the 1 May agenda pack.

4.2 An amendment to the minutes of the committee meeting held on 31 January was tabled. This was for the item on 'Health Services in Dulwich' discussion. A member of the public had requested that the record be corrected.

RESOLVED

It was agreed to amend the record by inserting in the second paragraph the following text:

'The chair asked whether other suggestions can be made beyond the two options outlined in the consultation document. Andrew Bland said that other options can be considered as long as they meet the case for change. He did not claim that the CCG has a monopoly on good ideas. '

5. HEALTH SERVICES IN DULWICH

5.1 The chair noted the consultation documents on Health Services in Dulwich, as well as the thorough list of organisations to be consulted with. Representatives from the Southwark Clinical Commissioning Group (CCG) introduced themselves : Rebecca Scott, Programme Director- Dulwich ; Andrew Bland , Managing Director CCG; Robert Park - non executive director, PCT, and shortly to be a lay member of the CCG, as from the 1st April. The team distributed printed colour versions of the brochure of the consultation plan(as in the agenda pack).

5.2 The Programme Director said that amendments to the consultation plan have been done following suggestions received at the January meeting, and the consultation plan is on the website, as agreed. She explained that a marketing company it targeting 300 outlets. In addition to this there has been a direct mail to 800 organisations, and many of these are being following up, if it is indicated that they serve particularly important groups, such as communities that are more excluded.

5.3 The programme is targeting three important groups: those that need short term interventions, women who are pregnant and families and people with long term health conditions. The consultation document provides a table of things the CCG want to see provided, but this will not be all in one place. The Programme Director explained that there are two main options: Option A is more centralized with back up from GP practices; Option B devolves more services to larger GP practices. She explained that if Option B is followed the CCG would want to increase equality of access. The Programme Director ended by saying the CCG think these options will work well, but if people have other ideas we want to hear them.

5.4 A member asked how people could suggest other options and the Programme Director explained that if people make suggestions at events this will be an opportunity to explore issues; for example transport. The Managing Director added that there is a case for change as the CCG is spending too much. He explained as long as people make suggestions that fit within the needs of spend, clinical safety then they can be considered. The commissioners emphasised that points made during the consultation need to reflect the needs of the whole population.

5.5 .A member complemented the consultation document by noting how easy and clear it was to read. He said it was one of the best he had seen. He queried if there was an existing bias, and noted that Option B has more ticked boxes. The Managing Director clarified that numerical detail does not add weighting and that both are deliverable ; there is no preferred view.

5.6 A member asked if the blood taking (phlebotomy) service was an efficient use of resources at Dulwich Hospital and the officer responded it was used at full capacity. The chair asked for detailed figures. The Managing Director commented that members are right to raise the issue of efficiency of services like this and that some practices supplying phlebotomy services struggled to break even. A member commented the aim is surely to lure people away from hospitals and queried if efficiency is the most important question? The commissioners agreed that they are trying to encourage people to use community settings, but efficient use of resources is a key issue. A member said in his view the Dulwich Hospital is the most viable site, however he though that we need to get community buy in.

5.7 A member asked if the site will be owned by the new the NHS Prop co [NHS Property Services Ltd]. The Managing Director confirmed they would in April.

5.8 A member commented that a majority of his constituents are very happy with devolved services, as the Acute Hospital can have very long waits. A member asked why the consultation document plays down Dulwich

Hospital's already central role, and asked why the CCG are not clearer about the services presently being delivered there. He noted page 43 mentions Dulwich Hospital, but the list does not mention Dulwich Hospital under 'Health Centre' on page 44. The Programme Director said the CCG do make clear that this is the only viable place for the Health Centre. A member asked if the CCG can make that clearer in the future? The Managing Director agreed, with the small caveat that if a site search later revealed another site then the CCG would consider that; but he said that this is very unlikely.

5.9 A member asked if there is a risk that the NHS Prop co could dispose of the site? The Managing Director responded that this is very unlikely as the CCG have existing services there, and in any event would this would be subject to consultation with scrutiny and others. A member raised the risk that a 'nasty capitalist controller organisation' could get hold of this data and see that there was no mention of Dulwich Hospital , and then use the efficiency argument to look at other sites . The Programme Director said given that Dulwich Hospital sits right in the middle of Dulwich a better location is very unlikely. The lay member added that he is local, with connections, and given the importance of the site to the community this would be resisted.

5.10 Members asked about the cost implications of investing in bricks and mortar. The Managing Director explained that a Health Centre would cost slightly more – but the CCG can do both options. A member asked if people will still need to go to King's, for test such as scans? The Managing Director responded that there will still be some things that are too expensive to be devolved at local level, such as complex procedures or expensive machines.

5.11 A member asked about the coordinating of services, for example older people are often being cared for by other older people. She voiced concerns about the level of coordination. The Managing Director commented that there is an integrated pathway for frail and elderly people. He acknowledged that it does need development, but emphasized its existence. Members asked if this can be monitored. The Managing Director noted that this consultation will not cover everything and that the CCG do need to think about skills and workforce redesign. The member responded that this is a new development and care in the community requires enormous time and resources from friends and families. She asked where the CCG would find additional resources and reported that people are feeling the impact of community care.

5.12 A member commented that her GP practice (Paxton Green) was one of the last to reorganize and now she now finds it very inaccessible. She reported that it used to be possible to easily get an early appointment. The Managing Director responded that this surgery is in Lambeth and GPs are

commissioned by NHS Commissioning, rather than the CCG. He said that the CCG do however collect comments and can influence the delivery of GP practices.

5.13 The chair commented that at the start of the New Year he does want to do a review of GPs. He reported that he too has received complaints from constituents, both of GPs and also the patient complaint process. Another member supported this and commented that he used to be able to get an appointment on the same day, and now you can wait 8 to 9 days.

5.14 A local resident, Elizabeth Rylance Watson, commented that there are no flyers about the Dulwich consultation on the ground. She reported that she did receive the consultation plan at a consultation event, but received no follow up information. She added that there is nothing on the notice board outside the Dulwich Hospital, or on the door of the closed library. She also reported that she went to the well attended Southwark Pensioners Forum and they raised concerns about the consultation period of three months.

5.15 Another resident, Kenneth Hoole, commented that he thought the plan was a propagandist document and not an outcome of an open consultation. He described the document as photographic and typographical bling: produced by Saatchi and Saatchi. He said that the proposals were hand me downs from the old PCT, and said that there is an existing pairing between a practice and the proposed option of a Health Centre at Dulwich. He mentioned a private meeting that he was concerned about. He said that the plan makes no mention of respite care, and there is little about mental health. He said that there were flaws and gaps in the consultation plan, and he viewed this as deliberate, and that the plan was following a managerial agenda. He ended by saying he considered the slot at the end for alternative views could not remedy the emphasis on monopoly views.

5.16 The Managing Director said he would provide a response in writing to the committee on these points and reported that the CCG have already responded to many of the points already. Chair asked Kenneth Hoole to provide a written copy of his presentation, which he agreed to do, after making any amendments that could lead to litigation.

RESOLVED

Southwark Clinical Commissioning Group agreed to provide an update on:

- The numbers of people using the Dulwich Hospital phlebotomy service, with a brief comment its capacity and efficiency.

- An update on the integrated pathway for frail and elderly people, with a

particular comment on coordination of care and support for carers.

6. TRUST SPECIAL ADMINISTRATOR (TSA) RECOMMENDATIONS

6.1 The chair welcomed King's Medical Director, Mike Marrinan and Director of Strategy, Jacob West. They opened their presentation by commenting that the TSA made the recommendation for King's College Hospital Trust to acquire the PRUH. The Medical Director explained that there are no major plans to change the delivery of services at King's College Hospital as a result of this, although they are hoping to decompress some activity. He emphasised that there are not any plans to bus patients around.

6.2 The Medical Director said that this is predicated on the restructure of South East London healthcare services, which was initiated by the bankruptcy of South London Healthcare Trust (SLHT) and subsequent appointment of the TSA, however restructuring is going on throughout the country of health care. He explained the new model emerging is for larger Acute Hospitals with Accident and Emergency wards, District General Hospitals and Local Hospitals. He said this will lead to a dramatic increase in consultant delivered care, and said that there is clear evidence that the earlier you see a consultant the better the outcome. He commented that the notion that everything can be done in a local hospital is just not true: however Southwark residents are lucky as they are close to two large Acute Hospitals He added that there may be some travelled involved for elective care, and reported this is still under negotiation with the Department of Health.

6.3 A member asked if the Department of Health had supplied enough money for the proposed changes. The Directors reported that this has not been agreed yet, which they said is frustrating and problematic. They added everything is on the assumption that King's receive enough money. The Medical Director commented that King's have made proposals, however the Department of Health think it should be much less.

6.4 The chair asked what King's would do if there is not enough money. The Directors said they can give the committee an assurance that the plans will not be taken forward without adequate funds. They explained that the financial risk rating for King's College Hospital Trust is three, and they do not want to be downgraded. He ended by saying that they have given the Department of Health a detailed apprised is what is needed, which is not greedy, but what they need. He ended by saying they will not do it unless it is doable, however King's think the gap is bridgeable.

6.5 A member commented on the quality of consultants and the extent of their treatment of private patients .The Medical Director explained that consultants have set contracts of time with the NHS. He added that Kings have the highest productivity of consultants, while South London Healthcare Trust had the lowest. He said this is predicated by the assumption of giving good care and high aspirations.

6.6 A member asked about the board and the Medical Director commented that there were many good people at SLHT, but an impossible structure. He added that he is sure medical care can be brought up in short space of time. He said that King's have great human capital in our consultants which gives strengths and depth. A member asked who would be lost and the Directors explained that because King's senior managers will be in charge this means some senior manager will go at the PRUH, however some may be integrated. He emphasised that most clinicians will remain, but some senior nurses and many senior administrators will be lost. The Medical Director said that staff reassurance is an important part of the process as this has been a difficult time.

6.7 A member asked about the decompression of King's College Hospital and the Medical Director said that Neurology will be decompressed - so we can increase neurosurgery.

6.8 A member noted that the Medical Director reported that there would be no travel for acute care out of the borough, however what about Elective Care? He responded that the model of elective care is not fully worked out. He said that King's do have anxieties about the profitably and Guys and St Thomas do too. He explained that Elective Care is the part that makes money and subsidises other care. A member commented a very cynical interpretation would be that this is an attempt to bankrupt of other parts of the health service.

6.9 A member asked about patient records at PRUH and the Medical Director said that this is a key issue, because delivering on these could cost around 20 million: PRUH have no WiFi, or existing electronic records. A member asked if all record would be converted he responded that the emphasis will be in new records being digitalised.

6.10 The Medial Director said that King's have a vision of two sites but the same Trust. He said that there will need to be an investment and it will take time. He commented that Kings' have good systems that will help; however these are also subject to improvement. He explained that it is never easy for a District General Hospital to compete with an Acute Hospital and he said that the bringing together of an Acute Hospital with a General Hospital in one Trust will be helpful.

6.11 A member asked what King's is doing to reassure staff and the community The Strategy Director emphasised strong communication, and noted that PRUH and King's College Hospital are both jammed from the long and unprecedented winter.

6.12 The chair then asked the Medical Director about the liver transplant service and how people were able to access NHS livers as private patients. He explained that this is mostly because the livers are marginal and of poor quality, but very occasionally of good quality but there is no NHS match.

6.13 The chair said he had concerns about the tariff not being released under FOI. The Medical Director explained that the only fee is to the surgeon, anaesthetist, and a payment to use the hospital. The Medical Director commented that this is a highly regulated service and indicated that he would like to come back to the next meeting with a fuller report.

RESOLVED

The committee requested that King's College Hospital keep the committee apprised of its negotiations with the Department of Health.

