Open Agenda

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

Monday 15 July 2013
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Agenda Item 4

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

MINUTES of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Wednesday 1 May 2013 at 7.00 pm at Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Mark Williams (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Denise Capstick
Councillor Norma Gibbes
Councillor Rebecca Lury

OTHER MEMBERS PRESENT:

OFFICER AND HEALTH PARTNER SUPPORT:
Professor John Moxham; Director of Clinical Strategy, King's Health Partners
William McKee; Director of Transition and Transformation, King's Health Partners
Dr Michael Heneghan; Liver Consultant, King's College Hospital
Mr Chris Rolfe; Head of Communications, King's College Hospital
Zoe Reed; Executive Director Strategy and Business Development, South London and Maudsley NHS (SLaM)
Philippa Garety; Professor of Clinical Psychology , Clinical Director and Joint Leader Psychosis Clinical Academic Group (SLaM)
Andrew Bland; Managing Director of the Business Support Unit Southwark Clinical Commissioning Group (SCCG)
Tamsin Hooton; Director of Service Redesign SCCG
Ying Butt, deputy Chief Nurse, Community Guy's & St Thomas' NHS Foundation Trust
Cliff Bean; Director of Patient Safety, SlaM
Julie Timbrell; Scrutiny Project Manager

1. APOLOGIES

1.1 Apologies were received from Councillors The Right Reverend Oyewole and Mann with Councillors Chopra and Mitchell attending as substitutes.

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

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 Councillor Mitchell mentioned his long standing involvement in campaigning for Dulwich Hospital.

4. MINUTES

4.1 The minutes of meeting held on 25 March 2013 were agreed as an accurate record with the following amendments :

RESOLVED

It was agreed that Mr. Kenneth Hoole's comments recorded in the minutes under the Health Services in Dulwich item, would be amended to make clear that he said that the consultation plan looked *as if* it was produced by Saatchi and Saatchi; that more than one practice was linked to Dulwich Hospital, including Dr Shama's surgery; and that Mr. Hoole chose to amend his comments to *avoid* litigation.

4.2 Members of the public asked a number of questions about Health Services in Dulwich and the chair requested the following information :

RESOLVED

Southwark Clinical Commissioning Group agreed to provide the committee with briefing notes on:

- The overall spend on Health services in Dulwich so that

people can respond to the consultation with sufficient understanding of the finances.

- The ownership of NHS assets in Dulwich, including an explanation of what property is held leasehold/ freehold and what property will transfer to the NHS Property Services Ltd.

5. SOUTHWARK CLINICAL COMMISSIONING GROUP

5.1 Tamsin Hooton, Director of Service Redesign at Southwark Clinical Commissioning Group (SCCG), gave a verbal update on Southwark and Lambeth Integrated Care; Frail and Elderly Pathway. She reported there had been significant progress, but the initiative is slightly behind where they would like to be. This is community based multiple disciplinary team. Primary care are engaged to access the risk of all people over 70 years of age and the initiative is also focused on simplifying discharge from hospitals to the community. The chair requested board papers and encouraged members to look at these and consider follow up questions.

5.2 Andrew Bland; Managing Director of the Business Support Unit (BSU) SCCG referred to the Register of Interest circulated with the papers. He explained there are regular opportunities to update. The NHS commissioning board provided more guidelines on good practice.

5.3 A member commented that declarations appear variable and that sometimes members declare their political party membership, and that of their partners, while other members do not appear to be doing this. Andrew Bland responded that there are minimum requirements but people can declare more. The member queried how clear the policy was on political affiliations and Andrew Bland indicted he would circulate the updated policy to the committee.

5.4 Andrew Bland reported that the SCCG had received renewed guidance on contracts. He had received a note from the scrutiny project manager on the legal clause that the council uses to ensure providers are subject to scrutiny and he will consider this.

RESOLVED

<u>Frail and Elderly pathway</u>

SCCG will provide boards papers.

It was recommended that this is added to the work plan of the next administrative committee and Members will be encouraged to submit questions in advance.

SCCG Conflicts of Interest and providers 'subject to scrutiny'

SCCG guidance and policy on the Register of Interests and Declarations of Interest will be circulated to the committee.

The SCCG will report back on progress to include a clause in contracts that will ensure that all providers are subject to scrutiny.

6. PRESSURE ULCER FOLLOW UP REPORTS AND PRESENTATIONS

6.1 Ying Butt, Deputy Chief Nurse, Community, Guy's & St Thomas' NHS Foundation Trust (GST) ;Cliff Bean, Director of Patient Safety, SlaM ; Tamsin Hooton, Director of Service Redesign , SCCG and Professor John Moxham, Director of Clinical Strategy, King's College Hospital presented and contributed to this item .

6.2 Ying Butt, Deputy Chief Nurse (GST) presented Guy's & St Thomas report on Community Acquired pressure sores and noted that in the time period inquired about there were 19 pressure ulcers acquired prior to visiting hospital and three of the patients were Southwark residents. Ying Butt explained 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.

6.3 A member asked about procedures and the Tamsin Hooton , SCCG , explained that there is a requirement for services to make a record of all pressure sores for people receiving health services, including funded nursing care. A member asked if there was guidance on this and he was told there was. Health professionals explained that there was a recent meeting on developing better protocols for sharing information about pressures sores between providers and commissioners . Cliff Bean, SlaM, commented that they are now monitoring this better as there is a focus on pressure sores through the Patient Safety Thermometer.

6.4 Members asked if there has been an increase in pressures sore and clinicians said that hospitals are seeing an increase of stage 2 and 3, and sometimes grade 4, pressure ulcers in patients not seen previously by clinicians. Professor Moxham commented that King's is seeing an increasing number of frail elderly people coming in to hospitals needing total care and also intensive care. The Deputy Chief Nurse, GST, explained many patients have co morbidity .Cliff Bean, SlaM, commented this often involves people with dementia or on an end of life path.

6.5 A member asked if pressures sore were caused by carers not turning mattress or not enough nurses. Professor Moxham said there had never been more care, and mattress, and more resources focused on this in hospitals. Members asked for the causes and clinicians explained that extra cases may be from private residents and from private care homes and they will be looking at this forensically. Cliff Bean, SLaM, explained that people can acquire a serious pressure sore very rapidly, for example in one case somebody collapsed and could not move; by the time they were found they had developed a pressure sore. There were concerns raised that care in the community is not working.

RESOLVED

The Trusts will provide:

Follow up information on how community acquired Pressure Sore cases are resolved, with particular focus on quarter 2 2012/13 and new protocols being developed.

An analysis of why Pressure Sores are increasing, including data on where these are acquired.

7. SAFEGUARDING UPDATE

7.1 The papers were noted.

8. REVIEW : KING'S HEALTH PARTNER MERGER

8.1 The chair invited Professor John Moxham, Director of Clinical Strategy, King's Health Partners (KHP) and William McKee, Director of Transition and Transformation, King's Health Partners to update the committee. Professor Moxham reported that KHP are developing options for closer working, however progress has been slowed because of the impact of the TSA and the proposed acquisition of Princess Royal University Hospital (PRUH). He commented that there are two judicial reviews in the pipeline concerning the TSA and Lewisham Hospital.

8.2 William McKee introduced himself and explained he is a career trust chief executive and oversaw the merge of six previous Trusts in Northern Ireland. These are now fully integrated .He will be leading on closer integration of KHP and developing the business care.

8.3 He reported that KHP felt the respective organisations could do better if they came together more tightly. There is intense activity going through to June and if the partners think that there will be benefits then they will go to a full business case this autumn, which will then go to stakeholders. Options that are being explored include full merger or formal cooperation. A contract with consultants Mckinsey & Company has been agreed. A full merger would be considered by the Office of Fair Trading and Monitor, which takes time and KHP would not expect to hear back until 2014

8.4 A member asked about risks and William McKee said he will be commissioning a piece of work from a range of sources looking at the potential risks

8.5 KHP representatives were asked how a closer working relationship between partners would benefit local people. Professor Moxham said that KHP will see global quality services in people's backyard and the partnership would also be offering better services for people with co-morbidity. He assured members that KHP do not have to do this and that if the partners find the benefits in terms of better care are not there, they will not pursue the merger option. A member commented there are problems related to the democratic deficit; people do tend to be concerned about their services in their patch and local people will be concerned about the vastness of KHP and people's ability to exert influence. Professor Moxham commented that if a local resident had a stroke they would go to King's, but an aneurysm would be treated at Guys and St Thomas, whereas a bone transplant would take place at King's too - working at scale allows this level of specialism. A member remarked that

he understands the rational for the acute services but is less convinced that this will improve services to the local communities.

8.6 A member commented that the KHP population now include the patients served by Princess Royal University Hospital (PRUH). Professor Moxham commented that the TSA process been challenging. King's is a medically successful organisation but it is rammed full. The upside of King's acquiring PRUH is that can it can drive positive change and efficiency in the PRUH. However, he cautioned, the acquisition of PRUH is still not a done deal and no final decision has been made yet .King's will not take PRUH on unless there is sufficient transitional funding to invest in PRUH. There would also need to be enough money to provide more maternity and emergency capacity, as King's is already full.

8.7 Members asked about the relationship with SCCG and Professor Moxham said they are extremely cordial and that KHP will have to demonstrate a convincing case to our commissioners and patients. Andrew Bland, SCCG Managing Director commented that the SCCG have produced a statement on what would be good for KHP. He continued that the TSA have said that the solution to King's being too full is to bring to life Community Care. Professor Moxham commented that integrated care is the future is we all want to make best use of money

8.8 A member commented that adding PRUH to KHP means the addition of the Bromley population. Whereas before there was more of a focus on the local population of Southwark and Lambeth, with existing close community and geographical ties, this additional population is an additional layer of complexity, and there is the additional a risk that the acquisition of PRUH will not be completed. William McKee said that when KHP write the higher order business case KHP will write in an assumption that PRUH is acquired.

8.9 A member voiced concerns that the merger could be perceived as a done deal and asked to what extent people will be able to see the evidence of each option. KHP representatives responded that the board is arranging an away weekend for a deep dive to identify risks. The chair asked if this information will be published and KHP representatives responded that this would be encouraged but they are unable to say for sure. There was a discussion on if a merger of KHP would amount to a substantial variation. KHP representatives said that they thought that the Secretary of State would be neutral and that a merger would not need his or her approval.

RESOLVED

The committee asked to be kept up to date about progress with negotiations between King's and the Department of Health and to have first sight of early documents produced in June in connection with the business case for PRUH and the options for KHP.

9. KING'S COLLEGE HOSPITAL LIVER TRANSPLANT PRACTICE

9.1 The chair invited Dr Michael Heneghan, Liver Consultant, King's College Hospital, and Mr Chris Rolfe, Head of Communications, King's College Hospital to present the paper. The chair then remarked that on first sight of press reports he was concerned, however said he now feels reassured by the verbal and written reports received. He asked Dr Michael Heneghan to give an explanation of a patient's journeys and an explanation of how organs are offered and the processes involved.

9.2 Dr Michael Heneghan explained that King's transplant about 200 livers a year and are the largest centre in the UK. They have been pioneering processes to make more livers usable .There are two categories of priority: Group One is for NHS patients and European Union patients - NHS are the majority. If no recipients are available for NHS patients in the UK then a liver will be offered to Ireland and then further afield. Group Two is comprised of private patients; King's only perform between 2 and 8 operations a year. These recipients may get offered a liver because of rare blood groups such AB. Private patients only receive livers that would be discarded if they were not used for private patients.

9.3 A member asked how long livers are viable for and the Liver Consultant explained that they are viable for 12 -14 hours , however King's are trying to use organ resuscitation machines to keep them usable for longer. The Head of Communications explained that Kings also retrieve EU livers. He reassured the committee that whatever their views are on private operations, livers are always offered to NHS patients first.

9.4 The Liver Consultant explained King's is a site of excellence. King's turn down 5% of livers, whereas Newcastle does not use up to 65 % of its donated livers. Kings was one of the first centres to

split livers and take risks. Kings have a big list and the centre does what is can. Newcastle have smaller list and so wait for better organs, however King's outcomes are some of the best in the world. King's would like a national waiting list. It is worth bearing in mind that 50% of people on the waiting list do not want a marginal organ.

9.5 A member said he understands that under EU law the NHS is required to perform operations on EU patients. The King's representatives explained that King's tend to perform operation on patients from Malta and Cypress where there are reciprocal arrangements in place as these countries do not have the clinical capacity to do these operations in their local hospitals. There are also special arrangements with Dublin, particularly for children. In the last 5 years 28 patient have received organs from EU countries, half of whom are children. King's have received 20 organs from Cypress and Malta. The Republic of Ireland is a net exporter of around 300 organs.

9.6 Professor Moxham explained that the 3 month death rate for King's transplant recipients is incomparably better and much of this is down to experience and critical mass. The closer you live to a transplant centre the more likely you are to have a transplant .Good transport networks are related to successful organ donation too and Kings have been making links with Plymouth to improve access and clinical skill. Kings want to raise other providers to their level.

RESOLVED

The chair asked King's to send press releases, and other relevant information, to the scrutiny project manager when contentious issues arise.

10. REVIEW: PREVALENCE AND ACCESS TO PSYCHOSIS SERVICES; BME COMMUNITIES

10.1 The chair invited Philippa Garety, Professor of Clinical Psychology , Clinical Director and Joint Leader of the Psychosis Clinical Academic Group and Zoe Reed, Executive Director Strategy and Business Development, South London and Maudsley NHS to present and then invited questions

10.2 Members queried the evidence that ethnic minority members are more at risk generally but this reverses when a BME community reaches a certain level of density at a very local level. The Professor of Clinical Psychology explained that this is true of many immigrant communities and the second generation is more at risk than the first generation, unless they come from a war torn country. Members commented that Southwark and Lambeth have high levels BME communities in some wards; however Southwark still has high rates of psychosis. Philippa Garety responded that these communities would be more resilient, but only if there was a high density at a very local level. A member commented about half of Brunswick Ward is composed of BME communities and the Professor of Clinical Psychology said this is a good example; while members of BME communities might do better in Brunswick , they might do less well in College Ward. A member noted that Richmond has a low density of ethnic minorities but also low levels of psychosis. The Professor of Clinical Psychology explained that there are many interrelated factors such as levels of social exclusion, including employment levels.

10.3 A member commented that the causes seem to be related to societies problems and that people need support to maintain health, which could come though schools or through their neighbourhood communities; people need kindness and caring, particularly if they get unwell. The chair commented that the discussion suggested that focussing on social factors and reducing social adversity might yield the most useful recommendations.

RESOLVED

Public Health and Adult Social Care will be asked to provide a briefing paper.

Members will be asked to comment on the scoping document.

11. MARINA HOUSE UPDATE

11.1 Tanya Barrow, Community Safety Partnership Service Business Unit Manager, referred to the briefing tabled at the meeting and explained that the commissioning structure for Drug and Alcohol services is a complicated picture. There is a partnerships board with a pooled budget, which is top sliced. The council leads this and holds the SCCG budget through which services from SLaM

are commissioned and managed. Treatment is provision is declining because there is a national trend of declining opiate users.

11.2 There were despite protracted negotiations to deliver the Integrated Offender Management (IOM) service programme at Marina House; however it was not considered the right location. The substance misuse service user group have fed back positively on the current arrangements.

11.3 Local resident Tom White commented that the Older People Partnership Board frequently talk about alcohol misuse. He asked if there was good news on reductions in illegal drug use but increases in problematic alcohol consumption. Tania Borrow agreed that this is a national trend; however Marina House did not treat alcohol abuse. She explained that the service tends to offer different treatment services as alcohol is legal and drugs are illegal. She explained that there is a drugs needs assessment being conducted that will look at prevalence and the effectiveness of treatment options.

11.4 A member commented that the level one course for GPs to refer to drug service is not very demanding and more about awareness rising. She explained that the healthcare assistants at her place of work do this level of qualification, and that she was concerned that it was not an adequate level of training to equip General Practitioners to undertake referral work with patients with complex needs. Tania Barrow commented that the partnership do not want to want to force GP's to do higher level courses; furthermore some surgeries also have drug workers. She added that there are specialised services at Blackfriars complex and in hostels.

11.5 A member asked how treatment performance is measured and Tania Barrow commented that they look at levels of recovery and if someone re-presents within 6 months.