7. HOSPITAL LOCAL ACCOUNTS

7.1 Zoe Reed, SLaM Strategic Director, presented the draft quality account and explained that the top priorities were paying attention to physical health and reducing violence. She said that the Quality Accounts will be finalised in May, and that they are narrowing down priorities. A member referred to the information on complaints and noted the high level of the Psychosis CAG complaints and enquired what 'local resolution' meant. The Strategic Director said that this CAG has a very high level of activity so the level of complaints may well be proportionate and offered to provide some vignettes on how complaints were resolved locally.

7.2 Debbie Parker, Deputy Chief Nurse and Elizabeth Palmer, Acting Director of Assurance presented the papers from Guys and St Thomas's on the Quality Account, complaints and pressure ulcers. It was noted that the final Quality Account with data will be completed in May. A member asked about the 19 pressure ulcers acquired in the community and asked who looks after these patients, and if this would be the CCG. The Deputy Chief Nurse explained that when community acquired sores are picked up the hospital liaises with the organisations and may make a Safeguarding alert. Dr Zeineldine, Chair of the CCG, agreed that these were looked at to ensure that have the CCG have data and non attributable cases are highlighted. He said that the CCG have community teams looking at tissue viability and prevention. The chair

requested some follow up action on this by all concerned, particularly focussing on action taken following the identification of a pressure sore and what would lead to a safeguarding alert.

7.3 The chair noted that one of the complaints was about a fracture that had been missed on an x-ray. He asked how that this would be dealt with, of if a tumour was missed on a scan. The Director of Assurance said if there is reason to think there is a competence issue then this would be followed up, however she explained that sometimes these are to do with A & E fractures in children , which can very difficult to observe. She added that the hospital constantly look for patterns and trends.

7.4 The King's Medical Director presented the Quality Accounts report for King's College Hospital. He referred to the report and noted the Trusts achievements last year. He explained that King's did not achieve a target on diabetes; however action on this has now been mandated as a patient safety issue.

7.5 A member asked the Medical Director to explain 'ward ware'. He responded that this is part of the national early warning system. The nurse at the bed enters data into an iPod like device and which then gets electronically recorded. In an ideal world any untoward patent data would initiate an alert that would trigger a clinical response that would change the physiology of the patient. He explained that King's are developing the software. A member asked if the Trust will retain the intellectual software. He said in this case the project is being done with an outside private developer: but with lots of testing inside the hospital. He was then asked if the Trust keep software propriety in the NHS, and he said that is the general principle, but in this case the software is privately developed.

7.6 A member noted that there is an upward trend in complaints. The Medical Director agreed that there is an upward trend, and explained this is because King's are seeing an increase in activity. He explained that several years ago complaints were in the 1000's; much higher than now. He added that the Trust do look at hospital complaints data , which inpatients tend to use, and intelligence from PALs , which gets more information from outpatients. He commented that the Trust looks at complaints for trends and problems and noted that the Frances report is focusing our minds on this.

7.7 The chair noted that the recent Southwark Vulnerable Adult Safeguarding report indicated that there had been no Safeguarding alerts from any of the local Trusts and asked why this was so. Hospital Trust representatives commented that this might indicate a lack of a comprehensive link up and promised to look into this.

RESOLVED

SLaM will provide:

- Clarity on if the level of complaints received by the Psychosis CAG is proportionate to the level of activity.

- Some vignettes on how complaints were resolved through 'local resolution'.

Guys and St Thomas's and Kings College Hospital

Will provide more information on the community acquired pressure sores and explain the follow up action taken; including any referral to Safeguarding, and/or Clinical Commissioning Group and work done to liaise with community providers & organisations.

Guys and St Thomas, Kings College Hospital and SlaM

Hospital Foundation Trusts were asked to comment on why no safeguarding alerts were recorded being made to Southwark's Vulnerable Adult Safeguarding partnership board report 2011-12

8. SOUTHWARK CLINICAL COMMISSIONING GROUP

8.1 The chair invited the Managing Director of the Southwark CCG, Andrew Bland, and chair of the CCG, Dr Amr Zeineldine, to update on the move to delegated authority. The CCG representatives explained that in October of this year the CCG completed an authorization test. There were119 tests, that covered a range of areas including governance, audits, and the ability to commission health care effectively.

8.2 The Managing Director explained that this involved a process working with an external advisor. The CCG have been advised to do further work on the safeguarding plan, which is still draft, and the budget plans. He explained the budget had been delayed because of the impact of the TSA. He reported that the Safeguarding policy is now complete and the authorizing body is happy with financial plans.

8.3 The CCG representative explained that the CCG will be graded form 1 to 7. He said that 7 is the poorest grade and they expect to get around a grade 3, which will mean that the CCG is authorized with conditions.

8.4 Member asked if the TSA had also impacted on Lewisham and Lambeth

CCG budget plans, however the Managing Director said that Lambeth and Lewisham not deemed to have the same ambiguities around the TSA. He commented that the CCGs do not have the same team assessing us, but said the Southwark CCG is not seeking to dispute this as do consider this a not a good use of time, but we do think we have been treated fairly. He explained that there are stages and moderation to the assessment

8.5 The Chair commented that he understood that Lewisham have anxieties to the extent that they are wondering what is the point of having a CCG. The chair of the CCG said this is a result of being a membership organisation. The Managing Director said that the Southward CCG have a council of members that allows a layer of accountability with an independent chair. He added that the CCG is an active member of the Health and Wellbeing Board and in terms of going forward the CCGs are similar in many ways, but also different in some ways.

8.6 A member asked about the minutes and the Managing Director said that the CCG have been moving to produce these in two weeks, taking these with increased diligence, and they have also been taking amendments, just as this committee agreed tonight.

8.7 The Managing Director reported that they are will be publishing the register of interests on an annual basis and the chair requested to received this every May.

8.8 The Managing Director explained about third of decisions, around four a month, is going to a conflicts of interest panel.

8.9 There was a discussion about the recommendation that a clause is added to all contracts stipulating that providers will be subject to scrutiny and the Managing Director explained that national standard contacts come with are set with clauses , which are only subject to minor variation, however the CCG can add to local contacts.

8.10 The Managing Director referred to the recommendation for financial penalties and explained that the national contracts come with a variety of rewards and a plethora of penalties, but may not meet the area we or you want, and can vary. He then offered to provide a written summary.

8.11 The CCG were then asked about governance managing conflicts of interest. Managing Director said that there is guidance, but this is not compulsory. He explained that the CCG have to have a policy about this but there is no national standard. A member commented that this part of the Localism agenda. The chair of the CCG report that there is an assurance process, which the CCG have passed, and that there were some stipulations. He added that they would expect more uniformity among CCGs as clinical

commissioning develops. The Managing Director added that Southwark CCG did paid for advice from the Good Governance Institute, and the CCG chair said that the Southwark policy has influence the south east London cluster of CCGs.

RESOLVED

The CCG will provide the committee with members' 'Register of Interests' on an annual basis, at the May meeting.

Southwark Council's overview & scrutiny and legal team will provide the CCG with the specimen clause currently used by the council in contracts to ensue that all providers are subject to scrutiny, where possible.

9. WORK PLAN

9.1 The chair reported that he recently attended an initial meeting with Zoe Reed about the health inequalities / public health review on the prevalence of Psychosis among the BME population.

9.2 The chair indicated his intention to hold a review of access into GPS services. A resident asked if it would be possible to look at the 'out of hours services' and the chair responded positively. Another resident reported that she understands that SELDOC will continue as a cooperative, according to Southwark Pensioners Forum, and she intends to clarify this. A member noted that there will be a roll out of the 111 service and suggested that this be reviewed by the committee.

RESOLVED

Kings Health Partners will be asked for an update on the development of the full business case for the proposed merger.

CCG will be asked to present on the integrated pathway for frail and elderly people, and to provide their members' 'Register of Interests'.

It was proposed the new committee undertake the following in the next municipal year:

- A review of General Practitioners, which will consider access to appointments at surgeries, the Out of Hours service and the new 111 service.

- Receive reports at the inaugural meeting from the CCG, the Health & Well-being Board and the new Healthwatch.

A STATEMENT AND COMMENTS RELATED TO ITEM 5 ON THE AGENDA AS PRESENTED IN PART AT THE HEALTH AND CARE SCRUTINY COMMITTEE MEETING 7PM TOOLEY STREET 35TH MARCH 2013 SUBMITTED IN FULLER FORM RETROSPECTIVELY BY INVITATION FROM THE CHAIR.

WHEN MEMBERS OF THIS COMMITTEE COME TO THE CONSULTATION DOCUMENT UNDER ITEM 5, I BEG YOU TO BE AWARE THAT YOU ARE ABOUT TO BE USED TO GIVE CREDENCE TO WHAT IF IT WERE PUBLISHED BY A BUSINESS CONCERN WOULD BE IN DANGER OF FALLING UNDER THE HEADING OF A FALSE PROSPECTUS.

THE OUTRAGEOUSLY EXPENSIVE, PROPAGANDIST, WELL- PADDED DOCUMENT BEFORE YOU IS NOT WHAT IT PURPORTS TO BE . IT IS NOT REALLY THE OUTCOME OF AN OPEN AND TRANSPARENT ENGAGEMENT EXERCISE WITH THE COMMUNITY.

THE FLAWED ENGAGEMENT DOCUMENT HAS LED TO A FLAWED CONSULTATION DOCUMENT.

FOR EXAMPLE: IN THE ENGAGEMENT DOCUMENT, THE TWO LIMITED PROPOSALS ON OFFER FOR OUR FUTURE HEALTH AND CARE SERVICES ARE LITTLE MORE THAN MODEST MODIFICATIONS OF PROPOSALS, LONG SHELVED BY THE PRIMARY CARE TRUST. THE PROPOSALS ARE **REACH-ME-DOWNS , MANIFESTING AN UNBELIEVABLE CO-INCIDENCE OF COMPONENTS OLD AND CURRENT PROPOSALS.**

THE MOVE OF GP PRACTICES ONTO THE SITE IS ONE DOCUMENTED PREVIOUSLY; WITH ONE PRACTICE NAMED DIRECTLY ON ARCHITECTS PLANS DRAWN UP UNDER BRIEF FROM THE SPCT, (DR SHAMA'S PRACTICE). AND ANOTHER THAT HAS TO BE THE MELBOURNE GROVE PRACTICE WHICH HAS BEEN REPEATEDLY REFERRED TO IN TERMS OF THE INTENTIONS TO MOVE IT ONTO THE SITE.

SURELY THIS PAIRING IS A CO-INCIDENCE TOO FAR, FAR TOO FAR TO JUSTIFY ANY CLAIM THAT WHAT IS BEING OFFERED AT THE BASE OF THE TWO OPTIONS REPRESENTS WHAT THE PEOPLE HAVE LONG AND REPEATEDLY ASKED FOR.

AMONG OTHER SIGNIFICANT FLAWS THE ENGAGEMENT DOCUMENT MADE **NO MENTION OF THE COMMUNITY HOSPITAL** AND **NO MENTION OF RESPITE CARE. MENTAL HEALTH GOT ONLY A COUPLE OF WORDS**. SO IT CAN BE SHOWN THAT THE ENGAGEMENT DOCUMENT WAS DEEPLY FLAWED BY GAPS LEFT THERE BY DELIBERATE INTENT.

HENCE; THE FLAWED CONSULTATIVE DOCUMENT BEFORE YOU.

I WAS NOT ALONE IN POINTING OUT THE FLAWS AS FAR BACK AS MAY OF LAST YEAR. IMPORTANT POINTS RAISED IN MY LETTER TO THE PROJECT IN MAY LAST YEAR WERE IGNORED AND THE ENGAGEMENT CONTINUED WITH THE FLAWS AND GAPS LEFT IN PLACE.

THE RESULT OF THE COMMUNITY HOSPITAL BEING LEFT OUT HAS BEEN THE OPPORTUNITY FOR THE SCCC AND ITS PROJECT BOARD TO BOAST IN WRITING THAT (I QUOTE) 'ONLY A FEW' WROTE-IN THE NEED FOR HOSPITAL SERVICES.

MOST OF US WHEN FILLING IN FORMS DO NOT AND ARE NOT EXPECTED TO AMEND THE STRUCTURED CONTENT OF A FORM IN FRONT OF US ; CERTAINLY NOT **A FORM DECORATED WITH SO MUCH TYPOGRAPHICAL AND PHOTOGRAPHICAL BLING.**

SO NO NASTY SURPRISE THERE FOR ANYONE WITH A VESTED INTEREST IN THE TWO PROPOSED OPTIONS.

THE AUTHORS OF THE ENGAGEMENT DOCUMENT SAW TO THAT.

EVEN THE REPORT OF THE PUBLIC MEETING OF JULY WAS DEEPLY FLAWED. COMPLAINTS ABOUT WHICH AND ABOUT OTHER MATTERS HAVE BEEN AWAITING WEEKS FOR A RESPONSE. I AM GIVEN TO UNDERSTAND THAT I WILL GET ONE IN APRIL. TOO LATE TO HAVE ANY LOCAL IMPACT, OF COURSE; THOUGH IN ANOTHER FORUM WHO KNOWS ?

WITHOUT SO MUCH AS AN EXCUSE BEING OFFERED, THE LONG PROMISED PRIMARY CARE CENTRE WITHIN A FLAGSHIP COMMUNITY HOSPITAL, HAS BEEN REMOVED FROM THE FUTURE **PLANNED FOR US *NOT* WITH US.** OUR COMMUNITY HOSPITAL WAS NOT REMOVED FROM THE OPTIONS BY THE PEOPLE. THE HEALTH AUTHORITY HAS REMOVED IT AS PART OF SOME MANAGERIAL POLICY AND MANAGED AGENDA.

IN RESPECT OF POLICY YOU SHOULD RECALL THAT DULWICH COMMUNITY COUNCILLORS AGREED A MOTION REGRETTING A PREVIOUS NEGLECT OF THE PROPOSAL TO CREATE THE PROMISED COMMUNITY HOSPITAL. UNTIL OR UNLESS THAT AGREED MOTION IS FORMALLY SET ASIDE THIS COMMITTEE MUST HAVE FULL REGARD TO IT AS AN EXPRESSION OF THE WISHES OF THE PEOPLE OF THE DULWICH COMMUNITY AREA. PRIVATE UNDERSTANDINGS THAT MAY OR MAY NOT HAVE BEEN AGREED SINCE THEN BETWEEN THE SCCG AND ITS PROJECT BOARD AND DULWICH COUNCILLORS AT A PRIVATE MEETING THAT **DID** TAKE PLACE CANNOT OVERTURN THAT AGREED MOTION HOWEVER STEALTHILY IT IS BEING DONE.

THE CONSEQUENCES OF ANY UNCRITICAL RECEIPT OF THE CONSULTATION DOCUMENT WILL BE THE WIDENING OF AN UNACCEPTABLE GAP BETWEEN THE ACUTE HOSPITALS AND GP PRACTICES. CONDONING THE ABANDONMENT OF OUR COMMUNITY HOSPITAL WILL ALSO OPEN THE DOOR TO PRIVATE HEALTH SERVICES BEING ON OFFER ON OUR LAND WITHIN A CONTEXT OF COMMERCIAL AMBITION BOLSTERED BY SOME NHS CONTRACTS.

THE PROJECT IN EFFECT ADMITTED IN THE ENGAGEMENT DOCUMENT THAT IT WAS GOING TO PURSUE A POLICY FOR SERVICES BASED ON PROMOTING HOME TREATMENT OR CARE IN THE HOME OR IN THE COMMUNITY OR WHATEVER THE CURRENT TERM IS THIS WEEK THAT IS A WRONG HEADED, **UNCOSTED POLICY**, WHICH IS NOW ARROGANTLY FLAUNTED THROUGH THE CONSULTATION DOCUMENT NOTWITHSTANDING THE TWO OPTIONS FOR A MODEST POSSIBLE DEVELOPMENT OF A HEALTH FACILITY ON OUR LAND.

IN THEIR VIEW, ADOPTING SUCH A POLICY REMOVES THE NEED FOR ANY LEVEL OF HOSPITAL PROVISION OUTSIDE THE ACUTE HOSPITALS. BUT THAT IGNORES THE PRESSURES ON THE ACUTE HOSPITALS AND THE NEED FOR CERTAIN PRIMARY CARE LEVEL SERVICES TO BE MANAGED BY GPS WITHIN A COMMUNITY HOSPITAL.

OPTIONS THAT ALLOW FOR THE DISPERSAL OF SCARCE AND EXPENSIVE RESOURCES ACROSS THE AREA ARE DEVISIVE, WASTEFUL, OBSTRUCTIVE OF INTEGRATION, AND CAN ONLY LEAD TO POST-CODE LOTTERIES FOR HEALTH AND CARE SERVICES AT PRIMARY CARE, SURGERY ADDRESS LEVEL, WITHIN DULWICH AND SURROUNDING AREAS.

THE LOCATION OF A SLOT AT THE BACK OF THIS PROPAGANDIST DOCUMENT WHERE OTHER VIEWS AND OPTIONS MAY BE AIRED CANNOT SATISFY THE NEED FOR SUCH VIEWS TO ENJOY THE CONSULTATIVE STATUS WHICH THE SPCT AND THE COMMISSIONING GROUP HAVE SEIZED AS A MONOPOLY FOR THEIR OWN MYOPIC VIEWS.

THIS IS IN CLEAR DISREGARD OF THE COMMITMENT ANNOUNCED FROM THE CHAIR TO ACT FIRMLY SHOULD OTHER OPTIONS NOT BE ALLOWED A PLACE IN THE PUBLIC CONSULTATION.
THE PUBLIC IS NOT GOING TO BE CONSULTED ON THOSE OTHER OPTIONS THROUGH THE SIMPLE EXPEDIENT OF KEEPING THEM OUT OF THE CONSULTATION DOCUMENT.

THE COMMITMENT I REFER TO WAS MADE TWICE FROM THE CHAIR OF THIS SCRUTINY COMMITTEE. I LOOK FORWARD TO THAT FIRM ACTION BEING TAKEN. AS PART OF WHICH, THIS COMMITTEE SHOULD WITHHOLD ANY LEVEL OF SUPPORT FOR THE DOCUMENT AND **JOIN WITH THE COMMUNITY TO ESTABLISH THE COMMUNITY'S OWN VIEWS AND NEEDS WITHOUT PRE-EMPTION** BY THE SOUTHWARK COMMISSIONING GROUP; A PRE-EMPTION OF THE COMMUNITY'S VIEWS WHICH HAS BEEN CONSISTENTLY PRACTICED; A PRE-EMPTION WHICH MANIFESTS ALL THE MANAGERIAL AND ETHICAL PROPENSITIES EXHIBITED AT THE TOP OF THE NHS AND NOW BELATEDLY BEING EXPOSED TO PUBLIC GAZE.

THE COMMITTEE WILL HAVE NOTED THAT MANY IN THE POLITICAL PARTIES ARE MOVING TOWARDS THE SUPPORT OF PUBLIC CAPITAL EXPENDITURE FOR CONSTRUCTION AND OTHER INFRASTRUCTURE BUILDING WORKS IN ORDER TO REVITALIZE THE ECONOMY.

THIS IS GOOD NEWS.

IT STANDS IN CONTRAST TO THE PESSIMISM OF THE AUTHORS OF THE ENGAGEMENT AND CONSULTATION DOCUMENTS. IT OPENS-UP THE PROSPECT FOR THE RENEWAL OF WORK UNDERTAKEN ON THE REFURBISHMENT OF DULWICH COMMUNITY HOSPITAL WHERE MILLIONS HAVE ALREADY BEEN SPENT; MILLIONS SURELY NOT TO BE WASTED TO ALLOW FOR MORE DEMOLITION AND THE BUILDING OF A MODEST HEALTH FACILITY BRINGING WITH IT THE CERTAIN DANGER OF A HEAVY LEASEHOLD BURDEN ON SOUTHWARK INSTEAD OF THE FLAGSHIP COMMUNITY HOSPITAL THAT WE HAVE LONG AND REPEATEDLY BEEN PROMISED. IT COULD AND SHOULD BE DEVELOPED WITHIN OUR OWN BUILDING ON OUR OWN LAND.

Kenneth Hoole,
East Dulwich Society. March 2013

NHS
Southwark
Clinical Commissioning Group

For the Attention of Cllr Mark Williams

CCG Responses to Mr Ken Hoole's statement at the Health, Adult Social Care, Communities and Citizenship Overview and Scrutiny Sub-Committee held on 25 March 2013

Mr Hoole's statement	NHS Southwark CCG response
A STATEMENT AND COMMENTS RELATED TO ITEM 5 ON THE AGENDA AS PRESENTED IN PART AT THE HEALTH AND CARE SCRUTINY COMMITTEE MEETING 7PM TOOLEY STREET 35TH MARCH 2013 SUBMITTED IN FULLER FORM RETROSPECTIVELY BY INVITATION FROM THE CHAIR. WHEN MEMBERS OF THIS COMMITTEE COME TO THE CONSULTATION DOCUMENT UNDER ITEM 5, I BEG YOU TO BE AWARE THAT YOU ARE ABOUT TO BE USED TO GIVE CREDENCE TO WHAT IF IT WERE PUBLISHED BY A BUSINESS CONCERN WOULD BE IN DANGER OF FALLING UNDER THE HEADING OF A FALSE PROSPECTUS. THE OUTRAGEOUSLY EXPENSIVE, PROPAGANDIST, WELL- PADDED DOCUMENT BEFORE YOU IS NOT WHAT IT PURPORTS TO BE . IT IS NOT REALLY THE OUTCOME OF AN OPEN AND TRANSPARENT ENGAGEMENT EXERCISE WITH THE COMMUNITY.	The CCG believes and can demonstrate that this document is genuinely based on views garnered from patients and the public. The CCG's Engagement process was held over a three month period and has been publicly reported on. It has been used as the basis for the work of the Project and is referenced in the Pre-consultation Business case and the Consultation document
THE FLAWED ENGAGEMENT DOCUMENT HAS LED TO A FLAWED CONSULTATION DOCUMENT. FOR EXAMPLE: IN THE ENGAGEMENT DOCUMENT, THE TWO LIMITED PROPOSALS ON OFFER FOR OUR FUTURE HEALTH AND CARE SERVICES ARE LITTLE MORE THAN MODEST MODIFICATIONS OF PROPOSALS, LONG SHELVED BY THE PRIMARY CARE TRUST. THE PROPOSALS ARE **REACH-ME-DOWNS , MANIFESTING AN UNBELIEVABLE CO-INCIDENCE OF COMPONENTS OLD AND CURRENT PROPOSALS.** THE MOVE OF GP PRACTICES ONTO THE SITE IS ONE DOCUMENTED PREVIOUSLY; WITH ONE PRACTICE NAMED DIRECTLY ON ARCHITECTS PLANS DRAWN UP UNDER BRIEF FROM THE SPCT, (DR SHAMA'S PRACTICE). AND ANOTHER THAT HAS TO BE THE MELBOURNE GROVE PRACTICE WHICH HAS BEEN REPEATEDLY	Previous plans for bringing together general practices on the Dulwich Community Hospital site were part of a wider plan for a community hospital. This overall plan, while supported locally, was not approved by NHS London at the time. It is a fact that elements of previous plans are the same or similar to current proposals under consultation. Current proposals are the product of the CCG's engagement work and the consideration of the Project team.