11.6 A member commented that there were a number of promises for Marina House, and the reconfiguration of drugs services, which he is concerned have not come to pass. He added that the explanation about IMO is useful, but he was concerned about the rest of the services. The committee were given certain assurance about Blackfriars, however the footfall looks different. He commented that this engenders certain scepticism about the information given during the consultation.

11.7 Members queried if levels of drug use level are going down; one member said he thought this was the national picture and that Richmond are seeing a reduction in cases, however another member commented that she is seeing an increased proportion of drug users at Belmarsh Prison where she works.

11.8 Chair invited Tom White to make further comment. He said that he thought it was a dire situation to recommend that drug users go to Blackfriars for treatment as this is often not easy. He raised concerns about the loss of lives because of a lack of self referral options and added that local MPs think it was retrograde step to end the self referral, but SLaM refuse to re-consider this. He said that comparisons are made with other illness - but drug use is completely different.

11.9 He complained about the quality of the consultation document circulated with the agenda and said that he thought that information was missing. He went on to say that although the letter says that the £95 000 was not applied for in the end he has documents saying that this was accepted. Tom White said he knew Mike Farrell, a drug treatment expert, who used to treat GPs and dentists at Marina House. Tom White said he was concerned where health professionals would now be able to access treatment. He ended by saying that he thinks that Marina House is virtually empty, while there are record numbers of drug users arriving at King's College Hospital. He thought Marina House was effectively being closed down as a drug treatment centre, without consultation.

11.10 The chair thanked Tanya Barrow for her presentation and requested further information on the points raised by Tom White and the committee.

RESOLVED

SLaM and Southwark Clinical Commissioning Group will be asked to present.

The following information will be requested:

- The number of patients presenting at King's over the last 5 years with drug and alcohol problems, including a breakdown on the number of Southwark residents.
- Information on where GPs and dentists with drug misuse problem are being provided with treatment.
- Mental health emergency crisis room at Kings and to what extent people in crisis do use this facility to access mental health treatment, including prescriptions.
- Statistics from the police on the number of arrests for drug and alcohol offences, including trends for the last 5 years

Briefing note to: Health, Adult Social Care, Communities & Citizenship Scrutiny sub-Committee

30th April 2013.

Provided by Tanya Barrow, Community Safety Partnership Manager

Re: Marina House, Camberwell

The substance misuse SLaM contract is now managed as part of the wider contract with SLaM by the CCG. The Council Substance misuse team will manage the service via a section 75 agreement which is currently being drafted.

There has been a steady decline in the numbers of people in treatment in Southwark since 2010 when the consultation was completed. This is due to a number of factors including treatment being more affective and therefore an increase in the numbers of clients leaving treatment drug free and not returning. This is known as a "successful outcome" (2009 = 1763, 2010 = 1664, 2011 = 1489, 2012 = 1481, 2013 = 1432) and a decease in the number of people requiring complex prescribing services ie opiate users (this is in line with national trends).

Following the outcomes of the consultation (lead by the then PCT) complex prescribing services ceased at Marina House. This is in line with other boroughs ie only one complex prescribing centre per borough. A range of alternative access methods were developed including outreach and shared care ie prescribing services delivered via gps.

Following the consultation, SLaM and the IOM partners worked for 18 months to develop plans to deliver offender related services from Marina House. Unfortunately, despite protracted discussions, an agreement could not be reached for a number of reasons including financial constraints and a failure to agree terms of licence between SLaM and the MET Police. The IOM is now based at London Probation Service offices in Borough.

The PCT was fully aware of the discussions and the decision to withdraw from pursuing the IOM at Marina House.

A remodel of Southwark substance misuse treatment services was completed in July 2012 ensuring that anyone presenting to any treatment service in Southwark will receive a full, comphrensive assessment of their needs and access to a range of interventions, including, if necessary complex prescribing. This was not the case previously. There are a number of substance misuse agencies operating in the Camberwell area at which people can self refer and present for treatment. The IOM would not have offered this.

The Substance Misuse Service User Council (who represent substance misuse service users at all levels in the treatment system) have feedback no issues with those seeking treatment not being able to do so because of a lack of facilities in the Camberwell area.

At this time, there is no requirement for an additional complex prescribing service or additional treatment capacity in Camberwell. The treatment system (with a steady decline in numbers requiring complex prescribing but an increase in other types of substance use) has enough capacity and flexibility to treat the numbers entering the system wherever they present.

The newly merged Drug and Alcohol Team in Southwark Council have commissioned a full needs assessment that is due to complete in October 2013. This will confirm if we have the access routes and care pathways right for those seeking treatment now and in the future.

Safeguarding comment from Adult Socialcare

-the table in the Safeguarding Annual Report being referred to (p.41 - 42) on which there were zero acute/SLAM referrals relates to location of alleged abuse**.** There were indeed no referrals in 11/12 where the alleged abuse happened to patients whilst in acute or SLAM settings, according to our records. As such the letters from the acute trusts are correct.

- there are also cases where the acute trusts identify safeguarding issues in relation to concerns about a patient that may have happened before they arrived and they make a referral (for example the referral in relation to the bed sore case discussed elsewhere on the agenda) (This is source of referral**).** This data was not included in the Safeguarding Annual Report but could be in future. There were 22 acute referrals of this sort in 2011/12.

SCCG responses to questions raised at the 1 May 2013 meeting under item 4 .

The overall spend on Health services in Dulwich so that people can respond to the consultation with sufficient understanding of the finances.

The level of spend on Dulwich residents healthcare by the CCG will change each year for a multitude of factors. An apportionment of overall planned (budget) spend by head of population would suggest a figure of £74.5m in 2013/14.

Details of the ownership of NHS assets in Dulwich, including an explanation of what property is held leasehold/ freehold and what property will transfer to the NHS Property Services Ltd.

NHS Southark CCG does not own property in the area.

NHS Property Services now own two properties in the Dulwich area:

- Dulwich Community Hospital (freehold)
- Melbourne Grove GP Practice (freehold)

Guy's and St Thomas' NHS Foundation Trust occupy a further two properties in the Dulwich area:

- Townley Road Clinic (leasehold)
- Consort Road Clinic (freehhold)
- Bowley Close Centre (freehold)

NHS
Southwark
Clinical Commissioning Group

Conflict of Interest Policy

Title: Conflict of Interest Policy	**Status: Approved**
Document Type & No: Corporate Policy	**Date of issue: June 2013**
Version No: 1.0	**Review date: May 2014**
Sponsor: Malcolm Hines, Chief Finance Officer	**Pages: 41**

NHS
Southwark
Clinical Commissioning Group

Contents

1. Background

1.1. In the new healthcare commissioning system, where providers are involved in commissioning decisions, there is an increased risk that decisions relating to how care is provided and by who, may be influenced by private interests. This may call the probity of the Clinical Commissioning Group (CCG) into question.

1.2. As CCGs have responsibilities which include the stewardship of significant public resources, and the commissioning of health services to the local population, each governing body must ensure that the organisation inspires confidence and trust from its staff, partners, funders, suppliers and the public from its staff, partners, funders, suppliers and the public. It must demonstrate integrity and avoid any potential or real situations of undue bias or influence in decision-making.

1.3. All CCGs have statutory requirements they must legally comply with regarding conflict of interest. Section 140 of the National Health Service Act 2006, inserted by the Health & Social Care Act 2012, sets out that each CCG must:

- maintain one or more register of interest of: the members of the group, members of its governing body, members of its committees or sub-committees of its governing body, and its employees;
- publish, or make arrangements to ensure that members of the public have access to these registers on request;
- make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group, and record them in the registers as soon as they become aware of it, and within 28 days; and,
- make arrangements (set out in their constitution) for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not and do not appear to, affect the integrity of the CCG's decision-making processes.

1.4. The NHS (Procurement, Patient Choice and Competition) Regulations 2013 set out that commissioners must:

- manage conflictsandpotential conflicts ofinterests whenawardingacontractby prohibitingthe award of a contract wheretheintegrityoftheaward has beenor appears tohave been affectedbyaconflict;
- keep appropriaterecords of howtheyhave managed anyconflicts in individual cases.

1.5. NHS England (previously known as NHS Commissioning Board) has thus published detailed guidance for CCGs on the discharge of their functions and requires each CCG to have regard to the guidance: *Managing Conflicts of Interests: Guidance for clinical commissioning groups, March 2013.*

1.6. NHS Southwark CCG recognises the importance of all of its members to be fully aware of the guidance and continuously mindful of conflicts of interest. It has laid out these expectations in the Southwark CCG Constitution.

2. Introduction, Aims &Objectives

2.1. This policy sets out how NHS Southwark CCG will manage any conflicts (or potential conflicts) of interest arising from the business of the organisation. It also sets out the organisation's commitment to on-going training, raising awareness on conflicts of interest and an induction programme for new members of the CCG.

2.2. This policy will guide the NHS Southwark CCG Governing Body in ensuring that robust health need assessments, consultation mechanisms, commissioning strategies and procurement procedures enable conflicts of interest to be identified and mitigated, in the best interests of patients and the public.

2.3. The policy will support all members and employees of NHS Southwark CCG to act in accordance with the Nolan Principles of Public Life and the code of conduct set out by NHS England, recognising that perceptions of wrong doing, impaired judgement or undue influence can be as detrimental as actually occurring.

2.4. This policy is in line with current national guidance and will be reviewed periodically to ensure it complies with any modifications to national guidance.

3. Scope of the Policy

3.1. This policy applies to:

- The members of NHS Southwark CCG (practices),
- The members of the NHS Southwark CCG Governing Body;
- The members NHS Southwark CCG's committees and sub-committees of the Governing Body and,
- The employees of NHS Southwark CCG

4. Principles

4.1. All members, employees and appointees of NHS Southwark CCG are required to observe principles of good governance in the way the organisation's business is conducted (as set out in the CCG's Constitution (4.4)). These include:

- The Good Governance Standards for Public Services 2004, OPM[1] and CIPFA[2]
- The standards of behaviour published by the Committee on Standards in Public Life (1995) – *the Nolan Principles*
- The seven key principles of the NHS Constitution
- The Equality Act 2010

4.2. This policy also supports the three main principles of procurement law: equal treatment, non-discrimination, and transparency.

4.3. This policy complies with the standards of business conduct as set out by the Committee on Standards in Public Life (1995)

The Committee on Standards in Public Life (originally the Nolan Committee) was asked to investigate standards in public life. It established the '**Seven Principles of Public Life'** which should apply to all in the public service. These are:

1. **Selflessness**: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
2. **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
3. **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
4. **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
5. **Openness**: Holders of Public Office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
6. **Honesty**: Holders of Public Office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

[1] Office of Public Management
[2] Chartered Institute of Public Finances and Accountancy

7. **Leadership**: Holders of Public Office should promote and support these principles by leadership and example.

4.4 This policy supports the principles of managing conflicts of interest as detailed in the guidance *Managing Conflicts of Interests: Guidance for clinical commissioning groups, March 2013*[3]:

- **Doing business properly.** If health needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are correct from the outset conflicts of interest become much easier to identify, avoid or deal with as the rationale for all decision-making will be clear and transparent and should withstand scrutiny;

- **Being proactive not reactive.** Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible stage: by considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making roles, by ensuring individuals receive proper induction and understand their obligations to declare conflicts of interest, by establishing and maintaining a registers of interests, and by agreeing in advance how a range of different situations and scenarios will be handled rather than waiting until they arise;

- **Assuming that individuals will seek to act ethically and professionally but may not always be sensitive to all conflicts of interest.** Most individuals involved in commissioning will seek to do the right thing for the right reasons. However, they may not always do it the right way because of lack of awareness of rules and procedures, insufficient information about a particular situation, or lack of insight into the nature of a conflict. Rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this;

- **Being balanced and proportionate.** Rules should be clear and robust but not overly prescriptive or restrictive. They should protect and empower people by ensuring decision-making is efficient as well as transparent and fair, not constrain people by making it overly complex or slow.

5. Definition of 'Conflict ofInterest'

5.1. A conflict of interest is defined as:

- A conflict between the private interests and the official responsibilities of a person in a position of trust[4]

[3] NHS England, 28th March 2013
[4] Webster dictionary definition

- A set of conditions in which a professional judgement concerning a primary interest [such as patients' welfare or the validity of research] tends to be unduly influenced by a secondary interest [such as financial gain][5]

This definition includes:

- Direct pecuniary interests: where an individual may get direct financial benefits from the consequences of a commissioning decision (for e.g. as a provider of services)

- Indirect pecuniary interests: where for e.g. an individual's partner is a member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision.

- Non-pecuniary interests: where an individual holds a non-remunerative or not for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for e.g. where an individual is a trustee of a voluntary provider that is bidding for a contract)

- Non-pecuniary personal benefits: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for e.g. a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

- Situations where a member is closely related to, or in a relationship with an individual who they know to be in ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS

5.2 The NHS Southwark CCG acknowledge it as important that:

- perception of wrong-doing, impaired judgement or undue influence may be as detrimental as it actually occurring;
- if there is any doubt, it is better to assume a conflict of interest and act appropriately rather than to ignore it; and
- it is not necessary for financial gain to be present for a conflict to exist.

6. Accountability & Responsibilities

6.1 It is the responsibility of all listed below to ensure that they are not placed in a position which creates a conflict or potential conflict between their private interests and their NHS Southwark CCG duties.

[5] Dennis F. Thompson (1993), Understanding Financial Conflicts of Interests (New England Journal of Medicine, 329(8), 573)

- members of the NHS Southwark CCG (practices),
- members of the Southwark CCG Governing Body;
- members of Southwark CCG committees or sub-committees and the committees or sub-committees of its Governing Body &
- employees of NHS Southwark CCG[6]

7. Declaration of Interests

7.1. In line with national guidance NHS Southwark CCG require the following interests to be declared using the Declaration Form in Appendix 1:

- Roles and responsibilities held within member practices
- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG
- Shareholdings [more than 5%] of companies in the field of health and social care
- Positions of authority in an organisation [e.g. charity or voluntary organisation] in the field of health and social care
- Any connection with a voluntary or other organisation
- Research funding/grants/ sponsorships that may be received by the individual or any organisation they have an interest or role in
- Any other role or relationship which would impair or otherwise influence the individuals judgement or actions in their role within the CCG

7.2 NHS Southwark CCG requires all applicants for appointments to the CCG or its Governing Body to declare any relevant interests. This is a requirement of the application process. All appointments will be followed by a requirement for a formal declaration form to be submitted.

7.3 NHS Southwark CCG requires that all members update their declarations of interests at least annually.

7.4 All members are required to confirm their declarations as a standing item on the agenda for every Governing Body meeting, committee and subcommittee meeting. Declarations will be recorded in the minutes of the meeting.

7.5 New declarationsare required when an individual changes role or responsibility with NHS Southwark CCG (including the Governing Body), and when an individual's circumstances change in a way that

[6] A COI compliance statement has been written into job descriptions for NHS Southwark CCG posts since at least April 2013 onwards

affects the individual's interests (e.g. a new role outside the CCG or setting up of a new business or relationship).

7.6 The NHS Southwark CCG Chief Officer should be informed of any interests requiring registrations within 28 days of a member taking office, or within 28 days of any changes to a member's register of interest.

8. Privileged information

8.1. No–one should use confidential information acquired in the pursuit of their role within the CCG to benefit themselves or another connected person, or create the impression of having done so.

8.2. Members of NHS Southwark CCG, employees and the Governing Body should take care not to provide any third party with a possible advantage by sharing privileged, personal or commercial information, or by providing information that may be commercially useful in advance of that information being made available publically (such as by informing a potential supplier of an up and coming procurement in advance of other potential bidders), or any other information that is not otherwise available and in the public domain.

9. Declaration of Gifts or Hospitality

9.1. Any gift or hospitality offered over £10 or equivalent should be recorded by submitting a completed declaration form (Appendix 3).

9.2. One-off gift of low intrinsic value (less than £10 per item) such as pens, diaries, calendars and mouse mats need not be refused and do not need to be declared. However if several such gifts are received from the same or related source such that their total value over any 12-month period exceeds £10, they should be declared using the form at Appendix 3 and recorded in the CCG Gifts and Hospitality Register, to be published on the internet site.

9.3. The recipient of the gift is obliged to inform the Governance team who will record the gift in an appropriate manner.

9.4. Such records will be reviewed by NHS Southwark CCG's Audit Committee on a six monthly basis and should be viewed as being in the public domain.