REFERRED TO IN TERMS OF THE INTENTIONS TO MOVE IT ONTO THE SITE. **SURELY THIS PAIRING IS A CO-INCIDENCE TOO FAR**, FAR TOO FAR TO JUSTIFY ANY CLAIM THAT WHAT IS BEING OFFERED AT THE BASE OF THE TWO OPTIONS REPRESENTS WHAT THE PEOPLE HAVE LONG AND REPEATEDLY ASKED FOR.	
AMONG OTHER SIGNIFICANT FLAWS THE ENGAGEMENT DOCUMENT MADE **NO MENTION OF THE COMMUNITY HOSPITAL** AND **NO MENTION OF RESPITE CARE. MENTAL HEALTH GOT ONLY A COUPLE OF WORDS**. SO IT CAN BE SHOWN THAT THE ENGAGEMENT DOCUMENT WAS DEEPLY FLAWED BY GAPS LEFT THERE BY DELIBERATE INTENT. **HENCE; THE FLAWED CONSULTATIVE DOCUMENT BEFORE YOU.** I WAS NOT ALONE IN POINTING OUT THE FLAWS AS FAR BACK AS MAY OF LAST YEAR. IMPORTANT POINTS RAISED IN MY LETTER TO THE PROJECT IN MAY LAST YEAR WERE IGNORED AND THE ENGAGEMENT CONTINUED WITH THE FLAWS AND GAPS LEFT IN PLACE. THE RESULT OF THE COMMUNITY HOSPITAL BEING LEFT OUT HAS BEEN THE OPPORTUNITY FOR THE SCCC AND ITS PROJECT BOARD TO BOAST IN WRITING THAT (I QUOTE) 'ONLY A FEW' WROTE-IN THE NEED FOR HOSPITAL SERVICES.	The CCG has responded to Mr Hoole when he wrote to us last year making these points, and the responses are summarized here: 1) The engagement process was always about services, rather than buildings, because we want to consider facilities in the light of the services we needed. The CCG did not talk in any detail at all about any kind of health building in the engagement document. 2) At a meeting of the Dulwich Community Council on 24 January 2012 there was a call for some structure to the engagement, as 'starting with a blank sheet of paper' is difficult. Given this request we produced a document with some ideas for discussion to generate debate. Mental health and respite care were not given extensive coverage in that document, but many people fed back to us about mental health services, and a few mentioned respite care and community hospitals. Mr Hoole's comment about mental health being an important aspect of wider health care was made by a number of people, and our service model proposals, as set out in the consultation document, include mental health. In addition to this it should be noted that the NHS does not commission respite care, and therefore are not in a position to consult about changes in respite care services.
MOST OF US WHEN FILLING IN FORMS DO NOT AND ARE NOT EXPECTED TO	Both the engagement survey and consultation survey allow for free text

AMEND THE STRUCTURED CONTENT OF A FORM IN FRONT OF US ; CERTAINLY NOT **A FORM DECORATED WITH SO MUCH TYPOGRAPHICAL AND PHOTOGRAPHICAL BLING.**	and additional thoughts, views and ideas without having to change the structure of the survey. Our experience with the engagement exercise showed us that people are prepared to use these opportunities in surveys and write their views down clearly – indeed the engagement survey responses gave us a very rich data set on which to base the proposals set out in the consultation document. The CCG intend and hope by making the consultation document attractive and accessible we will encourage a wide readership.
SO NO NASTY SURPRISE THERE FOR ANYONE WITH A VESTED INTEREST IN THE TWO PROPOSED OPTIONS. THE AUTHORS OF THE ENGAGEMENT DOCUMENT SAW TO THAT.	The pre-consultation business case sets out the detail behind the proposals set out in the consultation document and the case for change behind it. The CCG were very clear that they would only consult on proposals that addressed the case for change and are deliverable. However, the CCG acknowledge that there may be other possible options and are very happy to hear about them. We therefore have included question 9 in the body of the survey, in which we ask whether respondents have any views on whether there are any other ways in which health services in Dulwich and the surrounding area might be delivered.
EVEN THE REPORT OF THE PUBLIC MEETING OF JULY WAS DEEPLY FLAWED. COMPLAINTS ABOUT WHICH AND ABOUT OTHER MATTERS HAVE BEEN AWAITING WEEKS FOR A RESPONSE. I AM GIVEN TO UNDERSTAND THAT I WILL GET ONE IN APRIL. TOO LATE TO HAVE ANY LOCAL IMPACT, OF COURSE; THOUGH IN ANOTHER FORUM WHO KNOWS ?	This matter was addressed at the CCG Governing Body meeting that took place in public on the 11 April 2013. Mr Hoole's submission and our response were made available. Mr Hoole was not able to be present, but we also wrote to him afterwards outlining our actions at the meeting.
WITHOUT SO MUCH AS AN EXCUSE BEING OFFERED, THE LONG PROMISED PRIMARY CARE CENTRE WITHIN A FLAGSHIP COMMUNITY HOSPITAL, HAS BEEN	As mentioned above, the previous plans for a community hospital, while

REMOVED FROM THE FUTURE **PLANNED FOR US *NOT* WITH US.** OUR COMMUNITY HOSPITAL WAS NOT REMOVED FROM THE OPTIONS BY THE PEOPLE. THE HEALTH AUTHORITY HAS REMOVED IT AS PART OF SOME MANAGERIAL POLICY AND MANAGED AGENDA. IN RESPECT OF POLICY YOU SHOULD RECALL THAT DULWICH COMMUNITY COUNCILLORS AGREED A MOTION REGRETTING A PREVIOUS NEGLECT OF THE PROPOSAL TO CREATE THE PROMISED COMMUNITY HOSPITAL. UNTIL OR UNLESS THAT AGREED MOTION IS FORMALLY SET ASIDE THIS COMMITTEE MUST HAVE FULL REGARD TO IT AS AN EXPRESSION OF THE WISHES OF THE PEOPLE OF THE DULWICH COMMUNITY AREA. PRIVATE UNDERSTANDINGS THAT MAY OR MAY NOT HAVE BEEN AGREED SINCE THEN BETWEEN THE SCCG AND ITS PROJECT BOARD AND DULWICH COUNCILLORS AT A PRIVATE MEETING THAT **DID** TAKE PLACE CANNOT OVERTURN THAT AGREED MOTION HOWEVER STEALTHILY IT IS BEING DONE.	supported locally, were not supported by NHS London, who did not agree the PCT's business case. The proposals set out in the consultation document include bringing together a range of primary and community health services under one roof. The Local Authority has been formally invited to respond to the consultation, and local councillors have been briefed about the proposals and the consultation process. The consultation plan has been reviewed by the Overview and Scrutiny sub-committee. No private understandings or agreements have been made with elected members of the local authority.
THE CONSEQUENCES OF ANY UNCRITICAL RECEIPT OF THE CONSULTATION DOCUMENT WILL BE THE WIDENING OF AN UNACCEPTABLE GAP BETWEEN THE ACUTE HOSPITALS AND GP PRACTICES. **CONDONING THE ABANDONMENT OF OUR COMMUNITY HOSPITAL WILL ALSO OPEN THE DOOR TO PRIVATE HEALTH SERVICES BEING ON OFFER ON OUR LAND WITHIN A CONTEXT OF COMMERCIAL AMBITION BOLSTERED BY SOME NHS CONTRACTS.**	The proposals bring together a range of primary and community health services including moving some outpatient services from hospital into community settings, hence bringing services closer to where people live. The NHS has an obligation to tender for all new health services under the arrangement of 'Any Qualified Provider' and this is regardless of where these services might be provided.
THE PROJECT IN EFFECT ADMITTED IN THE ENGAGEMENT DOCUMENT THAT IT WAS GOING TO PURSUE A POLICY FOR SERVICES BASED ON PROMOTING HOME TREATMENT OR CARE IN THE HOME OR IN THE COMMUNITY OR WHATEVER THE CURRENT TERM IS THIS WEEK THAT IS A WRONG HEADED, **UNCOSTED POLICY**, WHICH IS NOW ARROGANTLY FLAUNTED THROUGH THE CONSULTATION DOCUMENT NOTWITHSTANDING THE TWO OPTIONS FOR A MODEST POSSIBLE DEVELOPMENT OF A HEALTH FACILITY ON OUR LAND.	The proposals we make are consistent with national and London-wide policy and seek to maximise the amount of care that can safely and cost-effectively be provided to a high standard in either people's homes, local health facilities or one's own GP practice. Clearly views of stakeholders and members of the public relating to this point can be made through the consultation process and will be

	considered.
IN THEIR VIEW, ADOPTING SUCH A POLICY REMOVES THE NEED FOR ANY LEVEL OF HOSPITAL PROVISION OUTSIDE THE ACUTE HOSPITALS. BUT THAT IGNORES THE PRESSURES ON THE ACUTE HOSPITALS AND THE NEED FOR CERTAIN PRIMARY CARE LEVEL SERVICES TO BE MANAGED BY GPS WITHIN A COMMUNITY HOSPITAL.	The proposals include a wide range of services to which GPs would be able to refer their patients. In one of the options more of these services would be located in general practices (including a practice based at on the Dulwich Hospital site), and in the other the services are more centralised. The CCG recognise pros and cons of both, but wish to hear the public and stakeholder view.
OPTIONS THAT ALLOW FOR THE DISPERSAL OF SCARCE AND EXPENSIVE RESOURCES ACROSS THE AREA ARE DEVISIVE, WASTEFUL, OBSTRUCTIVE OF INTEGRATION, AND CAN ONLY LEAD TO POST-CODE LOTTERIES FOR HEALTH AND CARE SERVICES AT PRIMARY CARE, SURGERY ADDRESS LEVEL, WITHIN DULWICH AND SURROUNDING AREAS.	The CCG will only be able to devolve services to practice level / in the community where it is both safe and cost-effective to do so. Currently, some patients can access a wider range of services at their general practice. The intention behind the proposals is to reduce this inequality by ensuring that all practice patients can access a wider range of services- if not at their own practice then at one nearby or at the health centre on the Dulwich Community Hospital site.
THE LOCATION OF A SLOT AT THE BACK OF THIS PROPAGANDIST DOCUMENT WHERE OTHER VIEWS AND OPTIONS MAY BE AIRED CANNOT SATISFY THE NEED FOR SUCH VIEWS TO ENJOY THE CONSULTATIVE STATUS WHICH THE SPCT AND THE COMMISSIONING GROUP HAVE SEIZED AS A MONOPOLY FOR THEIR OWN MYOPIC VIEWS. THIS IS IN CLEAR DISREGARD OF THE COMMITMENT ANNOUNCED FROM THE CHAIR TO ACT FIRMLY SHOULD OTHER OPTIONS NOT BE ALLOWED A PLACE IN THE PUBLIC CONSULTATION. **THE PUBLIC IS NOT GOING TO BE CONSULTED ON THOSE OTHER OPTIONS THROUGH THE SIMPLE EXPEDIENT OF KEEPING THEM OUT OF THE CONSULTATION DOCUMENT.** THE COMMITMENT I REFER TO WAS MADE TWICE FROM THE CHAIR OF THIS SCRUTINY COMMITTEE. I LOOK FORWARD TO THAT FIRM ACTION BEING TAKEN. AS PART OF WHICH, THIS COMMITTEE SHOULD WITHHOLD ANY LEVEL OF SUPPORT FOR THE DOCUMENT AND **JOIN WITH THE COMMUNITY TO**	As described above, both the engagement survey and consultation survey allow for free text and additional thoughts, views and ideas without having to change the structure of the survey. The survey is available both within the full document and on-line. Our experience with the engagement exercise showed us that people are more than prepared to use these opportunities in surveys and write their views down clearly. As mentioned before, the engagement survey responses gave us a very rich data set on which to base the proposals set out in the consultation document. We are offering drop-is sessions and are also running discussion-style

ESTABLISH THE COMMUNITY'S OWN VIEWS AND NEEDS WITHOUT PRE-EMPTION BY THE SOUTHWARK COMMISSIONING GROUP; A PRE-EMPTION OF THE COMMUNITY'S VIEWS WHICH HAS BEEN CONSISTENTLY PRACTICED; A PRE-EMPTION WHICH MANIFESTS ALL THE MANAGERIAL AND ETHICAL PROPENSITIES EXHIBITED AT THE TOP OF THE NHS AND NOW BELATEDLY BEING EXPOSED TO PUBLIC GAZE.	meetings where members of the public can discuss the proposals, ask questions, and put other ideas to us if they wish. We also have a schedule of discussions with patient participation groups and existing groups covering a wide range of people from all groups in the community, Where options that address the case for change are presented to us then we have agreed to consider them alongside the existing options.
THE COMMITTEE WILL HAVE NOTED THAT MANY IN THE POLITICAL PARTIES ARE MOVING TOWARDS THE SUPPORT OF PUBLIC CAPITAL EXPENDITURE FOR CONSTRUCTION AND OTHER INFRASTRUCTURE BUILDING WORKS IN ORDER TO REVITALIZE THE ECONOMY. THIS IS GOOD NEWS	No specific CCG response – this is Mr Hoole's view
IT STANDS IN CONTRAST TO THE PESSIMISM OF THE AUTHORS OF THE ENGAGEMENT AND CONSULTATION DOCUMENTS. IT OPENS-UP THE PROSPECT FOR THE RENEWAL OF WORK UNDERTAKEN ON THE REFURBISHMENT OF DULWICH COMMUNITY HOSPITAL WHERE MILLIONS HAVE ALREADY BEEN SPENT; MILLIONS SURELY NOT TO BE WASTED TO ALLOW FOR MORE DEMOLITION AND THE BUILDING OF A MODEST HEALTH FACILITY BRINGING WITH IT THE CERTAIN DANGER OF A HEAVY LEASEHOLD BURDEN ON SOUTHWARK INSTEAD OF THE FLAGSHIP COMMUNITY HOSPITAL THAT WE HAVE LONG AND REPEATEDLY BEEN PROMISED. IT COULD AND SHOULD BE DEVELOPED WITHIN OUR OWN BUILDING ON OUR OWN LAND.	The work-up of the full business case will consider the full range of possible funding options, and also whether a future health facility should be located in a refurbished part of the existing building or a new build.

NHS
Southwark
Clinical Commissioning Group

Improving health services in Dulwich and the surrounding areas

Progress on consultation process – response to complaintsand comments from Elizabeth Rylance Watson – updated 27 March 2013

Introduction

The consultation on 'Improving health services in Dulwich and the surrounding areas' commenced on 28 February 2013 and will run until 31 May 2013. This paper gives a summary of the promotionand consultation activities that have taken place so far.

The publicity will run throughout the three month period, with materials entering the public domain at various points.

Consultation materials

A 60 page consultation document has been produced and was made available in print and online on 28 February 2013 with the launch of the consultation.Summary and large print versions are now available online and in print.

We are distributing 2000 copies of the consultation document and 100,000 copies of the summary document.

Distribution

An external company (Impact) has now completed the initial distribution for us, and have distributed posters, summary documents and full documents to every GP surgery, dentist, pharmacy andoptician in Southwark and also those in Lambeth and Lewisham, on the respective border-side of each borough.

In addition, 300 high street and community-based outlets across the borough (libraries, community centres, shops, cafes, restaurants etc) have received in the region of 45,000 summary documents. Many local independent stores have agreed to display consultation materials inside their premises, although they have generally declined permission to put promotional materials in their windows. National branded chains generally have a policy of not displaying information, although we will continue to approach them.

Advertising

Adverts for the consultation and events have appeared in the South London Press and SE21and 22 magazines. NHS Southwark Clinical Commissioning Group runs regular monthly advertorial features in Southwark News, and the consultation featured prominently as part of the 28 March edition. An outdoor hoarding at the Dulwich Community Hospital site has now been installed.

There are numerous posters now advertising the consultation in Dulwich Community Hospital.

All GP Practices have received posters and copies of the summary document, and on 28th March at their locality meeting south Southwark GPs received further copies of the poster for display. We will continue to supply them throughout the consultation period.

Exhibition

There is a new exhibition about the plans now in the exhibition space at Dulwich Community Hospital. Next week there will be new signage advertising it in the building.

Direct mail

A copy of the consultation document has been sent directly to over 800 organisations/groups including all GP practice patient participation groups, dentists, pharmacies& opticians, primary and secondary schools,nurseries, places of worship and faith groups inviting them to participate in the consultation and offering to visit them. Community Action Southwark are mailing all of the community and voluntary sector organisations working in the health and social care field with a hard copy of the document, on our behalf.

Individual letters and copies of the full document have been sent directly to all Southwark Councillors, Chairs and CEOs of local NHS organisations, Lambeth and Lewisham Overview and Scrutiny Committees, and chairs of the four representative committees – medical, pharmaceutical, optical and dental.

Email promotion

In partnership with Community Action Southwark we have contacted approximately 150 community and voluntary sector organisations. In addition the 200 organisations in the Community Support Directory, a resource which lists organisations offering support to disabled and older people, have also received information. All members of Southwark LINk have also received information about the consultation via email promotion. Repeat emails are scheduled for the coming weeks.

Briefings for key stakeholders

Briefings are being held for local councillors and the relevant Cabinet Members.

Events completed

To date, we have carried out 20presentations/discussions/events with local groups, including Patient Participation Groups and service user groups, three stakeholder briefings and three drop in events.

All feedback received at these events is being captured on a standard pro-forma and will be given to Opinion Leader to include in the evaluation of responses.

Further events

There are two further drop-in events and two public deliberative events scheduled. These events are being promoted via our distribution system, in local newspapers and via our network of contacts.

A further 30 events with specific groups have already been scheduled, with additional ones being planned as the consultation progresses.

Of particular note is our commitment to consult with hard-to-reach groups. A number of the groups named in the consultation plan have already been scheduled and the CCG's Diversity& Human Rights lead is working closely with the local Forum and Community Action Southwark to secure the remainder. This will be supplemented with additional groups that are identified as this work progresses.

Door to door delivery

There will be a delivery of the summary document to every household in the south of the borough over the next two weeks.

Street Teams

There will be street teams handing out copies of the summary document to people in busy parts of the south of the borough on a Saturday 10.00 – 3.00. This will include Lordship Lane and Rye Lane. We have also approached Sainsbury's on Dog Kennel Hill, who will not allow this to happen at the weekend, but have agreed to us handing out summary documents on a Tuesday or Wednesday, and we will be doing this. The pharmacy in Sainsbury's has already received copied of the summary document.

Additional Groups

If there are additional groups or distribution points that could be contacted over and above the lists we presented to the Overview and Scrutiny Sub-Committee we would be happy to add them into our distribution.

Rebecca Scott
Programme Director

Colin Beesting
Communication and Engagement Manager

Agenda Item 5

NHS
Southwark
Clinical Commissioning Group

Briefing note for Clr Mark Williams

In response to the following query:

The numbers of people using the Dulwich Hospital phlebotomy service, with a brief comment its capacity and efficiency.

It is difficult to be precise about the number of patients attending Dulwich hospital for phlebotomy, as the information reported is on a pathology test basis, not a patient basis and some patients have multiple tests done on a single phlebotomy visit.

From the most recent information we have, the average number of patients who received a blood test during 2012/13 was 3,173 per month. The number of patients receiving a blood test varied from month to month. We estimate there are 6,000 blood test requests per month from all Southwark GP practices.

The CCG is aware that there are sometimes very long waits at Dulwich hospital for blood tests and that this impacts upon patient experience. This has been raised with Kings College Hospital NHS Foundation Trust via our contracting processes. The CCG carried out a review of phlebotomy in the last year, and are considering a range of options to improve the service, including shifting this to a more dispersed locality based model.

The issue of phlebotomy is under consideration as part of the current Dulwich consultation, and as the CCG develops its primary and community care strategy, we will be developing options and an implementation plan to improve access to phlebotomy for all Southwark patients.

Tamsin Hooton
Director of Service Redesign

26 April 2013

Agenda Item 6

Guy's and St Thomas' NHS
NHS Foundation Trust

Southwark Council
Overview and Scrutiny Committee

01 May 2013

Further information on 19 pressure ulcers reported July 2012 – Sep 2012

Status: A Paper for *Information*

Elizabeth Palmer, Acting Director of Assurance

Guy's and St Thomas' NHS
NHS Foundation Trust

Overview and Scrutiny Committee

01 May 2013

A paper prepared by Liz Coles, Senior Patient Safety Manager and Elizabeth Palmer and presented by Yinglen Butt, Deputy Chief Nurse Community

1.0 Purpose of the paper:

1.1 At the meeting on 25 March Southwark Council, Overview and Scrutiny Committee was presented with a paper providing information on pressure ulcers reported by Guy's and St Thomas' NHS Foundation Trust (GSTT) in quarter 2 2012/13.

1.2 In that quarter GSTT reported 30 grade 3 and 4 pressure ulcers to Lambeth PCT – our commissioner.

1.3 Of these 19 were pressure ulcers which developed prior to any contact with GSTT services. We are still required to report these, however we do not investigate or carry out root cause analysis as they were not acquired whilst receiving acute or community healthcare from GSTT and are closed as not attributable.

1.4 The OSC asked for further information on these 19 pressure ulcers where a Southwark resident or a care setting in Southwark was involved.

1.5 A review of records identified three Southwark residents.

2.0 Further information requested:

2.1 All pressure ulcer data is collated on a centralised database within the acute setting (ETRACE) and RIO within the community. Data such as borough of residence is not currently held on ETRACE. Individual records have been reviewed to get the information the OSC requested.

2.2 Review of the 19 records identified three patients resident in Southwark.

2.3 It is important to note that when a pressure ulcer is identified as not acquired while receiving care from Guy's and St Thomas' services it is still reported to the commissioners and if there are any safeguarding concerns a referral to the local authority safeguarding team will be made in accordance with pan London safeguarding procedures.

2.4 Information on three residents of Southwark admitted with pressure ulcers of grade 3 or 4 that were not attributable to GSTT.

Date reported to commissioners	Resident postcode	Grade	Outcome of initial investigation for 'admitted with' pressure ulcer	Safeguarding referral made
20/06/2012	SE16	4	Patient admitted with a grade 4 pressure ulcer. This was an ongoing pressure ulcer originally acquired at Lewisham Hospital.	No
16/07/2012	SE16	3	Patient discharged from Kings College Hospital on 16/07/12 with a grade 3 pressure ulcer and then admitted to GSTT.	No
22/09/2012	SE1	4	Admitted from nursing home with grade 4 pressure ulcer. This was reported to Southwark Social Services, who carried out a review. Social services were content that a comprehensive plan of care was in place and being implemented. The patient had a grade 3 pressure ulcer on admission to the nursing home in 2009, general frailty made it unavoidable.	Yes

4.0 The Overview and Scrutiny Committee is asked to:

- **Note the report for information**

Elizabeth Palmer **15 April 2013**

South London and Maudsley NHS
NHS Foundation Trust

Pressure Ulcer Data for LB Southwark Scrutiny Committee

All pressure ulcers grade 3 and above incidents are alerted to the relevant local authority safeguarding leads. In addition, all pressure ulcers grade 3 and above are notified to the relevant Borough CCG through STEIS within 48 hours and a full internal investigation is carried out and reviewed by the CCG.

When a pressure ulcer is detected at any given grade (1-4) it is reported as an incident and reviewed weekly with the senior nursing and safety team and scrutinised for improvement, deterioration and safeguarding concerns. Recent changes to the categories on Datix to report pressure ulcer incidents have led to greatly improved monitoring, reporting and classification.

The organisation has been working closely between GSTT and commissioners to discuss care arrangements and nursing pathways for those particularly in Band 1 continuing care homes, to ensure approaches to preventative pressure related care are aligned and collaborative, and that service users have access to both generalist and specialist nursing care that is patient centred to their own care requirements.

SLaM has a CQUIN for pressure ulcer prevalence improvement for 2013/14 and performance against this is monitored via the performance systems with the Trust.

Table 1: Southwark Resident Patient's Pressure Ulcer Data Q2 2012/2013 (01 July to 30 September)

Date	Patient	Location	Acquired in SLaM	Admitted to SLaM	Grade of PU	SVA Alert to LA	Notified to CCG
04/07/2012	A	Croydon Inpatient Ward		Yes, from community	Grade 2	N/A	N/A
26/09/2012	B	Lambeth Continuing Care Unit	Yes		Grade 3	Yes, to Lambeth	Yes, to Southwark
26/09/2013	C	Lambeth Continuing Care Unit	Yes		Grade 3	Yes, to Lambeth	Yes, to Southwark

Table 2: Non Southwark Resident Patients who Acquired Pressure Ulcer's in Southwark Inpatient Units and Care Homes Data Q2 2012/2013 (01 July to 30 September)

Out of the nine reported pressure ulcers in Q2 none were acquired in inpatient units in Southwark.