10. Maintaining a Register of Interests

10.1. NHS Southwark CCG has established a Register of Interests as required in the national guidance. The Register is published on the

CCG public website, will be made available at CCG Governing Body meetings, and on request by writing to:

Corporate Governance Manager
NHS Southwark Clinical Commissioning Group
1st Floor, Hub 5, PO Box 64529
London SE1P 5LX

Email address: southwarkccg@nhs.net

10.2 The Register of Interests will be updated following every Governing Body and committee meeting.

10.3 The Register of Interests will be maintained and held by the Corporate Governance team based at NHS Southwark CCG headquarters.

10.4 The Register of Interests will be published as part of the CCG's Annual Report and Annual Governance Statement.

10.5 The Register of Interests will be presented to the NHS Southwark CCG Audit Committee and the Local Authority Overview and Scrutiny Committee annually. Scrutiny of the Register of Interest and the process and policy on Conflict of Interest will form a regular part (annual) of internal and external governance.

11. The role of the Corporate Governance team

The Corporate Governance Manager/ team will:

- Receive declarations of interests from all new members and employees of the CCG and Governing Body.
- Update the Register of Interests and ensure it is uploaded to the CCG public website within 3 working days of the Governing Body meeting
- Maintain the Register of Interests with the help of the Corporate Secretary
- Ensure the Register is physically available at all Governing Body meetings
- Ensure declaration of interest is taken as a standing item at every CCG Governing Body, committee and sub-committee meeting and is signed by all attendees.

12. Procedure to be followed in Governing Body meetings, or Committee/ Sub Committee meetings

12.1. Declaration of Interests will be a standing item on the agenda of all Governing Body meetings, committees and sub-committee meetings, after introductions and apologies (see also Section 16).

12.2. The Register of Interests will be circulated to all members for acknowledgement of entries and signatures. Blank forms for declarations will also be made available from the staff member servicing the meeting. The interests of those individuals that are "In attendance" rather than full members, will be captured in the minutes of the meeting only.

13. Procedure to be followed when a Governing Body or Committee/ Sub Committee member is conflicted

13.1. If, during the course of a meeting, an interest not previously known/ recorded is identified or stated, a declaration will be made by the member, specifying the agenda item the potential conflict of interest relates to, and detailing the nature of that conflict. This will be recorded in the minutes.

13.2. Where an interest is significant, or when the individual or a connected person has a direct financial interest in a decision, the individual should not take part in the discussion or vote on the item, but may be allowed to sit with the public, where this is relevant.

13.3. If that exclusion affects the quoracy of the meeting, the item should be postponed to another such time when quoracy can be reached without conflicts, having found a suitable replacement.

13.4. If the conflicted member is a specialist/ expert, quoracy may be achieved on the following occasion by inviting an external independent expert from another CCG or trust.

13.5. Alternatively, there may be circumstances where the Chair of the meeting judges it appropriate for the individual concerned to attend the meeting and contribute in the discussion having declared an interest (waiver), but not to participate in any decision-making resulting from such discussion (i.e. not having a vote in relation to the decision).

13.6. If the Chair of the meeting is personally conflicted, the deputy chair will conduct proceedings, providing they are not also conflicted. If the Chair and Deputy are both conflicted, then a Chair will be appointed by the remainder of the Committee/ Governing Body members.

The National Health Service (Clinical Commissioning Groups) Regulations 2012 specify that the Accountable Officer, the Chief Finance Officer, the registered nurse, hospital consultant and the Lay

Person who chairs the Audit Committee, are ineligible to be the chair of the CCG Governing Body.

13.7. Declarations of interest will be recorded in the minutes detailing:

- the nature and extent of the conflict
- an outline of the discussion
- the actions taken to manage the conflict
- use of the waiver and reasons for its implementation

13.8. If there is any doubt as to whether an interest should be declared, a declaration should be made and advice sought from the Lay Member with responsibility as the Guardian for Conflict of Interests (see Section 17).

14. Procedure to be followed when two or more members are conflicted

14.1 In circumstances where two or more members of the Governing Body/ Committee or Sub-Committee are conflicted, the decision would be referred to the Conflict of Interest Panel by the Chair of the meeting.

15. Conflict of Interest (CoI) Evaluation Panel

15.1. The Conflict of Interest Evaluation Panel will provide neutrality in the evaluation process and will have the following membership, who are not conflicted. :

- The Lay member with CoI guardian responsibility (See Section 17)
- The Chief Officer
- Lambeth and Southwark Director of Public Health
- Plus co-opted clinical or procurement expertise if necessary, at the discretion of the Chief Officer.

If exceptionally, any of the members are conflicted, an additional Director or Lay Member will be substituted.

15.2. The Evaluation Panel will evaluate the proposal for quality and cost-effectiveness and if satisfied it would be recommended to the CCG Governing Body meeting. The Panel's consideration and decision will be fully minuted and attached to the relevant Governing Body meeting papers.

15.3. A CoIEvaluation Panel will be held approximately 4 weeks, or as necessary.

15.4. The Governing Body meeting will receive and adopt the Panel's conclusions.

16. The Role of the Chair of the Governing Body/ Committee/ Sub Committee meeting

16.1. The Chair has a key role in overseeing governance and particularly in ensuring that the governing body and the wider CCG behaves with the utmost transparency and responsiveness at all times and in line with national guidance and professional codes of conduct.

16.2. The Chair is able to give an unbiased view on possible internal conflicts of interest.The Chair takes the lead, particularly at meetings, in ensuring that Governing Body members, members and staff follow the policy. If the Chair is conflicted, he will leave the meeting for the particular agenda item and the deputy-chair will conduct proceedings.

16.3. In advance of Governing Body/committee and sub-committeemeetings, the Chair of the meeting will review agenda for any conflicts of interests. If any conflicts are identified, the Chair will process outlined in paragraphs 13.2 onwards will be followed.

16.4. The Chair of the meeting will decide on the course of action regarding how to proceed should conflicts of interest arise within the meeting, and whether a matter needs to be referred to the Conflict of Interest (CoI)Evaluation Panel. In making such decisions, the Chair may wish to consult the Conflict of Interest Guardian for advice. All decisions should be recorded in the minutes of the meeting.

16.5. After the Governing Body/committee and sub-committeemeetings, the Chair of the meeting will sign the agenda to agree that conflicts of interests were appropriately managed.

17. The Role of the Lay Member as Conflict of Interest Guardian

17.1. NHS Southwark CCG Governing Body has appointed one of the Lay Members (with a lead role in Governance) to act as “Conflict of Interest (CoI) Guardian”. The Lay Member should have no provider interest, is not a medical doctor or a healthcare provider and is therefore independent and impartial with regard to decisions related to commissioning of services.

17.2. The Lay Member will act as a conduit for members of the public who have any concerns in regard to Conflicts of Interest. Members of the public will be able to contact the Lay Member regarding concerns via the NHS Southwark CCG website.

17.3. The Lay Member is responsible for ensuring that the CCG applies conflict of interest principles and policies rigorously and provides the CCG with independent advice and judgment where there is any doubt about how to apply them to individual cases.

17.4. The Lay Member will act as Guardian for conflict of interest and decide if the matter needs to be referred further to the evaluation panel.

17.5. The Lay Member will have a lead role in ensuring that the Governing Body and the wider CCG behaves with the utmost probity at all times and be able to give an independent view on possible internal conflicts of interest.

17.6. The scope of the Conflict of InterestGuardian's work is to:

- judge whether or not there is a risk of a conflict of interest arising
- advise how the risk should be minimised.

17.7. The Conflict of InterestGuardian operates:

- reactively, when the Chair of a meeting, individual Governing Body member, or Southwark CCG as a whole or seek advice on a specific issue,
- pro-actively, when a potential Conflict of Interest risk is identified and acts on it. The Conflict of InterestGuardian is a voting member of the Governing Body and is familiar with the work of the organisation and the roles of Clinical Leads. The Conflict of Interest Guardian is, therefore, in an informed position to identify such risks when they arise.

In either mode the Conflict of InterestGuardian will discuss the issue with those involved (and any other relevant party) and issue written advice or judgement for the Governing Body. The members of the Governing Body, its committees and sub-committees have agreed that they will accept the advice or judgement of the Conflict of InterestGuardian in such cases.

The role of the Conflict of Interest Guardian is fully documented in the NHS Southwark CCG constitution.

18. Appointment of Governing Body/ Committee Members

The appointment process for Governing Body members is fully documented in the NHS Southwark CCG Constitution.

18.1 Any individual who has a material interest in an organisation which provides or is likely to provide substantial business to a CCG (either as a provider of healthcare or commissioning support services) should not be appointed as a member of the Governing Body. Appointments will be considered on a case by case basis.

18.2 The Secondary Care Doctor on the Governing Body should have no conflicts of interest i.e. they should not be employed by any organisation from which the CCG secures any significant volume of provision.

18.3 The Registered Nurse on the Governing Body should have no conflicts of interest i.e. they should not be employed by any organisation from which the CCG secures any significant volume of provision.

19. Designing Services

19.1. In the course of new or existing service designs NHS Southwark CCG will engage with relevant providers, especially clinicians, to confirm service specifications and such engagement when done transparently and fairly, is entirely legal and not contrary to competition law.

19.2 NHS Southwark CCG will take all necessary steps and ensure safeguards are in place to avoid and manage conflicts of interest arising from such engagement towards service redesign by following the three main principles of procurement law, namely, equal treatment, non-discrimination and transparency. This includes ensuring that the same information is made available to all.

20. Procurement of Services

20.1 NHS (Procurement, Patient Choice and Competition) Regulations 2013 set out that all commissioners must:

- manage conflicts andpotential conflicts of interests when awardingacontract by prohibitingthe award of a contract wheretheintegrityoftheaward has beenor appears tohave been affectedbyaconflict,and,
- keepappropriaterecords of howtheyhave managedanyconflicts inindividual cases

20.2 Under section78 ofthe Health and Social Care Act 2012, Monitor willguidanceon compliance with anyrequirements imposedbythe regulationsmadeunder section 75,andhow it intends to exercise the powers conferredonit bythese regulations.

20.3 NHS Southwark CCG will implement and adhere to any such guidance from Monitor/ NHS England.

21. Declaration of Interests for Bidders/ Contractors: Appendix 2

21.1 NHS Southwark CCG recognises that Conflict of Interests may vary according to the route that a service is commissioned. Examples of different options include:

- **Competitive tender.**WhereaCCG is commissioningaservice through competitive tender (i.e. seekingto identifythebestprovider or set of providers fora service), a conflict could arise where GP practicesorotherproviders in which CCG members have an interestare amongst thosebidding.

- **AnyQualified Provider.**Where aCCGwants patientstobeable to choosefromarange of possibleproviders and is thereforecommissioningaservice through AnyQualified Provider, a conflict could arisewhere one ormoreGPpractices (or otherproviders in which CCG members have an interest)are amongst the qualifiedproviders fromwhichpatients can choose. In these circumstances, thereare anumberof options for demonstratingthat GPpracticeshave offeredfullyinformedchoice at thepoint of referraland for auditingand publishingreferral patterns.These will build on well-established procedures for declaringinterests when GPsor other clinicians makea referral.

- **Singletender.**Where the CCG is procuring services from a GP practice where thereare no other capableproviders, i.e. this is theappropriate procurement route and theproposed service goes beyond thescopeofthe services provided byGP practices under their GP contract.

21.2. The conflicted person is expected to declare any interest early in any procurement process if they are to be a potential bidder in that process. Failure to do so could result in the procurement process being declared invalid and possible suspension of the relevant member from the CCG.

21.3 Where a relevant and material interest or position of influence exists in the context of the specification for, or award of a contract, the conflicted person will be expected to:

- Declare the interest using the Declaration of Interests for bidders / contractors template (Appendix 2)
- Ensure that the interest is recorded in the CCG's Register of Interests
- Withdraw from all discussion on the specification or award
- Not have a vote in relation to the specification or award, or any formal role in the procurement process

21.4. Conflicts and potential conflicts need to declared for all types of procurement routes including Competitive Tender, Any Qualified Provider or Single Tender.The "Code of Conduct" template at Appendix 4 sets out factors on which CCGs are advised to assure themselves

and their Audit Committee – and be ready to assure local communities, Health and Wellbeing Boards and auditors – when commissioning services that may potentially be provided by GP practices.

22. Ensuring transparency in Procurement (see Appendix 4)

22.1 NHS Southwark CCGProcurement Strategy (availableon the CCG'swebsite), approved by its GoverningBody,ensures that:

a) all relevant clinicians and potential providers, together withlocal members of the public, are engaged inthedecision-makingprocesses used toprocureservices, and;
b) service redesign and procurement processes are conductedinan open, transparent,non-discriminatoryandfairway

22.2 NHS Southwark CCG will aim to publish details of all contracts, including the value of contracts, as soon as possible after they are agreed, on the CCG website.

23. Statement ofconductexpected ofindividuals involved inthe CCG

23.1 This policy supports a culture of openness and transparency in business transactions. All employees and appointees of NHS Southwark Clinical Commissioning Group are required to:

- ensure that the interests of patients remain paramount at all times be impartial and honest in the conduct of their official business;
- use public funds entrusted to them to the best advantage of the service, always ensuring value for money;
- ensure that they do not abuse their official position for personal gain or to the benefit of their family or friends;
- ensure that they do not seek to advantage or further, private or other interests, in the course of their official duties.

23.2. In addition, the General MedicalCouncil(GMC) has recentlyupdatedits guidance on conflicts of interest, bothin its general coreguidance[7]andin separatesupplementaryguidance[8]. The GMC's guidance recommendsthat:

78 *You must notallow any interests youhave toaffect thewayyouprescribe for, treat, refer or commission services for patients.*

79 *If you arefacedwith aconflictof interest,you must beopenabout the conflict,declaring your interest informally, and you*

[7] GMC Good Medical Practice (2013)
[8] www.gmcuk.org/financial and commercial arrangements and conflicts of interests.pdf 51462148

shouldbeprepared toexclude yourself fromdecision making.

The GMC providesfurther advice, such as:

- *You must not try to influence patients'choiceof healthcare servicestobenefit you, someone closeto you,or youremployer.*
- *If youplan torefera patientfor investigation,treatment or care at an organization in whichyouhave afinancial or commercial interest, youmust tellthepatient about that interestandmake anote ofthis inthe patients'medical record.*
- *Wherethere is an unavoidableconflict of interest aboutthecareofa particular patient, you should record thisin thepatient'smedical record.*
- *You must keepup to datewithand followtheguidanceandcodes ofpractice thatgovern the commissioning of services where youwork.*
- *You must formally declare anyfinancial interest that you or someoneclose to you, or your employer hasin aprovider company, inaccordancewiththe governance arrangements inthe jurisdictionwhere youwork.*
- *You must take steps tomanage any conflict between yourduties asa doctor and your commissioningresponsibilities*

NHS Southwark CCG supports the GMCguidance.

24. Non compliance with policy

24.1. The NHS Southwark CCG will view instances where this policy is not followed as serious and may take disciplinary action against individuals, which may result in dismissal or removal from office. This approach is consistent with the following guidance:

- *Code of Conduct for NHS Managers*, Department of Health, (Oct 2002)
- *Code of Conduct in the NHS*, page 2, Department of Health/Appointments Commission (2004)
- *The Healthy NHS Board: Principles for Good Governance*, page 31, NHS National Leadership Council (2010)
- *Good Medical Practice*, GMC, Sec 73/74/ 75 & 76 (2006)
- *The code of conduct : Managing conflicts of interest where GP practices are potential providers of CCG commissioned services* (July 2012)

25. Data protection

The information in the Declaration of Interest Register will be processed in accordance with data protection principles as set out in the Data Protection Act 1998.

Data will be processed only to ensure that the conflicted person act in the best interests of the group and the public and patients the group was established to serve. The information provided will not be used for any other purpose, unless otherwise stated within statutory legislation. Signing the declaration form will also signify consent to the data being processed for the purposes set out in this policy.

26. Reporting

29.1 All issues raised to the Lay Member for Conflict of Interest will be logged with the Southwark CCG Governance team.

29.2. An annual report on management of Conflicts of Interest will be presented to the NHS Southwark CCG Audit Committee.

27. Monitoring

30.1 This policy will be reviewed annually by the Integrated Governance and Performance Committee and recommended to the Audit Committee.