King's College Hospital NHS
NHS Foundation Trust

Report to: **Southwark Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee**

Date: **25th April 2013**

From: **Paula Townsend, Deputy Director of Nursing**

Subject: **Admitted Pressure ulcers**

Background
Following a review from the last Southwark Health Overview and Scrutiny Committee, a request has been made by the chair to clarify some points around admitted pressure ulcers at King's College Hospital NHS Foundation Trust. This report addresses the points of clarification that have been requested under the following headings:

1. **What are admitted pressure ulcers?**

1.1 Admitted pressure ulcers include those patients who were admitted from the community, either their own home or care home or from another hospital.

2. **How many pressure ulcers were admitted the period Quarter 2 (1st July - 30 September 2012)?**

1.2 The numbers of admitted pressure ulcers for that period are as follows
Grade 2 – 130
Grade 3 – 12
Grade 4 - 10

3. **Can you please explain the criteria and process for reporting admitted pressure ulcers to a local authority safeguarding lead and / or to local commissioners?**

3.1The process for reporting pressure damage is as follows:

- When a patient is admitted to the trust with pressure damage it is recorded on the hospital e-TRACE system by the ward staff.
- The staff can select where the patient came from in a drop down box the options are; Patients home, care home, nursing home or other trust.
- On a monthly basis a report is compiled which shows both the acquired and admitted pressure ulcers and where on the body they occurred. The e-TRACE system will alert the Tissue Viability Team via email when a patient is admitted with or acquires a stage 3 or 4 pressure ulcer.
- When patients are admitted with multiple stage 2, stage 3 or stage 4 pressure ulcers the adult skin damage protocol is used to determine if a safeguarding

alert or referral is required. This consists of gathering information from the care providers to see what services are already in place for the patient and whether they were known to community team's e.g. Community Tissue Viability/District Nurses and looks at the following 5 questions;

1) Has there been a rapid onset and/or deterioration of skin integrity?

2) Has there been a recent change in medical condition e.g. skin or wound infection, other infection, pyrexia, anaemia, end of life care that could have contributed to a sudden deterioration of skin condition?

3) Have reasonable steps been taken to prevent skin damage?

4) Is the level of damage to the skin disproportionate to the patient's risk status for skin damage? E.g. low risk of skin damage with extensive injury

5) Was there compliance with the care plan

- If staff remain unsure whether a patient requires safeguarding referral having completed the skin damage protocol the safeguarding team are contacted for advice.

- Staff complete an Adverse Incident (AI) form if patients are admitted with Stage 3&4 pressure damage and this is investigated by the referring organisation. Patients with stage 3&4 pressure damage are referred to the Tissue Viability Team for a review and they will confirm the stage of the pressure damage and update risk office where appropriate.

- As an acute trust we have patients admitted with Stage 3&4 pressure damage who do not have any prior community care e.g. patients who may have had a stroke or a fall and are on the floor for a number of hours/days. The stage and location of the pressure damage is confirmed by a TVN member who will then update Risk Office.

- An AI is completed for all Hospital acquired stage 3 and 4 pressure damage, the TVN team will then review the patient and confirm the stage and request a root cause analysis (RCA) to be completed.

- From February 2013 all confirmed grade 3 and 4 pressure damage are reported as SUI's to the Commissioners and since 1st April all hospital acquired stage 3 & 4 are also reported on the STEIS system by the risk office.

4. Are you able to report on the 152 admitted pressure ulcers for the quarter and report from which boroughs they were admitted and the location i.e.care home?

4.1 From the e-trace system it is not possible to identify which boroughs the patient is from, therefore we are not able to supply Southwark specific data. Until recently data was reported to Yvonne Harding, Clinical Governance Manager at NHS South London Commissioning Support Unit. We are not clear how this data was then used. In the future the data will be reported quarterly to CSU. This will include all non-attributable and attributable pressure ulcers, split by responsible CCG, including information about previous care organisation as part of our CQUIN.

King's Health Partners
Update for Southwark Health Scrutiny Committee - 1 May 2013

King's Health Partners has achieved much since we came together as an Academic Health Sciences Centre four years ago. We have established Clinical Academic Groups to bring people together who are experts in their field - whether that's cancer care, dementia or diabetes - to offer patients the very best care and treatment, based upon reliable research evidence that it works. In doing so, we aim to provide high quality healthcare to people in south London whilst developing new treatments that will benefit people locally, nationally and internationally.

However, the way our partnership currently works is complicated because it involves three different NHS organisations with different structures, cultures and ways of doing things. As the Committee is already aware, for some time the partnership has been exploring the idea that it may be able to achieve more for patients – and achieve it more quickly – by creating a new academic healthcare organisation.

This paper provides an update on developments since February 2013 when the King's Health Partners Board agreed to develop a Full Business Case to consider options for organisational change.

Developing a Full Business Case
A Strategic Outline Case was published in July 2012. We are now preparing a more detailed Full Business Case (FBC) which will test a range of organisational models that could help us achieve our vision. One option open to us is that we create a single academic health organisation by merging the trusts and strengthening integration with King's College London. Initiatives short of a three-way merger are also being considered.

A dedicated delivery team has been set up to develop the FBC, led by William McKee, Director of Transformation and Delivery. It is being overseen by the King's Health Partners Board and the FBC Steering Group, a subset of the Partners Board **[see Appendix].** Work is currently underway across eight working groups to develop a robust review of the possible benefits of creating a new organisation and to outline the financial case.

What happens next?
Over the next few months we will be looking to involve as many staff and other stakeholders as possible in discussions about the case for change. The feedback we gain will form part of the Full Business Case which will be produced by Autumn 2013. Each of the NHS Foundation Trust Boards and the equivalent body within King's College London (the College Council) will then decide how it wants to proceed.

We are clear that any form of organisational change is only worth doing if it improves our ability to bring clinical services, research and education more closely together for the benefit of the patients and local communities we serve.

If the idea of merging is proposed and agreed by each of the partners, it would then be subject to scrutiny by Monitor and the Office of Fair Trading (and possibly the Competition Commission). This means that the very earliest any new organisation could be established, if approved by the regulators, would be the beginning of 2015.

We look forward to working with you as we develop our plans.

King's Health Partners, April 2013

Appendix

King's Health Partners Board membership:

- Prof. Sir Robert Lechler, Executive Director, King's Health Partners
- Lord Robin Butler, Chair, King's Health Partners
- Sir Rick Trainor, Principal, King's College London
- Ian Creagh, Head of Administration and College Secretary, King's College London
- Gus Heafield, Acting Chief Executive, South London and Maudsley, NHS Foundation Trust
- Madeliene Long, Chair, South London and Maudsley, NHS Foundation Trust
- Tim Smart, Chief Executive, King's College Hospital NHS Foundation Trust
- Prof. George Alberti, Chair, King's College Hospital NHS Foundation Trust
- Sir Ron Kerr, Chief Executive, Guy's and St Thomas' NHS Foundation Trust
- Sir Hugh Taylor, Chair, Guy's and St Thomas' NHS Foundation Trust

King's College Hospital NHS
NHS Foundation Trust

Report to the Southwark Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee, 1 May 2013

1. Introduction:

1.1 There has recently been national media coverage about liver transplant surgery at King's College Hospital (King's). It has been suggested that by treating fee-paying patients from overseas using NHS donor organs, UK patients needing transplant surgery are being disadvantaged.

1.2 This paper briefly outlines the rules and regulations for liver transplant surgery at King's, as defined by NHS Blood and Transplant (NHSBT) and the Department of Health (DH). This paper also explains the process (regulated by law) by which donor organs are allocated to UK and EU patients, as well as non-EU patients who pay for their treatment privately.

2. Liver transplant surgery at King's:

2.1 King's is home to the largest liver transplant centre in Europe, carrying out over 200 transplants every year. King's has a reputation for surgical excellence and innovation in this specialist field. Over the years, our surgeons have established new and pioneering liver transplant techniques; this includes the 'splitting' of livers so that the donated organ benefits more than one patient.

2.2 King's is also one of only a small number of centres to perform 'living related' transplant surgery in adults and children, which involves a living donor giving part of his/her liver to a relative. Similarly, King's has pioneered the successful use of organs retrieved from donors following cardiac death. This innovation has resulted in these organs being increasingly used in NHS practice throughout the UK.

3. Allocating organs to UK, EU and non-EU patients:

3.1 The vast majority of liver transplant operations carried out at King's are for UK, NHS patients. However, given our status and international reputation, we also treat NHS entitled patients from other European countries, as well as a small number of patients from countries outside Europe.

3.2 King's treats liver transplant patients from other European countries because they are entitled by law to NHS treatment. They also have limited or no access to liver transplantation in their own countries. All patients are assessed and prioritised for surgery according to clinical need, regardless of where they are from. All UK and European patients have the same rights to NHS treatment, and donated organs.

3.3 Patients from outside Europe come to King's for liver transplant surgery as private patients. These patients number approximately two a year. They only receive UK donor organs once these have been declared unusable for any NHS entitled patient in this country.

3.4 There are a number of reasons why a donor organ may be deemed unusable for an NHS entitled patient; this can be due to donor age, recipient age, clinical

condition of the recipient, clinical condition of the donor, the size of the donor and recipient, blood group, underlying liver disease of the recipient, and a number of other technical factors relating to the organ donation process.

3.5 In rare situations, where retrieved organs cannot be given to a suitable NHS or EU recipient at any transplant centre within the country, they are considered for non-EU patients.

3.6 The alternative to not using these organs is that they would be discarded, and potentially result in the death of an adult or child who might otherwise be given a chance of life.

3.7 No fee is received (by either the hospital or the surgeon) for the donor organ. Payment is received for the costs associated with the transplant operation, not for the organs from the deceased patients which EU patients (and, in turn, non-EU patients) are entitled to.

3.8 King's successfully utilises more donor livers than any other centre in the UK. Between 1 April 2007 and 31 March 2010, King's accepted the majority of livers that were offered to them, followed by Birmingham, who had the next highest acceptance rate. Overall, the proportion of livers declined by transplant centres in the UK ranged from 5% at King's and 13% at Birmingham to 61% at Newcastle, with other centres declining between 23% and 35% of their offers.

3.9 Our transplant team regularly retrieves organs from European countries and transports them back to King's for use in UK NHS patients.

4. The national position:

4.1 In response to recent media coverage about liver transplant surgery at King's, the Department of Health issued the following statement: "There are strict rules ensuring donated livers from the deceased are always allocated on the basis of clinical need, which is why having a transplant privately in no way means getting an organ more quickly. We have not banned any private organ transplants because there's no evidence they stop NHS patients having transplants or reduce public confidence in donating."

4.2 In addition, NHS Blood and Transplant said: "Our monitoring process has not highlighted any issues nor have issues been raised with us. We currently have no concerns about any of the units. Any unfounded media reports that question the integrity of this system could jeopardise public confidence in organ donation, lead to fewer organs being donated for transplant and lives being lost."

5. The future:

5.1 Media coverage of this issue is not new, but continues to be damaging to public confidence in the organ donation system. We have always been clear that we follow all the rules and regulations relating to liver transplant surgery at King's, and will continue to do so.

5.3 We report all transplant activity to NHS Blood and Transplant and the processes we have in place are fully audited on a regular basis.

Report to the Health and Adult Social Care Communities and Citizenship Scrutiny Sub-Committee 1st May 2013 Meeting

Focus: BME Psychosis: prevalence and access to services

1. Introduction

Healthwatch Southwark is a new organisation which began on the 1st April 2013. As such, the information that we have included in this brief report is sourced mainly from the legacy we gained from the Local Involvement Network (LINk Southwark).