30.2 The Corporate Governance Team& Lay Member with responsibility as Guardian for Conflict of Interest will review Register of Interest entries on a regular basis and take any action necessary highlighted by the review. All actions taken will be reported to the Integrated Governance & Performance Committee.

28. Training and Raising Awareness

28.1. NHS Southwark CCG will ensure that all members and employees are aware of this policy. The following steps will be taken to raise awareness:

- Policy will be introduced to new starters (employees and members) and will be included within the induction material and as part of development programme for new Governing Body members
- Inclusion in refresher training for Governing Body members and employees
- Annual reminders of the policy via internal communication methods and publication on the NHS Southwark CCG public website and intranet
- Regular reminders sent to all members to update declaration forms

- Staff and members should also refer to their respective professional codes of conduct relating to the declaration of conflicts of interest.

29. Equality & Diversity Statement

NHS Southwark CCG is committed to equality of opportunity for its employees and members and does not unlawfully discriminate on the basis of their "protected characteristics" as defined in the Equality Act 2010 - age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. An Equality Impact Assessment has been completed for this policy.

If members or employees have any concerns or issues with the contents of this policy or have difficulty understanding how this policy relates you're their role they are advised to contact the Governance Team on 020 7525 4569/ 0207 525 5250.

30. Links to other Policies/Documents and Guidance on CoI

The policy draws upon national guidance which sets out generic guidelines, principles and responsibilities for NHS organisations and General Practitioners in relation to conflicts of interests. This policy should be read in conjunction with:

- NHS Southwark Clinical Commissioning Group *Procurement Strategy*
- NHS Southwark Clinical Commissioning Group*Constitution including Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions*
- NHS Southwark Clinical Commissioning Group *Confidentiality Policy*
- NHS Southwark CCG *Integrated Risk Management Framework*
- NHS Southwark CCG *Working with the Pharmaceutical Industry Policy*

31. Cross References

Managing conflicts of interests: Guidance for CCG's – March 2013 - NHS Commissioning Board

Towards establishment: Creating responsive and accountable CCGs (and technical appendix 1): Code of Conduct

Code of conduct: Managing conflicts of interest where GP practices are potential providers of CCG-Commissioned Services NHSCB (July 2012)

CCG Governing Body Members: role outlines, attributes and skills (April 2012) NHSCB

Code of conduct for NHS Managers- DH (2002)

Code of Conduct and Code of Accountability - DH (1994)

Managing Conflicts of Interest in Clinical Commissioning Groups, NHS Confederation and RCGP (Sept 2011)

The Health & Social Care Act, March 2012

Procurement Guide for Commissioners of NHS funded services, NHS & DH (2010)

Ensuring transparency and Probity, BMA (May 2011)

Principles and rules of Cooperation & Competition NHS & DH (2010)

The Seven principles of Public Life (Nolan Principles), The Committee on Standards in Public Life (1995)

The Healthy NHS Board: Principles for Good Governance NHS Confederations (2010)

Good Medical Practice 2006 & Conflicts of Interest General Medical Council (2008)

The Good Governance Standard for Public Services, OPM CIPFA (2004)

Monitor: Enforcement Guide

NHS
Southwark
Clinical Commissioning Group

32. APPENDIX 1– Declaration Form for Member / employee/ governing body member / committee or sub-committee member

Guidance Notes:

This form is required to be completed in accordance with NHS Southwark CCG's Constitution and Section 14O of *The National Health Service Act 2006.*

Notes:

- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.

- If any assistance is required in order to complete this form, then the individual should contact Sheetal Mukkamala, Corporate Governance Manager.
  email: sheetal.mukkamala@nhs.net

- The completed hard copy of the form should be handed over/posted to:
  Sheetal Mukkamala,
  Corporate Governance Manager,
  NHS Southwark CCG,
  1st Floor, Hub 5, PO Box 64529
  London SE1P 5LX

- If sending by email, then a scanned signature will suffice.

- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.

- The register will be published in the Annual Report as well as every month after the Governing Body meeting on the CCG public website. It will also be available to public on request and during each Governing Body meeting.

- Any individual – and in particular members and employees of NHS Southwark CCG - must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.

- If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

- Individuals are advised to review the completed example before completing their own declaration to ensure they correctly understand the information required.

A declaration must be made whether such interests are those of the individual, a family member, any other close relationship of the individual. Interests that must be declared include but are not limited to:

1. Roles and responsibilities held within member practices;

2. Directorships, including non – executive directorships, held in private companies or PLCs;

3. Ownership or part – ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG;

4. Shareholdings (more than 5%) of companies in the field of health and social care;

5. Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;

6. Any connection with a voluntary or other organisation contracting for NHS Services;

7. Research/ funding grants that may be received by the individual or any organisation they have an interest or role in;

8. Any other role or relationship which would impair or otherwise influence the individual's judgement or actions in their role within the CCG.

An example of completed form is available with the Corporate Governance team.

NHS
Southwark
Clinical Commissioning Group

NHS SOUTHWARK CLINICAL COMMISSIONING GROUP
DECLARATION OF INTERESTS FORM

Name:		
Position within or relationship with CCG		
Interests		
Type of Interest	**Details**	**Interests of relatives/ close relationship that you know of, likely or seeking to do business with the CCG**
Roles and responsibilities held within member practices	*Materiality*[9] =	*Materiality* =
Directorships, including non-executive directorships, held in private companies or PLCs	*Materiality* =	*Materiality* =
Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG	*Materiality* =	*Materiality* =
Shareholdings (more than 5%) of companies in the field of health and social care	*Materiality* =	*Materiality* =
Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care	*Materiality* =	*Materiality* =

Any connection with a voluntary or other organisation contracting for NHS services	*Materiality=*	*Materiality =*
Research funding/grants that may be received by the individual or any organisation they have an interest or role in		
Other specific interests – e.g. users of health services commissioned by the CCG.		
Any other role or relationship which would impair or otherwise influence the individual's judgement or actions in their role within the CCG		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the NHS SouthwarkCCG Constitution and published accordingly.

Signed:
(please sign not print)

Dated:

33. Appendix 2- Declaration Form: Bidders/potential contractors/service provider

Declaration form: financial and other interests

This form is required to be completed in accordance with the CCG's Constitution.

Notes:

- All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) are required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with, the CCG.
- If any assistance is required in order to complete this form, then the Relevant Organisation should contact Sheetal Mukkamala, Corporate Governance Manager email: sheetal.mukkamala@nhs.net
- The completed form should be sent to:

  Sheetal Mukkamala,
  Corporate Governance Manager,
  NHS Southwark CCG,
  1st Floor, Hub 5, PO Box 64529
  London
  SE1P 5LX

- Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and the CCG must notified to the CCG by completing a new declaration form and submitting it to [*specify*].
- Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business or running of the CCG might arise.
- If in doubt as to whether a conflict of interests could arise, a declaration of the interests should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

- the Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for the CCG;

- a Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;

- the Relevant Organisation or any Relevant Person has any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgments, decisions or actions.

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Declaration Form: Bidders/potential contractors/service providers: financial and other interests

Name of Relevant Person	[*complete for all Relevant Persons*]	
Interests		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance**
Provision of services or other work for the CCG		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		
Any other connection with the CCG, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG's or any of its members' or employees' judgments, decisions or actions		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:

34. Appendix 3 - Declaration of Gifts and Hospitality Form

Under certain circumstances (see Section 9) the policy requires the declaration of gifts and hospitality offered to employees, members and member practices whether accepted or not.

It is the responsibility of all individuals to make any necessary declaration by completing this document, and submitting it to Corporate Governance Manager, NHS Southwark CCG, for inclusion in the register of gifts and hospitality that is maintained.

Name	
Job title/ Position in the CCG	
Department or Practice	
Details of what has been offered, by whom.	
Was the gift or hospitality accepted or refused?	
Signature	
Date	

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35. Appendix 4 –Code of Conduct – Procurement

[To be used when commissioning services from organisations in which CCG Governing Body members/ committee members have a financial interest, including GP practices and provider consortia]

Service:	
Question	**Comment/Evidence**
Questions for all three procurement routes	
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available?	

Why have you chosen this procurement route?[10]	
What additional external involvement will there be in scrutinising the proposed decisions?	
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process?	

Additional question for AQP or single tender (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	

Additional questions for AQP only (where GP practices are likely to be qualified providers)	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for single tenders from GP providers	
What steps have been taken to demonstrate that there are no other providers that could deliver this service?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

36. Appendix 5 –Code of Conduct template - 10 questions checklist

1. Do you have a process to identify, manage and record potential (real or perceived) conflicts of interest?
2. How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process?
3. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers?
4. Have you made arrangements to make registers of interest accessible to the public?
5. Have you set out how you will you ensure fair, open and transparent decisions about:
   - priorities for investment in new services
   - the specification of services and outcomes
   - the choice of procurement route (e.g. competitive tender, AQP, single tender)?
6. How will you involve patients, and the public, and work with your partners on the Health and Wellbeing Boards and providers (old and new) in informing these decisions?
7. What process will you use to resolve disputes with potential providers?
8. Have you summarised your intended approach in your constitution, and thought through how your governing body will be empowered to oversee these systems and processes – both how they will be put in place and how they will be implemented?
9. What systems will there be to monitor and publish data on referral patterns?
10. Has your decision making body identified and documented in the constitution the process for remaining quorate where multiple members are conflicted?

37. Appendix 6 - Conflict of interest discussion scenarios

Adapted from the RCGP/NHS Confederation brief on managing conflicts of interest September 2011

Scenario 1
Three GPs who are members of the governing body of a CCG have recently bought a small number of shares in Company X – a company set up by an investor and 16 local GP practices to provide community health services. Company X has recently paid for two local GPs to be trained as GPs with a special interest (GPwSIs) in gynaecology and has agreed to invest in the extension of a local surgery (where a commissioning group lead is a partner) and in purchasing ultrasound equipment so that a new GPwSI service can be set up.
The CCG has recently begun developing its strategic commissioning plan, which sets out its intention to see a shift of up to 30 per cent of outpatient gynaecology services from acute hospitals to community-based settings over the next three years. The CCG intends to develop a specification for these community services to be delivered by Any Qualified Provider.

Discussion
Although the GPs are not major shareholders in GP Provident, a conflict clearly exists as they could have made personal financial gain as a result of the CCG's commissioning strategy.
There is also a possibility that there could be a perception of actual wrongdoing. The CCG has to consider whether Company X has been given a competitive advantage over other providers or if these individuals have put themselves in a position to make a financial gain – due to access to insider knowledge about local commissioning intentions – and if it has put sufficient measures in place to avoid or remedy this. The individuals concerned should have declared their interest in Company X when they bought the shares, and again at any meeting when the CCG began to discuss its commissioning strategy.
The CCG should have a policy that clearly identifies circumstances under which members of the governing body should not participate in certain activities and considers the material nature of any conflict and whether the individuals could successfully discharge their responsibilities. The governing body will need to consider whether this policy requires them to exclude these members from certain decisions about the commissioning strategy, even if this means removing three key decision-makers from a central part of the group's business.
Even if not excluded from discussion of the strategy, these individuals may well be excluded by the group's policies from being involved in the development of the gynaecology service specifications (other than to the

extent any other potential supplier might be involved in such service planning), or from any subsequent contract monitoring. CCGs may wish to consider whether or not involvement with a provider company likely to develop services and bid for contracts in this way is compatible with being a CCG governing body member at all, as this scenario is likely to arise again.

Scenario 2

The diabetes lead of a CCG has been working on a community diabetes project for two years and has a plan to reduce diabetes outpatients activity by 50 per cent and to reinvest in education, patient education, more specialist nurses and community consultant sessions.

A cornerstone of this new service is a proposal to fund local practices for providing additional services, previously provided in secondary care, to improve prevention, identification and management of diabetes within primary care.

Discussion

Rather than benefiting a particular organisation, in this scenario all GP practices/primary care providers in the area could potentially benefit from the proposals being developed by the CCG, at the expense of existing secondary care providers.

The CCG may have to deal with the perception and challenge that it is favouring its members. However, this may be an appropriate commissioning decision, provided the CCG can demonstrate that:

- it is possible and appropriate to reduce the number of people being referred to hospital for the management of diabetes and related complications;
- it is expected to improve overall patient experience and outcomes;
- the benefits of having the service provided by GP practices – and integrating it with the services they already provide for registered patients – are so compelling that there are no other capable providers

The CCG should have set out and communicated the case for change and the rationale for the proposed service model clearly and transparently using the "code of conduct" template before taking, or recommending, the final decision to proceed.

When developing its diabetes commissioning strategy, the CCG should consult on, and then be absolutely clear about, who will have the opportunity to provide the service model. This should be consistent with its existing commissioning strategy and procurement framework and with the joint health and wellbeing strategy of the relevant Health and Wellbeing Board.

Other qualified providers should be given the opportunity to provide those elements of the new service model not specifically embedded in general practice, for example, specialist nursing and community-based consultant sessions.

Scenario 3

Dr X is the chair of a CCG. He is married to Dr Y. Dr Y is the clinical director for Health R Us, a company that has developed risk stratification software designed to enable primary care providers to identify vulnerable patients at risk of going into hospital and help them to put measures in place to address this.

Health R Us has offered to supply the software to Dr X's CCG free of charge for one year to help develop it. It will then be offered at a discounted price because of the work that the group would have done in developing it and acting as a demonstration site.

Discussion

There is no immediate financial gain to Drs X and Y from the decision to accept the software free of charge for a year. However, there is potential future gain to Dr Y (and therefore to her husband) as the clinical director of a company that could profit from a product that her husband's CCG has helped to develop, and from a preferential position as an incumbent supplier to that group.

Dr X should declare an interest and he should exclude himself from any decision-making about this project.

Any decision subsequently taken by the CCG should depend on whether or not the product on offer would help it to achieve an existing, stated commissioning objective (that is to say the CCG should not accept it just because it is on offer), and whether or not the deal being offered was in line with the CCG's existing policies for partnership working, joint ventures and sponsorship.

If the CCG has a clear, prioritised commissioning strategy and policies for working with other organisations from the outset, this decision should be fairly straightforward.

There is a question as to whether or not the group should accept this offer at all. Although it may meet an explicit commissioning objective, it may not be appropriate even then to accept the offer without some analysis of whether other companies might be willing or able to offer the same or better. The concern is not necessarily about the personal relationships involved, but more generally about whether this is an acceptable way for a public body to do business.

Scenario 4

Dr A is a member of a CCG with a longstanding interest in and commitment to improving health and social care services for older people. She has worked closely with local geriatrician, Dr B, for many years, including working as her clinical assistant in the past. They have developed a number of service improvement initiatives together during this time and consider themselves to

be good personal friends.
Recently, they have been working on a scheme to reduce unscheduled admissions to hospital from nursing homes. It involves Dr B visiting nursing homes and doing regular ward rounds together with community staff. It has been trialled and has had a measure of success which has been independently verified by a service evaluation. They would now like to extend the pilot, and the foundation trust that employs Dr B has suggested that a local tariff should be negotiated with the CCG for this 'out-reach' service.
The CCG has decided instead to run a tender for an integrated community support and admission avoidance scheme, with the specification to be informed by the outcomes of the pilot.

Discussion
Due to her own involvement in the original pilot, association with the incumbent provider and allegiance to her friend and colleague, Dr A has a conflict of interest She should not be involved in developing the tender, designing the criteria for selecting providers or in the final decision making even though she is a local expert. If the CCG has clear prompts and guidelines for its members, this should be obvious to Dr A, who should decide to exempt herself.
If the CCG is clear at the outset about its commissioning priorities and strategy and its procurement framework (setting out what kind of services would be tendered under what circumstances), its decision to tender for the service should not come as a surprise to the trust, or to the individuals involved.
CCGs need to ensure that they do not discourage providers, or their own members, from being innovative and entrepreneurial by being inconsistent or opaque in their commissioning decisions and activities.

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38. Appendix A – Policy Development Document Control Panel

Policy Title:Conflict of Interest Policy		
Version Number: Draft 1	Date of issue: Revised April 2013	Review date: April 2014
Policy Developer: Malcolm Hines (Responsible Director) Jacquie Foster/ Sheetal Mukkamala (Authors) Richard Gibbs (Policy Reviewer)		
Policy Developer's designation: CFO, Head of Governance and OD Corporate Governance Manager Lay Member/ Conflict of Interest Guardian		
Policy Developer's contact details: Telephone number: 020 7525 4569 E mail address: Jacquie.foster1@nhs.net		
File name and document pathway:		
Is this a new policy?	Yes	**No**
If 'Yes' – why is it required? (e.g. new legislation necessitating Trust compliance) Legislation for CCG establishment; national and local guidance.		
If 'No' – name of current policy under review: (If different from above)		
If 'No' – reason for reviewing current policy: change in legislation required amendment		
Does style and format comply with corporate image?	**Yes**	No
Does the policy include a monitoring compliance section?	**Yes**	No

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Who has been involved/ consulted with in order to develop this policy? (i.e. Committees, working groups, specific individuals etc,.) IG&P Group, OSC, Lay member /Conflict of Interest Guardian			
How does this policy link to:			
National Standards	National Service Frameworks		
Have you considered in your Policy Development the impact of your Policy on:			
Health & Safety at Work Act 1974	Yes	No	N/A
Equality Act 2010	**Yes**	No	N/A
Human Rights Act 1998	Yes	No	N/A
Data Protection Act 1998	Yes	No	N/A
Freedom of Information Act 2000	Yes	No	N/A
Civil Contingencies Act 2004	Yes	No	N/A
Mental Capacity Act 2005	Yes	No	N/A
Confidentiality	Yes	No	N/A
Other: (Please specify)			
Policy Ratification by ( ) on (Date):	Consulted with Staffside on (Date):		

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39. Appendix B – Equality Impact Assessment Tool

	Equality Impact Assessment Tool	Appendix B	
		Yes/No	**Comments**
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	N	
	• Disability	N	
	• Gender Reassignment	N	
	• Marriage and Civil Partnership	N	
	• Pregnancy and Maternity	N	
	• Race	N	
	• Religion or Belief	N	
	• Sex	N	
	• Sexual Orientation	N	
2.	**Is there any evidence that some groups are affected differently?**	N	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	NA	
4.	**Is the impact of the policy/guidance likely to be negative?**	NA	
5.	**If so can the impact be avoided?**	NA	
6.	**What alternative is there to achieving the policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	

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SOUTHWARK & LAMBETH
INTEGRATED CARE

Update
Southwark CCG Governing committee
June 2013

NHS Lambeth

NHS Southwark

Southwark Council
Social care

Lambeth
Social care

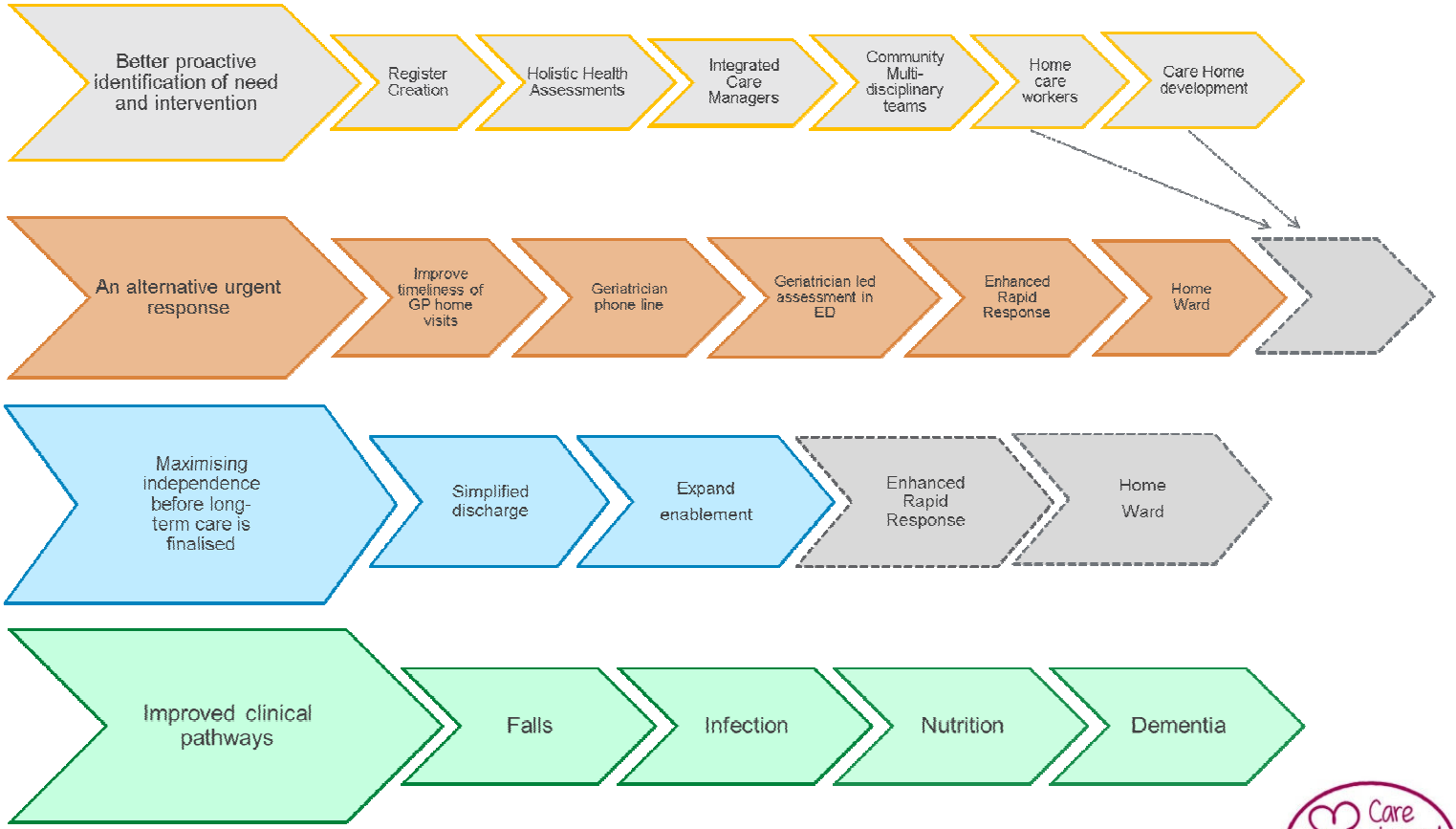
KING'S HEALTH PARTNERS

This report covers:

- An update on the older people's programme, currently live
- An update on supporting workstreams (finance, IT, governance, reporting)
- A look forward – our early plans for people with long term conditions
- Proposals to bid to be an integrated care 'pioneer'

The older people's programme:

- Is introducing a number of interventions (see below) to improve proactive care and urgent response
- Is intended to reduce emergency hospital bed days by 14% and placements in residential homes by 18%, by 2015



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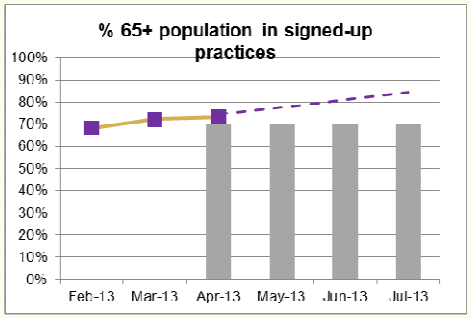
Progress - older people's programme:

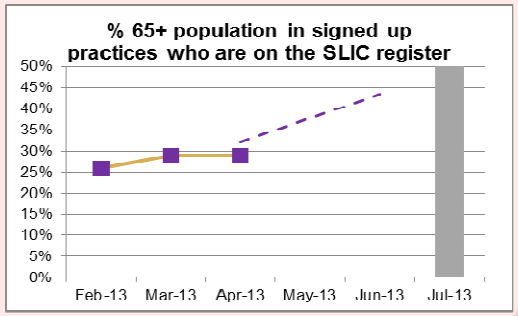
- The older people's programme has made good progress in getting GP signup (75% coverage), establishing CMDTs (all localities covered) and supporting establishment of a range of services (eg geriatrician-led raid assessment)
- However, activity in general practice (holistic health assessment, case management – paid for via a LES) is far lower than expected and for this reason, the programme is unlikely to deliver its intended benefits in 2013/14.
- The operations board has agreed to change the model of delivery so that recruitment to and management of key case management roles is supported centrally, to assist practices with capacity issues – work currently in progress
- In addition, the Ops board have prioritised the next wave of development work as:
    - Dementia
    - Home Care workers as early identifiers of need
    - Simplified Discharge
- We are continuing to implement the clinical pathway improvement work of:
    - Falls
    - Infection
    - Nutrition

Older people's programme: progress on general practice interventions

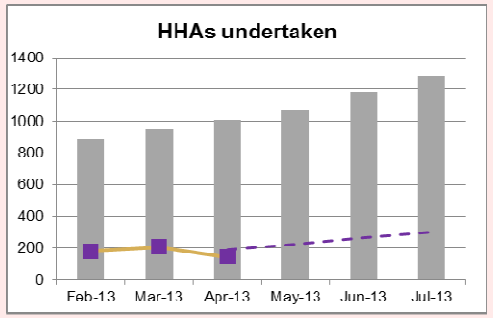
Practice sign up



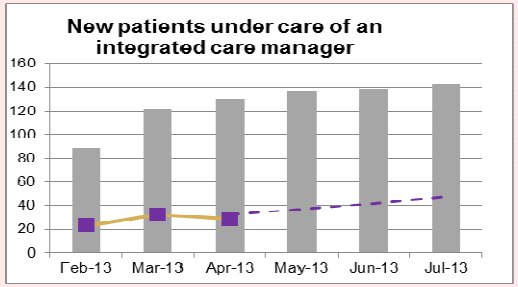
Register Creation



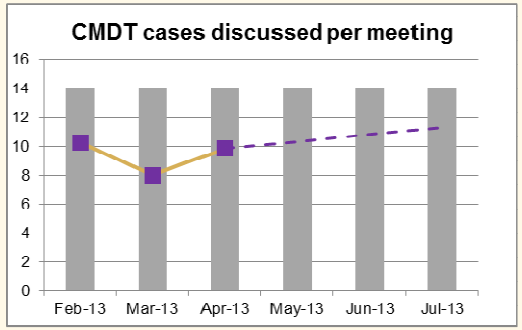
HHAs



Integrated Case Management



CMDTs



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SOUTHWARK & LAMBETH INTEGRATED CARE

Long term conditions:

we need a new paradigm to support people

Already today we must do better

In Southwark and Lambeth:

- LTCs are under-diagnosed
- Too many people with LTCs die prematurely
- QOF scores for LTC management are well below London average in 7 of 17 LTC diagnoses

The 'Scissors of Doom' - Growing demand with less funding

- Population in S&L expected to grow by 18% in next 10 years
- Aging population
- People live longer with LTCs
- Funding for NHS, Public Health and Social Services is falling well behind growth in demand

Doing more of the same better will not be enough

We must shift the LTC care paradigm from people being dependent recipients of care to enabling and supporting people with LTCs to live independently and optimally with their condition.

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Long term conditions: Our Agreed Programme Approach

A Functional Abilities	• Focus on improving / maintaining people's independent living and functional abilities
B Healthy Behaviours	• Encourage healthy behaviours and choices, especially self-care, to minimise consequences of LTCs
C Change Model	• Use a Change Model that addresses all system components who can enable sustained change
D Virtuous Spiral	• Rapidly sequence initiatives, start small and spread success and learning quickly • Use evidence to adapt actions at maximum speed and adjust implementation

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SOUTHWARK & LAMBETH INTEGRATED CARE

Our LTC programme will focus on the required behaviour changes and types of support, not clinical diagnoses

Dept. Health defines LTCs as:

- "...a health problem that cannot be cured but that can be controlled..."
- "LTCs can affect many parts of a person's life, from their ability to work and have relationships to housing and education opportunities."

NHS Mandate expects:

- Improvements in health-related quality of life
- People feeling supported in managing their condition
- Improving functional ability (e.g., ability to work)
- Reducing time spent in hospital
- Enhancing quality of life of carers
- Enhancing quality of life of people with mental illness
- Enhancing quality of life of people with dementia

Strong emphasis on improving independence and quality of active life (non-medical)

Suggestion:

Categorise LTC actions by the key behaviour changes and types of support, including self management, that improve health and well being most.

Promoting healthy behaviours – e.g.

- Smoking cessation
- Supporting exercise & fitness
- Enabling healthy eating
- Alcohol and sensible drinking
- Reducing social isolation

Optimising medication use – e.g.

- Regular medication reviews for those on multiple drugs – optimising use, minimising side-effects
- Helping people to take medications as prescribed
- Checking medication stock and home dispensation methods

Detecting and addressing risks early - e.g.

- Adaptations/skills, so those with impaired mobility / physical ability can do all the activities of daily living
- Support those with cognitive decline, to maintain their ability to run a household independently
- Facilities for those with epilepsy with frequent seizures and risk of injury
- Detecting people at risk and stratification (people with established diagnoses only, no screening or case finding)
- Early effective interventions
- Care management

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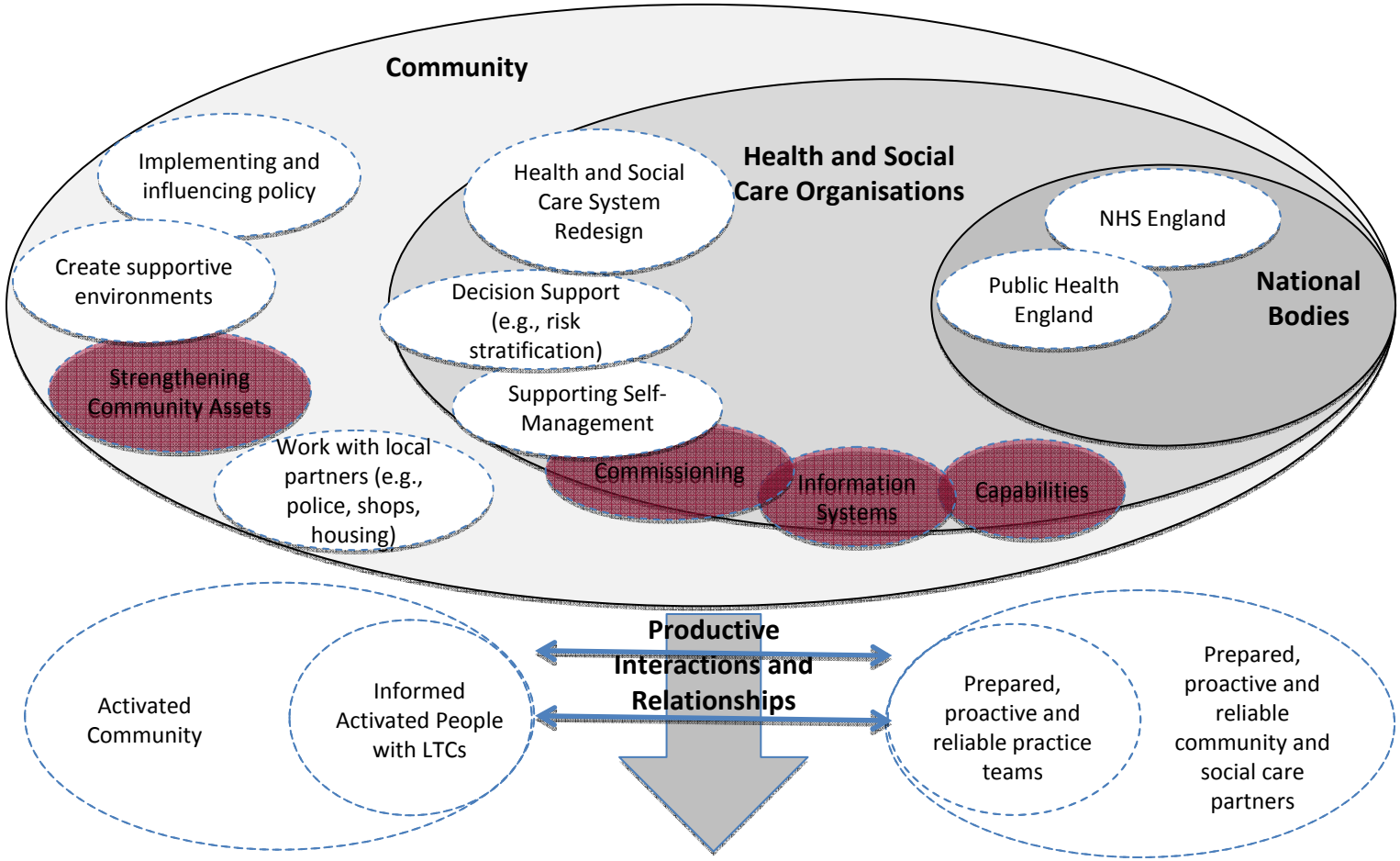
Our LTC programme will also build supporting resources in 4 key areas to enable a new community of care



Population Health and Wellbeing Outcomes
Clinical and Functional Outcomes
Value-for-Money Resource Utilisation

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Supporting workstreams - highlights:

Finance:

•We are currently testing commissioner and provider ambitions to radically change the way we fund care (capitated budgets) to support integration

•To support this we have completed a significant piece of work to generate a person-level dataset including all activity and costs relating to an individual for a year

•Our successful bid to be a DH 'Year of Care Early Adopter' has generated insights into the drivers of cost

IT:

•We are currently implementing a range of interim solutions to improve datasharing between hospitals <> GPs <> social care <> mental health, and at CMDTs, with full implementation by the end of this calendar year.