Healthwatch Southwark is aware that the issue of higher numbers of people from the BME communities being admitted on to wards and not accessing Talking Therapies is not in line with people of other ethnicities. This is both a local and national issue.

2. Evidence of the issue

2.1 From LINks

LINkSouthwark raised their concerns regarding the over- representation of people from Black and Minority Ethnic communities on the wards, in general, at quarterly run meetings with South London and Maudsley NHS Foundation Trust during 2012-13. These meetings were held with the four LINks in Croydon, Lambeth, Lewisham and Croydon to raise issues pertaining to the Trust's Quality Accounts.
These meetings were chaired by Cliff Bean, Deputy Director Quality and Assurance.

LINk comments within the Quality Accounts:

2009/10 Croydon LINk commented on page 44:

Priorities for 2010/2011
In terms of the proposed priorities for 2010/11, one major priority we believe is missing, based on the"Count Me In" census, is tackling the issue of the over - representation of people from BME groups in hospitaladmissions. We think this is an important area to address for Croydon. On a separate level, working groupmembers have raised the issue of an investigation into whether language needs are being met adequately.

2010/11 LINk Southwark highlighted the issue again on page 26:

There is no follow-up on BME ward over-representation despite it having been an area of concern identified in the 2009/10 QA

2011/12 LINk Southwark page 29

BME Overrepresentation
Common to this year's QA and that of 2010/11 is the lack of follow-up on over-representation of people from the BME communities, as first highlighted by Croydon LINk in 2009/10.

At the November 2012 Quarterly meeting LINk Southwark met with the usual SLaM and LINks personnel and Shubulade Smith a member of Schizophrenia Commission. As the author of the chapter of the Commission's Report *The Abandoned Illnes*son Mental Health and Minority Ethnic Groups (pages 48-51) we had an extensive discussion with her including questions and answers. This should be noted that SLaM were thanked for arranging this meeting which enabled a better understanding of this on a local as well as national level.

2.2 From People who use services

Healthwatch Southwark has received comments from a BME service user group who were asked to comment about psychological therapy services. From a group of 10 people 8 said that they would like to have therapy. Comments included:

"It has not been offered"
"Because you have CPN it is not offered"
"No Black psychologist"
"Need to know more about it/unable to make decision"

From a non- BME perspective we received a case study which follows:

"I was in the mental health system for 8 years before I was offered psychological therapy. This was only after I got involved in user-led organisations and began to ask for what I needed. Still, I was asking for a year, and it was only after two suicide attempts that I was offered CBT from a trainee at my CMHT. It seems to be that it is very scarce and hard to get hold of. It also seems that if you are not aware it is on offer then CPNs and psychiatrists do not raise awareness, preferring to medicate. That's my personal experience."

2.3 Recent research

See especially: Fearon, Paul "Can early intervention services modify pathways into care?" British Journal of Psychiatry 2013, 202:249-250.There has been considerable local research into early intervention services for psychosis (severe mental illness). Analysis by major ethnic groupings indicates that black patients are referred more by "emergency" type services, such as A and E or the justice system than by GPs. However, the length in time of the "pathway" is shorter, whereas white people are more likely to access mental health services through their GPs and take longer to receive diagnosis and treatment. The shorter pathway is associated with better

results but so far it is not clear whether this is due to “acute” presentations having a better outcome.

From the patients’ experience point of view, a pathway via coercive routes is obviously less desirable, and trust in and perhaps access to GP services needs to be improved as well as liaising with other agencies including the voluntary sector, and possibly “less stringent referral criteria” using terminology more relating to distress.

A key informative measure would be use of compulsory admissions broken down by ethnicity.

In addition gender analysis might shed light on appropriate intervention strategies.

3. Suggestions

Healthwatch Southwark will collect more information of real life cases through a number of means including Kindred Minds - A Southwark Black and minority ethnic (BME) user-led mental health project and other relevant sources and organisations in Southwark.

Note: Healthwatch Southwark will be writing our workplan for the year in May/ June and at the point of writing this report cannot confirm the areas of focus which will be chosen.

Key:

CPN-Community Psychiatric Nurse
CBT- Cognitive Behavioural Therapy
CPA- Care Programme Approach

South London and Maudsley NHS
NHS Foundation Trust

Psychosis in BME communities [incidence and access]

SLaM report to Southwark Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Philippa Garety PhD
Professor of Clinical Psychology
Clinical Director and Joint Leader
Psychosis Clinical Academic Group
South London and Maudsley NHS Foundation Trust

Definitions

Psychosis - a psychiatric term, which is commonly agreed to include experiences such as hearing or seeing things with no obvious cause (hallucinations), holding strong and unusual beliefs which other people don't experience or share (delusions) and confused or disturbed thoughts

The cause and development of psychosis involves social, psychological and physical factors

Definitions cont'd...

First-episode psychosis - Someone experiencing a first-episode psychosis may not understand what is happening. Symptoms are unfamiliar and frightening, leaving the person confused and distressed. If they do not know the facts and have no real understanding about mental illness, their distress may be increased by negative myths and stereotypes.

A psychotic episode occurs in three phases. The length of each phase varies from person to person.

Phase 1: prodrome

•The early signs of psychosis are vague and sometimes hardly noticeable. There may be changes in the way people describe their feelings, thoughts and perceptions

Phase 2: acute

•Clear psychotic symptoms are experienced, such as disorganised thinking, hallucinations or delusions

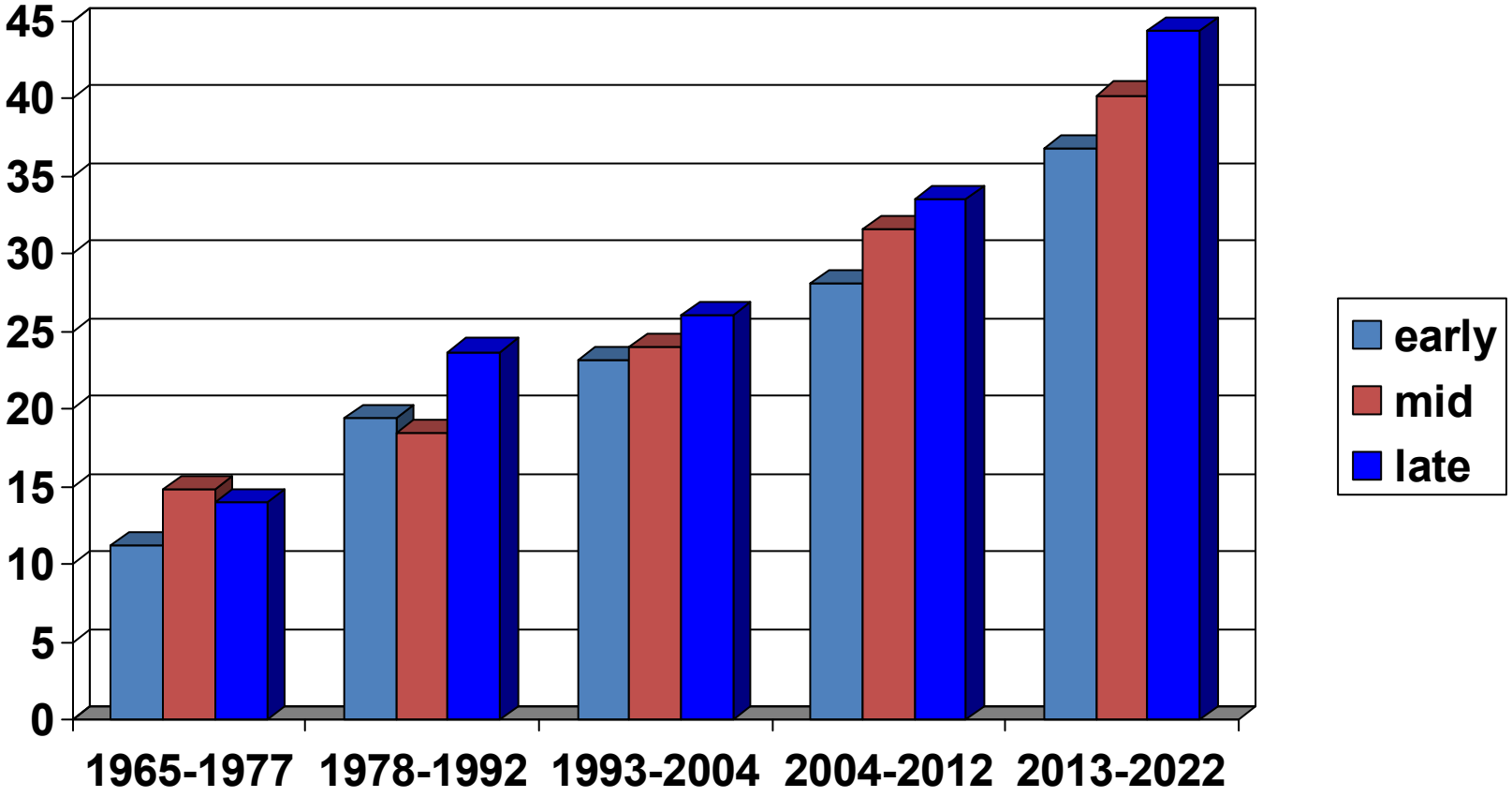
Phase 3: recovery

•Psychosis is treatable and most people recover. The pattern of recovery varies from person to person

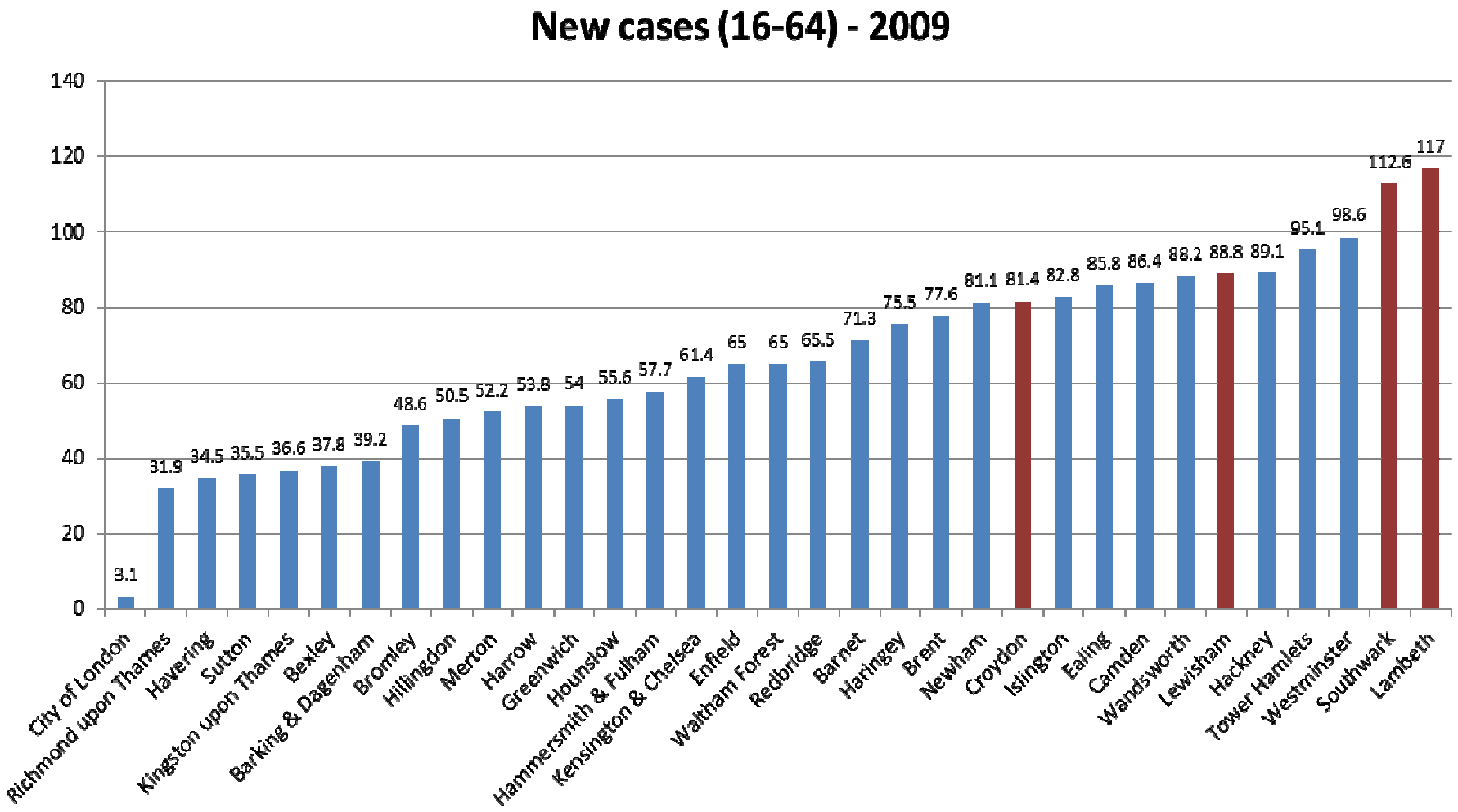
Epidemiology of Psychosis [Boydell, J]