Governance:

•We are establishing the citizen's board, interviewing for members on 13th June

Reporting:

•Our first phase reporting system is running (monitoring system outcomes and activity); this year information on patient views and costs will be encorporated

Care shaped around you

SOUTHWARK & LAMBETH INTEGRATED CARE

Our bid to be an integrated care ‘pioneer’:

- On May 14th, a national collaborative led by NHS England invited local health and social care organisations to express interest in becoming ‘Integration Pioneers’ by 28th June.
- **The SLIC sponsor board has agreed to submit a bid.**
- Pioneers are expected to work in a truly whole-system way (across health, public health and social care, and alongside other local authority functions and voluntary organisations), to achieve and demonstrate the scale of change that is required. They must also disseminate and promote lessons learned.
- There are a number of benefits of taking part:
    - Greatly increased local impetus for integration
    - Support from the national collaborative to unblock national-level issues (eg regarding nationally-held contracts, competition rules)
    - Potential support from the national collaborative for local issues (eg health economic and legal support)

What would our bid entail?

- We have a strong history to build on, helping us to meet the 'pioneer' criteria: of strong health-social care partnership in developing integrated care; of good involvement of local people and professionals in setting out a model of care; of establishing a sound financial business case; of leading innovation in financial models; of developing practical IT solutions.

- This is an opportunity to catalyse local thinking and set out a **radical, innovative proposal for integrated care**, that goes beyond the criteria. We know that there will be one or at the most two pioneers in London, so should ensure our application stands out.

- The sponsor board is currently working to define what our bid will set out but it may include the elements overleaf

What could our bid entail?

- A vision to transform planned and urgent care for individuals by taking a holistic approach not only for those already needing the most complex, coordinated care packages but also focusing on broad cross-cutting areas (smoking, obesity, isolation) that can prevent deterioration and ill-health earlier.
- Setting out a vision for a new relationship between individuals and services, with increased personal responsibility for health and self-care, with active community support
- Proposals covering a large area of Lambeth and Southwark, if not all of both boroughs (the criteria require a large footprint)
- A wide, strong partnership going beyond our existing partners to include community organisations and the voluntary sector as well as links to relevant local authority functions such as education and housing, including a clear rationale for this (what these new partners will contribute)
- A firm proposal to pool budgets or put all the money (including social care) in one pot, for example by introducing a shadow capitated budget from April 2014 (work and discussions already underway)
- Creation of a single person-level record and outcome tracking for individuals across the system (delivered through a Virtual Patient Record) (proposals currently on hold)
- Creation of a new Integrated Care Organisation for some or all of the patch, bringing staff (including GPs?) together
- Potential use of alliance contracting to underpin capitated budgets/the risk share/ICO (work currently underway)

Southwark Clinical Commissioning Group

NHS Southwark CCG

Pressure Ulcers

Introduction

Southwark CCG were asked to present a response to the following points raised following the previous years Vulnerable Adult Safeguarding report to the Adult Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-committee:

1) New protocols being developed on community acquired Pressure Sore cases to ensure they are resolved and information is shared between Trusts, the CCG and Adult safeguarding

2) An analysis of why Pressure Sores are increasing, including data on where these are acquired.

Information sharing to support Resolving Pressure Ulcers

The three main health providers in Southwark, Kings, SLaM and GST have come together to form a joint working group, the group is reviewing the current 'Safeguarding Adults and Skin Damage Protocol' which is in use. Members of the group include Safeguarding leads and Tissue Viability Team staff, the aim of the group is to further develop the protocol and to identify the process of how information and communication takes place between Trusts relating to the patient care pathway and how this informs the initiation of a safeguarding alert across providers and boroughs. Southwark CCG will be involved in contributing to the protocol to ensure that pressure ulcers that are a Serious Incident are reported and managed through the appropriate route as per guidance from NHS England and that commissioners are provided with evidence of the patient care pathway in practice.

NHS Southwark CCG review Trust wide Pressure Ulcer data of grades 2, 3 and 4 at the Integrated Governance and Performance meeting on a regular basis. Trends of Pressure Ulcer data is also analysed at the Monthly Clinical Quality Review Group which takes place jointly with Kings.

All incidences of Grade 3 and 4 Pressure ulcers reported by Kings, Guys & St Thomas including community services and SLaM are tracked and monitored to ensure the patient's care pathway is continuously delivered as appropriate to the patient's health needs.

The increase of Pressure Ulcers and where they are acquired

Kings has experienced an increased rate of acuity of frail and elderly patients which has contributed to an increase of activity in the Trauma and Stroke centres. Kings Virtual Ward provider 'Medihome' who provides hospital at home nursing care is presently running at full capacity therefore this has increase the number of incidence.

From 1st April Kings are reporting all Pressure Ulcers onto STEIS the national Serious Incident database managed by NHS England. Recent guidance from NHS England asks that all cases of grade 3 and above Pressure Ulcers are reported regardless of whether these were acquired in hospital or were noted on admission where the patient may have experienced a fall at home or may have previously resided in a care home. There is a robust system of monitoring Pressure Ulcers which ensures that patients under a previous provider of care upon where a Pressure Ulcer may have been acquired, is contacted to ensure an appropriate investigation and root cause analysis takes place. The National Patient Safety Thermometer CQUIN which requires a measurement of four categories of conditions one of which includes the recording of Pressure Ulcers has alerted an increase in reporting of the number of Pressure Ulcers, and those which qualify as a Serious Incident.

Where pressure Ulcers are acquired

Kings Hospital – All grade 3 and 4 Pressure Ulcers which have been acquired at the hospital are reported on STEIS and undergo a thorough root cause investigation followed by review and scrutiny at the Serious Incident Committee which commissioners attend. Training is provided to all staff as part of induction and consists of the identification, prevention and management of Pressure Ulcers. Kings Health Partners provide regular Pressure Ulcer Prevention management study days to all staff as well as regular ward based training. Pocket guides that help staff identify and categorise Pressure Ulcers are provided to all clinical staff along with an E-Learning support package.

Guys & St Thomas – all grades 3 and 4 Pressure Ulcers which have been acquired in the hospital are reported onto STEIS and undergo a root cause investigation. The action plan recommendations are reviewed at the monthly provider meetings.

South London and Maudsley – the Trust report all grade 3 and 4 Pressure ulcers as a serious incident and commence a root cause analysis investigation. This information is shared with commissioners who review and scrutinise the investigation and action plan recommendations at a monthly incident committee meeting. The Council safeguarding teams have been involved at recent meetings. There has been a reduction in reported Pressure Ulcers over the past 4 months at SLaM; this is due to an increase in early identification whereby each patient undergoes a body map upon admission and weekly thereafter. The Trust has placed focus upon providing comprehensive training to all staff to support and encourage the early identification and treatment of Pressure Ulcers.

Patient's home – A patient may be admitted into hospital with a pressure ulcer, in such an instance the hospital will immediately involve the TVN who will follow the Safeguarding protocol to asses and decide whether a safeguarding alert needs to be raised. The TVN team will assess the patient and make a referral to the community TVN team, they will share details and information such the type of pressure relieving intervention or equipment required and recommended. The patient will then be managed by the appropriate community team, or in the event of a safeguarding incident will be managed under the safeguarding team at the Local Authority.

Other previous Health care providers – In some cases a patient may be admitted to the hospital with a pressure ulcer which was acquired at a healthcare funded nursing home. Southwark CCG will contact the lead of the healthcare provider to ensure that this incident is reported as a serious incident a root cause analysis investigation takes place. Safeguarding teams at the council are alerted to all pressure ulcer serious incidents reported at health funded nursing homes.

King's College Hospital NHS
NHS Foundation Trust

Councillor Rebecca Lury
Chair - Adult Health,
Adult Social Care,
Communities &
Citizenship Scrutiny Sub-
Committee
Southwark Council
(via email to Julie
Timbrell)

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4 July 2013

Dear Councillor Lury

Follow up information relating to Pressure Sore Cases.

At the meeting of the Southwark Adult Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee held 1 May 2013 the Committee requested follow up information relating to the following two issues:

1) Related new protocols being developed oncommunity acquired Pressure Sore cases to ensure they are resolved and information is shared between Trusts, the CCG and Adult safeguarding, and
2) An analysis of why Pressure Sores are increasing , including data on where these are acquired

Attached is a briefing from Southwark CCG responding to the two follow up information requests. The paper has been produced by the CCG with data provided by the Trust as the analysis and presentation of community acquired pressure sores is the responsibility of Primary Care.

If you have any further queries please do not hesitate to contact me

Yours Sincerely,

Kumal Rajpaul

Mr Kumal Rajpaul
Tissue Viability Nurse Specialist

Briefing Paper to the Southwark Adult Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

15 July 2013

1) New protocols being developed on community acquired Pressure Sore cases to ensure they are resolved and information is shared between Trusts, the CCG and Adult safeguarding.

Kings College Hospital, SLaM and GST are working together to form a joint working group to reviewing the current 'Safeguarding Adults and Skin Damage Protocol' which is in use. Members of the group include Safeguarding leads and Tissue Viability Nurses and Trust Representatives. The aim of the group is to further develop the protocol and to identify the process of how information and communication takes place between Trusts relating to the patient care pathway and how this informs the initiation of a safeguarding alert. Southwark CCG will be involved in contributing to the protocol to ensure that pressure ulcers constituting as a Serious Incident are reported and managed through the correct route with relevant information relating to the patient care pathway.

KCH monitors all pressure ulcers via an online reporting system and the data is analysed on a weekly basis and reported monthly to the trust. It is scrutinised at the trust NMAS score card meeting. A root cause analysis is conducted for all hospital acquired grade 3 and 4 pressure ulcers and the outcome discussed at the SI committee meeting. A root cause analysis is also conducted on all admitted pressure ulcers that deteriorate in the trust.

All incidences of Grade 3 and 4 Pressure ulcers are reported by Kings on STEIS.

2) An analysis of why Pressure Ulcers are increasing, including data on where these are acquired

Kings has experienced an increased rate of acuity and activity of patients due to the Trauma and Stroke centre resulting in an increase of dependency and increased patient throughput. The intensive care units are currently running at 140% capacity with high risk patient groups with multiple comobidities. This increase in activity has resulted in an increase demand for pressure relieving equipment such as air mattresses. The trust has responded to this need by increasing the stock of systems to meet the demands

From 1st April Kings College Hospital has been reporting all Pressure Ulcers onto STEIS the national Serious Incident database held by NHS England. Recent guidance from NHS England requests that all cases of grade 3 and 4 PUs are reported regardless of whether these were acquired in hospital or were present on admission where the patient may have experienced a fall at home and was on the floor for several hours or may have previously resided in a care home. The comprehensive system of monitoring Pressure Ulcers ensures that the patients

previous provider of care upon where the Pressure Ulcer may have been acquired, is contacted to ensure the appropriate investigation and root cause analysis takes place. Kings Virtual Ward provider 'Medihome' who provides hospital at home nursing care is presently running at full capacity therefore increasing patient activity. The National Patient Safety Thermometer CQUIN which requires a measurement of four categories of condition includes the recording of Pressure Ulcer incidents this has alerted an increased number of Pressure Ulcers which qualify as a Serious Incident.

Where pressure Ulcers are acquired

Kings College Hospital – All grade 3 and 4 Pressure Ulcers which have been acquired at the hospital are reported on STEIS and undergo a thorough root cause investigation followed by review and scrutiny at the Serious Incident Committee which commissioners attend.

Training is provided to all staff as part of nursing and midwifery induction which consists of the classification, prevention and management of Pressure Ulcers. Kings Health Partners members (KCH, GST and Lambeth & Southwark PCT) provide regular Pressure Ulcer Prevention, treatment and management study days to nursing staff as well as provide regular ward based training with targeted training as part of Safety Express. The trust is constantly reviewing new ways of cascading information to the nursing and allied health care professional staff with the aid of pocket guides that help staff identify and categorise Pressure Ulcers. This is provided to all clinical staff and is further supplemented with an E-Learning package on pressure ulcer prevention, identification and treatment with a test to take at the end. More recently the trust is currently conducting a three month trial on a pressure ulcer pathway document which is at the patient's bedside giving nursing and allied health professional the information needed to identify and manage pressure damage at an early stage therefore preventing more severe pressure damage.

Guy's and St Thomas' NHS
NHS Foundation Trust

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09 July 2013

Julie Timbrell
Project Manager
Scrutiny team
Southwark Council
PO BOX 64529
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Dear Julie

Further to your request dated 10th June for further information following our response letter of 23rd April please find below the answers to the specific follow up questions that you raise in relation to safeguarding and pressure ulcers.

1.0 Who do patients report abuse to, and who investigates?

Patients may raise concerns about their care to any member of staff within the Trust. Safeguarding is everyone's business and this message is iterated through training and also included in all staff job descriptions. Any concern made by a patient must be listened to, taken seriously and responded to. The first priority is to ensure the patient feels safe and reassured.

Patients may raise a concern themselves or ask a relative or friend to raise a concern on their behalf. The patient, relative or friend can approach any member of staff to raise a concern.

Patients, relatives or visitors can also report any concerns to PALS which has teams based on both hospital sites. They can also report any concerns via the complaints procedure by writing to the Trust complaints team.

All written complaints in relation to standards of nursing care are read by the Chief Nurse and appropriate action is taken. Any concern in relation to the care of vulnerable patients is reported to the Safeguarding leads for adults or children. We hold weekly meetings where information from PALS, the patient experience team and complaints is discussed and reviewed to ensure appropriate action is being taken and that any themes are identified. We are planning to integrate our PALS and complaints services later this year.

All ward sisters have access to their patient experience data and are supervisory which allows clear visible leadership for patients. Many patients also have a key worker allocated to them that they can contact if they have any worries when they are no longer an inpatient. Out of hours the Site Nurse Practitioners provide expertise in managing any concerns raised by patients or support ward staff to manage these.

There are four main ways that a concern will be processed. They are as follows:

<u>Clinical Incident</u>
If the concern is a clinical incident this will be reported via the Trust's incident reporting system called Datix. Examples would include falls and pressure damage incidents amongst others. All Datix reports regarding falls or pressure damage grades 2, 3 and 4 are automatically sent to the safeguarding adults leads.
The safeguarding leads will advise the clinical team involved with the incident if a referral to the safeguarding multi agency procedures is required. If the incident fulfils the criteria for safeguarding, a

safeguarding referral will be made by the clinical team via the Electronic Patient Records (EPR) if the incident occurred within acute services and via the agreed referral process if the incident occurred within community services. The referral will be made to the health safeguarding team and social services.

A strategy meeting will be held between health and social services and any other relevant agency to plan the safeguarding investigation. The clinical team involved with the incident will investigate the incident using the Root Cause Analysis (RCA) process. All investigatory findings will be sent to the chair of the multi agency safeguarding group. The chair will then co-ordinate a case conference. The multi agency safeguarding group will scrutinise the investigation and seek further clarification if required. Actions will be agreed and lessons learnt shared.

If the incident does not meet the criteria for safeguarding, the investigation will be carried by the clinical team and an action plan formulated and monitored by the directorate team.

Complaints

When a complaint is received by staff verbally, in writing or via PALS it is logged by the complaints department and the appropriate clinical team is notified.

The safeguarding adults leads are also notified if a complaint is about a vulnerable adult. The allocated safeguarding adults lead will work with the clinical team and advise if a safeguarding referral to the multi agency procedures is required. If the complaint fulfils the criteria for safeguarding, a safeguarding referral will be made by the clinical team via EPR if the complaint relates to care provided within acute services and via the agreed referral process if the complaint is related to services within the community. The referral will be made to the health safeguarding team and social services.

A strategy meeting will be held between health and social services and any other relevant agency to plan the investigation. Health will investigate the complaint using the RCA process.

All investigatory findings will be sent to the chair of the multi agency safeguarding group. The chair will then co-ordinate a case conference. The multi agency safeguarding group will scrutinise the investigation and seek further clarification if required. Actions will be agreed and lessons learnt shared.

If the complaint does not meet the criteria for safeguarding, the investigation will be carried by the clinical team and an action plan formulated and monitored by the directorate team.

Allegations

An allegation is a concern against a member of Trust staff or a service that has resulted in harm to the patient. The Trust has allegation guidance to ensure that there is a fair, co-ordinated procedure for all staff that face an allegation.

All allegations are escalated to the Trust's Allegations Manager and verified via an email notification of the concern. Within two working days, the allegations panel made up of the safeguarding adults (or children's leads), Human Resources and senior clinical staff will have a strategy meeting to agree the way forward.

If the concern meets the threshold for either childrens or adults safeguarding, it will be referred on to the multi agency safeguarding procedures appropriately.

If the allegation does not meet the criteria for safeguarding, the investigation will be carried out by a lead investigator from the clinical team and an action plan formulated and monitored by the directorate team.

We have clear guidance in relation to the management of allegations. This guidance aims to support the management of allegations against staff (including substantive staff, bank staff, agency staff, contractors and volunteers) or services to ensure the safety of patients, carers and visitors. The primary aim of this guidance is to ensure that all staff within acute and community services understand their roles and responsibilities with regards to the management of allegations.

This guidance is used in conjunction with Trust:

- Disciplinary policy and procedures
- Serious Incidents policy and procedures
- Safeguarding Adults at Risk policy and procedures
- Capability policy and procedure
- Chaperoning Policy
- Raising a Matter of Concern policy and procedure
- Safeguarding the Welfare of Children: Children in Need and Child Protection policy and procedures

Police Investigations

Any concerns raised or that are identified at any stage of an investigation where it appears that a crime may have been committed, the police would be informed and where it is progressed to a police investigation, this will take precedent. All other investigations will be suspended pending the criminal investigation.

2.0 Details of safeguarding training provided.

There are two levels of training provided to staff:

- Level 1 which is awareness and is provided to all staff on induction and thereafter yearly via an attachment to payslips
- Level 2 which is training for the Alerter which covers four areas:
    - Safeguarding Adults
    - Mental Capacity Act 2005
    - Deprivation of Liberty Safeguards
    - Learning Disability and Reasonable Adjustments

Level 2 training is provided to all clinical staff who provide care and treatment to patients. The training requirement and type of training is entered on each individual staff members training profile. The Safeguarding Adults training compliance is as follows:

Acute Services Safeguarding Adults Training Data

Month	Number trained to date	Percentage of compliant staff	Total Number to train
April 2013	5046	87%	5761
May 2013	4972	87%	5677

Community Health Services Safeguarding Adults Training Data

Month	Number trained to date	Percentage of compliant staff	Total Number to train
April 2013	775	84%	921
May 2013	763	85%	895

Level 2 training is provided to all nurses and midwives as part of their induction on joining the Trust. Bespoke sessions are provided to therapy staff for all new starters and as part of the mandatory three

yearly update. There is a safeguarding adults e-learning package for junior doctors which they have to complete prior to starting in clinically areas. Consultants have safeguarding training during their mandatory training days.

3.0 The safeguarding whistleblowing procedures of all partners.

All staff can raise a concern in confidence with their line manager, someone more senior or their union. All concerns will be thoroughly and fairly investigated. The full policy, Raising a Matter of Concern (whistleblowing) is available via eHR on the Trust's intranet.

This policy may be used particularly if staff have concerns, particularly if they are concerned about possible:

- Malpractice
- Danger to patients, the public or the environment
- Unlawful conduct
- Ethical concerns about how services are provided
- Breach of a code of conduct
- Accountability
- Maladministration.

The Raising a Matter of Concern policy and procedure set out the steps to follow to raise concerns. The policy was formerly known as the Whistleblowing Policy. Whistleblowing is a mechanism to allow staff to raise serious issues of concern that are normally of a sensitive nature. There is protective legislation for employees called The Public Interest Disclosure Act 1998. This legislation protects staff who 'whistleblow', i.e. make disclosures in good faith and follow internal Trust processes at first.

Individuals making a disclosure must:

- Have a genuine belief in the information being disclosed
- Not make the disclosure for personal gain and
- Show that it is reasonable to make the disclosure.

It is recognised that staff can feel worried about raising concerns and the Trust wants to ensure that staff are able to do so with total assurance that any issue they raise will be dealt with sensitively.

Every member of staff has a responsibility to report any concerns they may have about patients, staff services or visitors.

The policy and procedure are attached.

4.0 New protocols being developed on community acquired Pressure Sore cases to ensure they are resolved and information is shared between Trusts, the CCG and Adult safeguarding.

The Health Provider sub-group has met and reviewed the protocol for deciding which pressure damage incident should be referred through the safeguarding multi agency procedures. The document is being revised as is the protocol in line with the London safeguarding procedures and the Department of Health Guidance on Clinical Governance and Safeguarding: an integrated process, (DH, 2010). The draft document will be circulated to all partner organisations, the local authorities and the CCGs for comment before presenting to the safeguarding boards for sign-off.

5.0 An analysis of why Pressure Sores are increasing, including data on where these are acquired

Pressure ulcer rates remain very low for a Trust of our size and complexity, with lower numbers of attributable pressure ulcers reported this quarter in comparison to the same period last year.

The number of patients admitted with grade 2 – 4 pressure ulcers remains fairly consistent at 40 -50 per month (see table below). When the data was analysed it did not show any trends or hot spots.

There is an equal spread of patients coming from nursing and residential homes and their own homes including those with and without social or healthcare input.

Month	Trust acquired Stage two	Trust acquired Stage three	Trust acquired Stage four	Number of patients admitted with grade 2 – 4 pressure ulcers
April 2012	4	0	0	46
May 2012	6	1	0	52
June 2012	7	0	0	51
July 2012	3	1	0	57
Aug 2012	9	0	0	45
Sept 2012	3	0	0	40
Oct 2012	3	0	0	35
Nov 2012	4	0	0	37
Dec 2012	6	0	0	31
Jan 2013	5	1	0	38
Feb 2013	5	0	0	37
March 2013	11	0	0	48
April 2013	6	1	0	40
May 2013	2	1	0	44

Our joint Acute/Community pressure ulcer forum continues to meet monthly, with recent actions including: reformatting Trust pressure ulcer reports, focusing on understanding the location and causes of ‘non-attributable pressure ulcers’ and updating on all ongoing initiatives to reduce pressure ulcer incidence. There will be a full integration of the tissue viability service across the acute and community service by the 1st of July 2013 this will further enable seamless patient care especially for complex patients.

We continue to ensure that all new staff coming to the trust have the training and support that they need to maintain our excellent standards in pressure area assessment and care.

We hold weekly Acute/Community meetings to identify “hotspots” that may require input or support. We have developed a pressure ulcer passport for those patients who move from acute to community to ensure continuity in care.

I hope that this information answers the questions that you have raised.

Yours sincerely

Deborah Parker
Deputy Chief Nurse

Guy's and St Thomas' NHS
NHS Foundation Trust

Trust Policy

Raising a Matter of Concern Policy (Whistleblowing)

Policy Summary
This Policy has been developed in response to the Public Interest Disclosure Act 1998, and enables workers to raise concerns about malpractice, ensuring that they are promptly and properly investigated and dealt with appropriately. This policy should be used in conjunction with the Raising a Matter of Concern Procedure.

Document Detail	
Document Type	Trust Policy
Document name	Raising a Matter of Concern (Whistleblowing)
Document location	Raising a Matter of Concern section in eHR (http://gti/eHR)
Version	2.1
Effective from	March 2012
Review due date	March 2013
Owner	Director of Workforce
Author	HR Policy and Partnership Manager
Approved by, date	Trust Management Executive 18 March 2010 Trust Joint Staff Committee, Policy Sub Group 16 March 2010 PSG March 2012
Superseded documents	Raising a Matter of Concern Policy 2005
Related documents	Raising a Matter of Concern Procedure (Whistleblowing) Trust Safeguarding Policy Counter Fraud Policy Grievance policy Disciplinary Policy, Procedure and Rules Health & Safety Policy Trust Values
Keywords	Concern, Whistleblowing
Relevant external law, regulation, standards	This Policy defines a corporate standard and procedure for implementation and monitoring of the Public Interest Disclosure Act (1998) Trust-wide, and takes account of the PAS 1998:2008 Whistleblowing Arrangements Code of Practice (2008) Standards for Better Health, NMC, GMC
Supporting references	N/A

Change History		
Date	Change details, since approval	Approved by
February 2012	Policy review in line with policy review cycle	PSG
08 November	Correction to the review date from February 2012 to 2013	P&P Manager

2012		

Raising a Matter of Concern Policy

1. Introduction

1.1 The Trust is committed to the highest standards of openness, integrity and accountability. An important aspect of accountability and transparency is a mechanism to enable you as an employee to voice concerns in a responsible and effective manner.

1.2 In line with that commitment we expect you, our employee, and others that we deal with, who have serious concerns about any aspect of the Trust to come forward and voice potential concerns. It is a fundamental term of every contract of employment that an employee will faithfully serve his or her employer and not normally disclose confidential information about the employer's affairs.

1.3 Nevertheless, where you discover information which you believe shows serious malpractice or wrongdoing within the Trust, then this information should be disclosed internally without fear of reprisal.

1.4 The Trust recognises that all of us, at one time or another may have concerns about what is happening at work. Usually these concerns are easily resolved, and the Trust encourages you to raise the matter rather than ignore it. This supports our Trust values such as taking pride in what we do and putting patients first.

1.5 This policy and supporting procedure aims to reassure you and enable you to raise your concerns at an early stage and in the best way.

1.6 Remember - if in doubt – please raise it!

2. Scope

2.1 This policy applies to all employees of the Trust including temporary or subject to fixed term contracts including Bank Staff. The policy also applies to agency workers whether under contracts with an external agency and those holding an honorary contract.

2.2 Although the Public Interest Disclosure Act (1998) does not specifically cover volunteers and independent consultants, the Trust encourages individuals to raise any concerns with a relevant employee of the Trust should they have cause to suspect, or evidence of any malpractice.

3. Rationale

3.1 As an employee, you can often be the first to realise that there may be something wrong within the Trust, your department or service. Usually these concerns are easily resolved, however, you may be worried about raising such issues or may want to keep your concerns to yourself for a variety of reasons, for example, being disloyal to your colleagues, managers or the Trust itself.

3.2 The Public Interest Disclosure Act (1998) gives significant statutory protection to employees who disclose a matter of concern reasonably, and responsibly, in the public interest, including the provision that employees should not be victimised as a result.

3.3 This process is often referred to as '**whistleblowing'**. To blow the whistle on someone is to alert a third party that that person has done, or is doing, something wrong.

3.4 This policy is concerned with disclosure of information that is, or may be, in the public interest, and is not intended to replace other Trust Policies and Procedures which cover standards of behaviour at work such as recruitment and selection, grievance, disciplinary and bullying and harassment.

3.5 This policy complements various professional or ethical guidelines and codes of conduct related to professional practice and is not intended to restrict freedom of speech and the publication of clinical or scientific research findings. If you are communicating in verbal or written form on Trust related issues, you should refer to the Media Policy and seek advice from the Trust Communications team.

4. Principles

4.1 The Trust are committed to this policy and to encouraging a policy of openness and participation in all aspects of work and services.

4.2 The policy is intended to help employees who have major concerns over any wrong-doing within Guy's and St Thomas' NHS Foundation Trust relating to unlawful conduct, malpractice or dangers to the public, patients or the environment. Specific examples could include:-

- Any concern about danger or illegality that has a public interest aspect to it, usually because it threatens others
- Health care matters including suspected mistreatment or abuse of patients and/or issues relating to the quality of care provided
- Health and safety issues which affect patients, visitors and staff
- Suspicion or knowledge of theft, fraud, corruption or other financial malpractice
- Concerns about the professional or clinical practice or competence of colleagues or other members of staff
- The treatment of other staff, including suspected harassment or discrimination
- Employment standards and/or working practices
- Concern that the environment is, or is likely to be, endangered
- Failure to comply with any legal obligation
- Information which may show that any of the above matters is being, or is likely to be, deliberately concealed
- Other unethical conduct

4.3 The Trust would rather that you as an employee raised the matter when it is just a concern, rather than wait for concrete proof. If something is troubling you that you think the Trust should know about or look into, you should refer to the **Raising a Matter of Concern procedure,** which supports and enables you to raise concerns within the Trust without reprisal and in a constructive and positive manner.

4.4 If you raise a genuine concern in accordance with this policy, and accompanying procedure, you should not suffer any detriment for doing so.

4.5 Any employee found victimising another employee for raising concerns, or any staff maliciously raising concerns, will be dealt with under the Trust's Disciplinary policy.

4.6 This policy and the accompanying procedure are primarily for concerns where the interests of others or of the Trust itself are at risk. It is not intended to be used where employees are aggrieved about an issue in relation to your employment, and

employees should refer to the Trust Grievance policy to address individual or collective issues which have no additional public interest.

5. Duties

5.1 **Trust Board have a responsibility to:**

- Make clear that Executive Directors and Senior Managers have a common and credible commitment to the principles of this Policy
- Designate a Trust Board member as named lead for raising a matter of concern. This is the Director of Workforce, Ann Macintyre.
- Ensure that serious concerns are thoroughly investigated internally, in order to avoid an employee raising their concern with external agencies because their concerns are unaddressed.
- Ensure that concerns raised to them (at level 3 within the Raising a Matter of Concerns procedure) and the outcome of these concerns, are notified to the designated named lead above for recording.

5.2 **Managers and Professional Heads at all levels of the Trust are responsible for:**

- Ensuring that all staff are familiar with and have access to the Raising a Matter of Concern Policy and Procedure
- Complying with the principles outlined in this Policy and the procedures identified in the Raising a Matter of Concern Procedure *(see Supporting Documents below)*
- Working with relevant Trust leads such as the Health and Safety Advisor and Head of Internal Audit on matters of concern
- Responding to concerns in a timely fashion with feedback to the employee as agreed within the Raising a Matter of Concern Procedure
- Keeping records on the number and nature of concerns as raised by employees
- Ensuring that employees are not intimidated or discouraged for raising legitimate concerns

5.3 **Employees are responsible for**;

- Speaking out about your concerns, and not making deliberate false allegations
- Identifying, with assistance as required from managers and/or Human Resources, the most appropriate process to follow
- Fully exhausting the accompanying Raising a Matter of Concern Procedure before raising the issue with external organisations (employees retain the right to discuss the issue informally with their professional organisation or trade union for advice (including contacting their telephone support line where they exist) see procedure paragraph 9.4). Where the issue concerns Children or vulnerable adults employees should consider speaking to a Trust designated Safeguarding Lead.
- Being explicit about what feedback you seek

5.4 **Human Resources are responsible for:**

- Advising managers, and ensuring that a consistent application is applied to each concern raised

- Ensuring that the policy and procedure is monitored, valid and in date in partnership with Trust Staff Side.

6. Monitoring compliance with this Policy

6.1 The following steps will be taken to monitor compliance and awareness of this policy. As per 5.1 above, the Trust Board have a responsibility to ensure that concerns raised to them at level 3 within the Raising a Matter of Concerns procedure, and the outcome of these concerns, are notified to the designated named lead (Director of Workforce) for recording.

Measurable Policy Objective	Monitoring/ Audit method	Frequency	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
The Policy and accompanying Procedure will be reviewed by the Audit Committee at least annually to ensure that it remains valid and in date	▪ Review of the annual Staff survey results in regards to Raising a Matter of Concern ▪ Review of number of formal concerns raised at level 3 of the raising a matter of concern procedure	Annual	Audit Committee	Audit Committee

7.Supporting documents

The following listed and hyperlinked policy and procedural documentation support and provide further guidance to the Raising a Matter of Concern Policy.