- Clear evidence of increasing incidence from 1965 onwards in South London. This is likely to be the result of:
- Increasing population size
- Increased proportion of young people at age at risk (20-35)
- Increased rates Black ethnic minorities
- Increased rates with cannabis use
- Increased rates with unemployment

Projections: schizophrenia per 100000 Southwark population 2004-2022



Predicted new cases: London Boroughs



Data from PsyMaptic

Kirkbride et al, BMJ Open (Feb 2013)

Incidence to Prevalence

- Incidence = number of new cases that develop in a given time
- Prevalence = number of cases that are present in a particular population at a given time
- Prevalence approx = incidence x chronicity

AESOP results (Fearon et al 2006)

- Incidence of psychosis even higher than previously thought
- Almost all psychoses
- Black minority groups particularly high rates
- For schizophrenia Black Caribbean people had 9.1 times higher rates
- 8 times higher rates for mania in Black Caribbean people
- Similar for other Black Minority Ethnic people
- Recent studies show similar differences in incidences

Risk Factors

- Unemployment - people 12 x more likely to become psychotic Black Caribbean unemployed people 60 x more likely than white employed people (Boydell at al 2012 – Study in Southwark)
- Crime - very strongly associated. 26% increase in rates of schizophrenia with a 10% increase in crime (Bhavsar submitted 2012)
- Psychosis increases with increasing population density (Mortensen et al 1999)
- Cannabis use - Recent finding cannabis use has a greater effect in inducing psychosis in urban environments - probable synergy (Kuepper et al 2011)
- Poor education

Black Minority Ethnic Groups

There have been various hypotheses attempting to explain the raised incidence in African and Caribbean groups, including:

- Selective migration
- Misdiagnosis based on racist assumptions

The differences are believed to be related to:

- Traumatic experiences (including racism/perceived racism), family breakdown and social support

  A recent study in Lambeth indicated that the increased incidence of psychosis in Black people disappeared once they formed >25% of the population at neighbourhood level (1500 people) (Schofield et al 2011).

The abandoned illness – extract from summary

a report by the Schizophrenia Commission. November 2012

- People with severe mental illness such as schizophrenia still die 15-20 years earlier than other citizens
- Only 8% of people with schizophrenia are in employment, yet more could and would like to work
- Service users and family members dare not speak about the condition. 87% of service users report experiences of stigma and discrimination
- Greater partnership and shared decision making with service users – valuing their experience and making their preferences central to a recovery focused approach adopted by all services
- Increasing access to psychological therapies in line with NICE guidelines
- CBT reduces re-admission rates in the short, medium and long-term
- Action to address inequalities and meet the cultural needs of all minority groups
- Extending the popular Early Intervention for Psychosis services [not cutting or diluting]

The abandoned illness cont'd...

Getting help early is crucial to good outcomes

'Early intervention services are valued on account of their ethos and approach. Those giving evidence emphasised the value base of early intervention services – their kindness, hopefulness, care, compassion and focus on recovery. They provide treatment in non-stigmatising settings, seek to maintain social support networks while an individual is unwell, take account of the wider needs of the individual and deliver education as a core part of the service to families, staff and service users.'

The OASIS Team

The OASIS team offers help to people who are at high risk of developing psychosis but who are not yet psychotic [Broome et al 2005].

First service of this type in the country

Without treatment about a third of people with symptoms will develop a first episode of psychosis within 12 months [Yung et al, 2003]

Clients are seen in non-psychiatric community settings to maximise accessibility and minimise stigma

OASIS has been very successful at engaging clients from ethnic minorities, who comprise 2/3rds of the client group. Among those managed by OASIS there are no significant differences between ethnic groups in the rates of psychosis, hospital admission and use of the Mental Health Act.

The STEP Team

Is a community based multi-disciplinary team which provides a holistic and comprehensive early intervention service to individuals aged 14-35 who are experiencing their first episode of psychosis

The team uses well-researched Early Intervention strategies and works intensively with service users and carers to promote engagement with the team and with treatment and to facilitate social inclusion and recovery

•There is an Adolescent Mental Health worker who is part of the STEP team and who works across both the Child and Adolescent Mental Health Service and STEP team, care co-ordinating the under 18's with psychosis and ensuring a smooth transition to adult services where this is necessary.

•Service users are encouraged to make informed treatment choices and are offered the following interventions:

Interventions

Engagement – flexible; can be seen at GP surgery, home or a community setting

Immediate contact – service users are seen within one week of referral

Supportive and empathic relationship in which service users' aspirations, strengths, priority need are central

Psychological interventions – including Cognitive Behavioural Therapy and individual and group work

Working with families – involvement in treatment plans, carers assessments and groups, family interventions

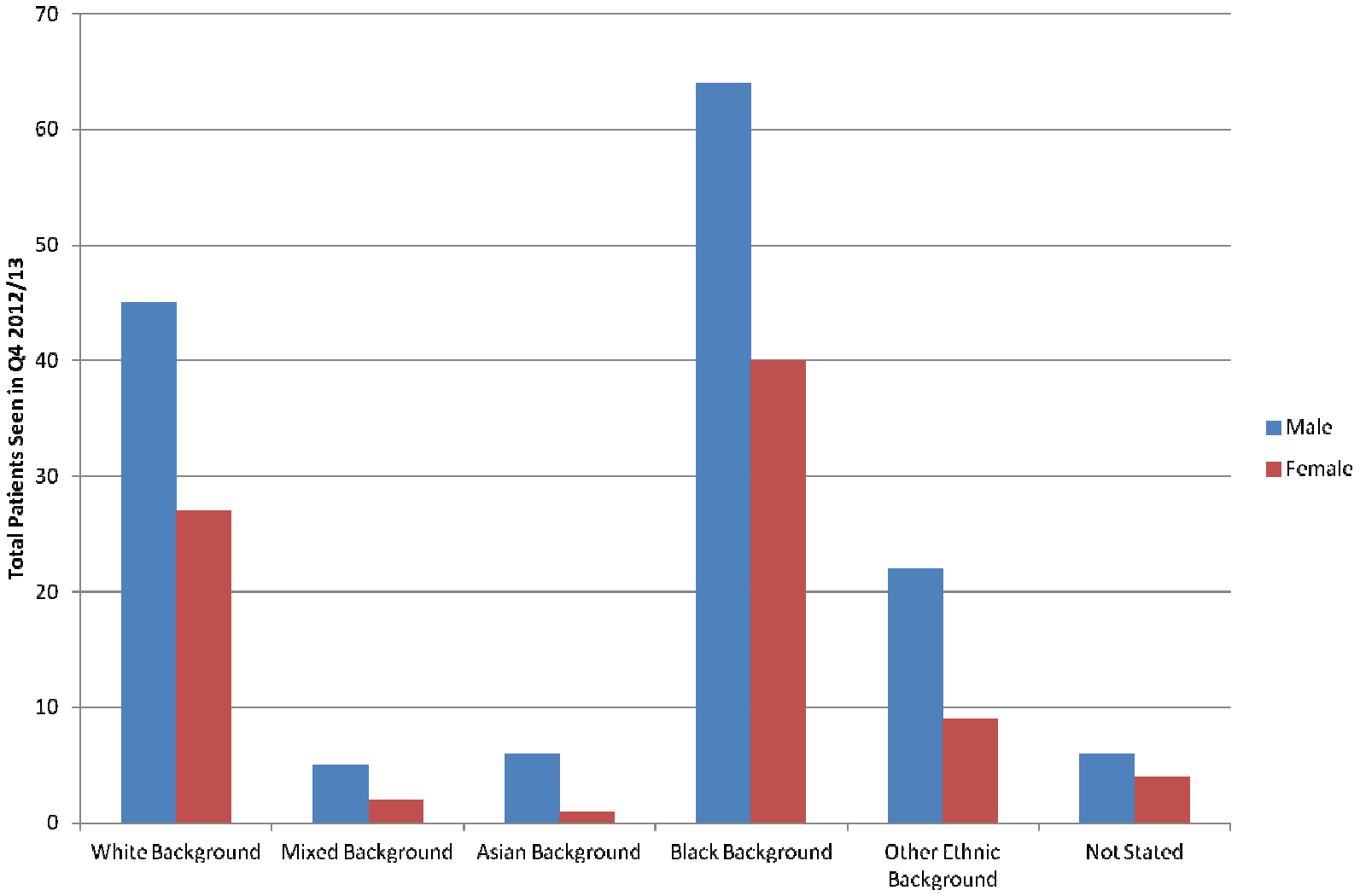
Social inclusion interventions – vocational and educational assessment and support, facilitating access to other agencies both mental health an mainstream

Medication – this involves use of low dose medication in the first instance with regular review and side effect monitoring

Relapse prevention – working to understand and recognise their early warning signs and make plans to prevent relapse where possible

Physical health – promotion of healthy lifestyle, physical wellbeing, good communication with primary care

OASIS and STEP patients seen in Q4 2012/13



Proportion of service users on CPA with a Schizophrenia spectrum diagnosis who have received CBT for Psychosis in the past year

CAG/Care Pathway	Ethnic Group	Proportion of service users received CBT	%
Overall Psychosis CAG	BME	268/2247	11.9%
	White	145/1240	11.7%
Southwark Early Intervention	BME	26/78	33.3%
	White	5/17	29.4%
Southwark Promoting Recovery	BME	45/336	13.4%
	White	29/212	13.7%
IAPT	BME	16/24	66.7%
	White	8/24	33.3%

CBT for Psychosis

- Our outcome data indicates that psychological interventions are equally successful with people from BME communities as white people
- However, there are some audit indications that drop-out rates are higher in BME groups and we are working to address this through improving the cultural competency of our psychological workforce

The abandoned illness

a report by the Schizophrenia Commission. November 2012

Shubulade Smith, Member of the Commission and Consultant Psychiatrist at the South London and Maudsley NHS Foundation Trust and Clinical Senior Lecturer at the Institute of Psychiatry, King's College London.

"The evidence about social adversity and mental illness was striking. I look after people with severe mental health problems. I am frequently struck by how much they have in common. So many have experienced horrendous emotional trauma and significant social deprivation regardless of whether they were born in the Caribbean, Afghanistan, Surrey or around the corner in Lambeth. All too frequently I wish that someone had intervened when the person was 4 or 5-years old.

All those factors which combined to bring them to my service may have been avoided. Is psychiatry the problem for most of my patients? Not where I work. It is imperative that we work at tackling the social inequalities that cause poor mental health. Doing so will undoubtedly improve the outcome for everyone, including those from BME groups."

Dolly Sen, Service User Consultant

"I always asked for some kind of psychological therapy or talking therapy but was told, no, it was too dangerous. I had to wait 20 years for something that was the most beneficial thing. [Therapy] has changed my life basically."

Talking to Norman Lamb on 19 December 2012

Agenda Annex

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

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Dated: April 2013