Raising a Matter of Concern Procedure and flowchart

Standards of Business Conduct

Grievance Policy and Procedure

Counter Fraud Policy

Disciplinary Policy and Procedure

Health and Safety Policy

Confidentiality Policy

Media Policy and Guidelines for Staff

Trust Values

Safeguarding and Child Protection Guidelines

Guy's and St Thomas' NHS
NHS Foundation Trust

Trust Procedure

Raising a Matter of Concern Procedure (Whistleblowing)

Document Detail	
Document Type	Trust Procedure
Document name	Raising a Matter of Concern (Whistleblowing)
Document location	Raising a Matter of Concern section in eHR (http://gti/eHR)
Version	2.2
Effective from	23 March 2012
Review due date	March 2013
Owner	Associate Director of Workforce
Author	HR Policy and Partnership Manager
Approved by, date	Trust Management Executive 18 March 2010 Trust Joint Staff Committee, Policy Sub Group 16 March 2010 PSG
Superseded documents	2.1
Related documents	Raising a Matter of Concern Policy (Whistleblowing) Trust Safeguarding Policy, Counter Fraud Policy, Disciplinary Policy, Procedure and Rules, Health & Safety Policy, Grievance Procedure, Confidentiality Policy, Media Policy and Guidelines for Staff
Keywords	Concern, Whistleblowing

Change History		
Date	Change details, since approval	Approved by
Jan 2012	Inclusion of new Whistleblowing help-line free phone number	Associate Director Of Workforce
February 2012	General review in line with policy/procedure expiry.	PSG
November 2012	Changed 'Head Of Workforce Relations' to 'Associate Director of Workforce'	P&P Manager

If you would like a Braille or large print copy of this procedure, or need to have it translated into another language, please contact the Human Resources Department, and it will be arranged

1. Introduction

1.1 This procedure is to be read in conjunction with the Trust Policy on Raising a Matter of Concern (Whistleblowing). All of us, at one time or another has concerns about what is happening at work. Usually these concerns are easily resolved, however it can be difficult to know what to do when they are about malpractice, dangers to patients, the public, environment, unlawful conduct, ethical concerns about the way services are provided, breaches of codes of conduct and accountability or maladministration.

1.2 You may be worried about raising such issues or may want to keep the concerns to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues or to the Trust. You may decide to say something but find that you have spoken to the wrong person, or raised the issue in the wrong way and are not sure what to do next.

1.3 The Trust is committed to the highest possible standards of openness, integrity and accountability. In line with that commitment we expect you, our employee, and others that we deal with, who have serious concerns about any aspect of the Trust to come forward and voice potential concerns.

1.4 The aim of this procedure is to enable you to raise your concerns at an early stage and in the best way. The Trust would rather that you raised the matter when it is just a concern, rather than ignore it.

1.5 Remember - if in doubt – please raise it!

1.6 **What is Whistleblowing?** To blow the whistle on a service provision or an individual is to alert a third party that a person or group of people have done, or is doing, something wrong.

2. Scope

2.1 This Procedure applies to all employees of the Trust including temporary or subject to fixed term contracts and Bank Staff. The policy also applies to agency workers under contracts with an external agency and those holding an honorary contract.

2.2 Although the Public Interest Disclosure Act (1998) does not specifically cover volunteers and independent consultants, the Trust would encourage individuals to raise any concerns with a relevant employee of the Trust should they have cause to suspect, or evidence of any malpractice.

3. Rationale

3.1 This procedure is concerned with disclosure of serious concerns and information that is, or may be in the public interest, and is not intended to replace other Trust Policies and Procedures which cover standards of behaviour at work (such as recruitment and selection, disciplinary and bullying and harassment).

3.2 These serious concerns covered by this procedure include:

- Any concern about danger or illegality that has a public interest aspect to it usually because it threatens others
- Health care matters including suspected mistreatment or abuse of patients and/or issues relating to the quality of care provided
- Health and safety issues which affect patients, visitors and staff
- Suspicion or knowledge of theft, fraud, corruption or other financial malpractice
- Concerns about the professional or clinical practice or competence of colleagues or other members of staff
- The treatment of other employees, including suspected harassment or discrimination.
- Employment standards and/or working practices
- Concern that the environment is, or is likely to be, endangered
- Failure to comply with any legal obligation
- Information which may show that any of the above matters is being, or is likely to be, deliberately concealed
- Other unethical conduct.

3.3 Thus, any serious concerns that you have about any aspect of service provision or the conduct of members of the Trust, or others acting on behalf of the Trust, can be reported under this Raising a Matter of Concern Procedure. This may be about something that:

- Makes you feel uncomfortable in terms of known standards, your experience or the standards you believe the Trust subscribes to;
- Is against Trust policies
- Falls below established standards of practice; or
- Amounts to improper conduct.

3.4 ***Please note:*** *there are existing procedures in place to enable you to raise a grievance relating to your own employment, and you should refer to the Trusts Grievance Policy to address individual or collective issues which have no additional public interest.*

4. Our Assurances to you

4.1 The Board and Chief Executive are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of other penalty as a result. Provided you are acting in good faith, it does not matter if you are mistaken. However, the Trust does not extend this assurance to someone who maliciously raises a matter they know is untrue, or who raises concerns frivolously or for personal gain.

4.2 <u>Harassment or Victimisation</u>

4.3 The Trust recognises that the decision to report a concern can be a difficult one to make. If what you are saying is true, you should have nothing to fear because you will be doing your duty to the Trust and those for whom you are providing a service

4.4 The Trust has a zero tolerance attitude to any harassment or victimisation (including informal pressures), and in these rare circumstances will take appropriate action to protect you if a concern is raised in good faith

4.5 Any investigation into allegations of potential malpractice will not influence or be influenced by any disciplinary or redundancy procedures that already affect you (if applicable).

4.6 Confidentiality

4.7 All concerns will be treated in confidence and sensitively. Every effort will be made not to reveal your identity if you so wish.

4.8 At the appropriate time, however, you may need to come forward as a witness. In this case the Trust will discuss with you how best to proceed. Therefore, the investigation process may reveal the source of the information and in doing so you may need to provide a statement as part of the evidence required.

4.9 The Trust does encourage you to put your name to your concern whenever possible. Please remember that if you do not tell the Trust who you are, it will be much more difficult for us to look into the matter, to protect your position or to give you feedback. Concerns expressed anonymously are much less powerful, but will be considered at the discretion of the Trust. In exercising this discretion the factors to be taken into account would include:

- The seriousness of the issues raised
- The credibility of the concern; and
- The likelihood of confirming the allegation from attributable sources

4.10 Concerns which can not be proven

4.11 If you raise a concern in good faith, but it is not upheld by the investigation, no action will be taken against you. However, if you raise a concern done frivolously, maliciously or for personal gain, formal action will be taken against you in line with the Trust Disciplinary Policy.

5. Reporting Concerns

5.1 There are three levels within this procedure and it is intended that all concerns will be dealt with fully and comprehensively at level 1. However, it is important that you are assured that your concern can be raised safely at a higher or different level as 2 and 3 below.

Level 1

5.2 As a first step, you should normally raise concerns with your immediate line manager or their manager if you feel unable to raise it with your manager directly. This wholly

depends on the seriousness and sensitivity of the issues involved and who is suspected of the malpractice.

5.3 If, for whatever reason, you feel unable to approach management in the area in which you work or the area where you have identified the concern, you should raise your concern at Level 2 or 3, as appropriate.

5.4 The manager with whom you raise the concern is responsible for either dealing with the matter directly or nominating an investigating manager, who will ensure that the concerns are appropriately investigated.

5.5 The investigating manager who is dealing with your concern will establish and confirm the following with you and will then go on to investigate the concern or escalate to another person or relevant department for further consideration. They will:

- reassure you that there will be no reprisals due to you raising the concern.
- take concerns seriously
- consider them fully and sympathetically
- seek advice from other professionals / colleagues e.g. HR where appropriate
- ask you when the concern first arose and (where relevant) what is prompting the decision for you to speak up at this particular time.
- ask you whether the information is firsthand or hearsay
- check whether confidentiality is sought from you.
- ask you what feedback you would like
- consider with you, without prejudice, whether you would want to be temporarily moved to another work area (investigating managers would be advised to seek further advice from their HR representative before any final decision is made)
- ask you if there is anything else relevant that you should disclose or mention

Level 2

5.6 If, for whatever reason, you have felt unable to approach management in the area in which you work, or the area where you have identified the concern, please raise your concerns as follows:

5.7 **Clinical Care:** If there are professional concerns about Clinical Care that have not been resolved within the immediate clinical team they should be raised confidentially with the relevant Professional Head, Clinical Director or Heads of Nursing.

5.8 **Fraud and Corruption:** If there are concerns relating to Fraud and Corruption, and it is suspected that a direct line manager is involved and you do not feel able to raise it with their line manager, then you should raise it with the Trust's Local Counter Fraud Specialist, on extension 87181. Alternatively, the matter may be reported using the NHS Fraud Reporting Line, on 0800 028 40 60. This is a recognised means of

reporting a fraud concern under NHS counter fraud regulations and its use would not be regarded as a failure to follow internal reporting procedures.

5.9 **Health and Safety:** if there is a concern with Health and Safety involving your line manager and you do not feel able to raise it with their line manager, then you should raise it with the Trust's Health and Safety Manager on ext 81512

5.10 For concerns that do not fit specifically in to one of the above categories you should seek advice from the Associate Director Of Workforce via email or on extension 84976.

5.11 The manager to whom the concern has been raised to is responsible for either dealing with the matter directly or nominating an investigating manager. He or she will ensure that the concerns are appropriately investigated. The nominated manager will be selected on who is appropriate to deal with the particular issue raised.

5.12 ***Please note:*** *Contact details for the above will be kept up to date on eHR, where you can seek further information.*

Level 3

5.13 The Trust will guarantee that it will handle all concerns fairly and properly, and your use of this Procedure will help the Trust to achieve this. If you feel that the matter is so serious that you cannot discuss it with any of the above or if level 1 or 2 have been followed and you still have concerns, then you should contact a member of the Trust Board directly (either an Executive or Non Executive Director). Appendix A provides contact details.

5.14 Executive Directors such as the Chief Nurse/Chief Operating Officer and the Medical Director will be happy to discuss professional and clinical concerns raised by colleagues.

5.15 The Chief Executive and the Trust Chairman are always willing to be approached on clinical or non-clinical matters if you feel, for whatever reason, that you are unable to approach others.

5.16 The designated named lead for 'Raising a Matter of Concern' is a member of Trust Board. This is the Director of Workforce.

5.17 The Chief Executive, Chairman, designated named lead for 'Raising a Matter of Concern' or other Trust Board members will normally nominate a deputy such as a member of the Trust Management Executive, to investigate the concern raised and will notify the designated named lead of the concern raised and the outcome of the investigation.

5.18 The designated named lead will keep a record of concerns raised at level 3.

6. What happens once I've raised my concern?

6.1 Concerns may be raised in writing or verbally, however you may be asked to put your concern in writing if matters are taken forward. The earlier you express the concern the easier it is to take action.

6.2 The following format should be used as a guideline:

- The background and history of the concern (giving relevant dates)
- The reason why you are particularly concerned about the situation
- Although you are not expected to prove beyond doubt the truth of an allegation, you will need to demonstrate to the person contacted that there are reasonable grounds for your concern

6.3 All concerns will be given full and sympathetic consideration. The person (or their nominated investigating officer) with whom you have raised the concern should initially assess:

- How serious and urgent the risk is
- Whether the concern can be best dealt with under this procedure or whether it would be better dealt with under a different policy or procedure, for example the grievance procedure
- Whether there is a need for assistance or referral to senior managers and/or a specialist function

6.4 Communication with you after you have raised the concern

6.5 The investigating manager dealing with your concern is responsible for taking corrective action (if required) or liaising, escalating and/or working in conjunction with the relevant department / person for further support in resolving matters. Whatever action is or is not taken, you will normally be written to and given a thorough explanation of the reasons for this within 14 calendar days of initial discussion.

6.6 This deadline may be extended at management discretion if required and you will be notified of this either in writing or verbally.

7. What if I'm dissatisfied with the outcome?

7.1 If, having followed the above Procedure, you remain dissatisfied with the outcome of your concern at level 3 you consider no action or effective action has been taken to resolve the problem and/or you consider that the Trust will discharge or conceal evidence concerning the complaint and/or you consider you will be victimised for bringing a matter in accordance with internal disclosure proceedings and you honestly and reasonably believe that the information and any allegation contained in it are substantially true and the disclosure is not for personal gain, but it is in the public interest, then you may lawfully raise your concerns with one of the Prescribed Regulatory Bodies.

7.2 The Chief Executive should be notified of this intention to raise a matter of concern with a Prescribed Regulatory Bodies at the point of exhaustion of Level 3, and you should ensure you read the information contained in the sections below.

8. Independent Advice

8.1 The Trust recognises that an individual may be unsure whether to use this Procedure or may want independent advice at any stage, and also recognises the value of support that can be given by professional organisations. Therefore all employees retain the right to discuss the issue informally with their professional organisation or trade union, and with statutory bodies such as the Nursing and Midwifery Council, the General Medical Council, and Health Professionals Council Physio's would seek advice from their union Chartered Society of Physiotherapy (CSP) , seeking their advice. Having sought advice, staff should still exhaust this procedure before raising the issue formally with any external organisation.

8.2 Independent contacts include:

- Employee's professional association or trade union (including their telephone support line where they exist). Contact details are available on GTi.
- The independent charity *Public Concern at Work* on 020 7404 6609. *Public Concern at Work* is a registered charity who is a leading authority on public interest whistleblowing. More information can be obtained about them at www.pcaw.co.uk.
- The new, free advice line for NHS and Health and Social Care staff, available from January 2012: **08000 724 725** The helpline will operate on weekdays between 08.00 and 18.00 with an out-of-hours answering service available at weekends and on public holidays.
- More information about *the Public Interest Disclosure Act* can be obtained from the Department for Business Innovation and Skills (www.bis.gov.uk) or from *Public Concern at Work*.

9. External disclosures

9.1 If you consider making a disclosure directly to external persons or organisations, or to the Police, MP's and even the media, you should be aware that your employment may not be protected under the Public Interest Disclosure Act if you have not first raised your concern internally, in line with this procedure. The legal position regarding external disclosures is complex and therefore employees are strongly advised to seek professional advice or legal advice before starting such a course of action (see above).

9.2 External Disclosure to Prescribed Regulatory Bodies

9.3 The Trust recognises that the role of external oversight/regulators is important in reassuring you and other stakeholders that the Trust will deal with any malpractice properly. The Trust intends that this procedure gives reassurance that you can feel safe and supported when raising concerns internally.

9.4 All employees should be aware that only in exceptional circumstances as specifically defined by the Public Disclosure Act 1998 will disclosure to one of the Prescribed Regulatory Bodies be justified without first having exhausted the Trust's internal procedures. Additional information on the Public Disclosure Act can be found on e-HR.

9.5 Prescribed Regulatory Bodies include:

- Counter Fraud Services
- Audit Commission
- Monitor
- Department of Health
- CQC

9.6 Wider disclosures and disclosures to Non-Prescribed Regulatory Bodies

9.7 If you have exhausted this internal procedure without satisfaction, and have consulted the appropriate Prescribed Regulatory Body, you may consider raising the matter with other external bodies such as the Media, Members of Parliament or the Police.

9.8 Such wider disclosures are only protected under the provisions of the Public Disclosure Act 1998 if the matter has been raised internally, they are not made for personal gain, and the matter falls under one of the categories below:

- Exceptionally serious
- Not raised internally or with the Prescribed Regulatory Body because the employee reasonably feared that they would be victimised
- Not raised internally because the employee reasonably believed that there would be a 'cover up' and there is no relevant Prescribed Regulatory Body
- Raised internally or with a Prescribed Regulatory Body, but was not dealt with properly

10. Unauthorised disclosure of confidential information

10.1 You are advised that unauthorised disclosure of confidential information to external organisations, particularly information relating to the care and treatment of individual patients will be regarded as a most serious matter and will normally warrant disciplinary action up to and including dismissal.

11. Supporting documents

11.1 The following listed and hyperlinked policy and procedural documentation support and provide further guidance to the Raising a Matter of Concern Policy.

- Raising a Matter of Concern Policy
- Grievance Procedure
- Counter Fraud Policy
- Disciplinary Policy and Procedure
- Health and Safety Policy
- Confidentiality Policy
- Media Policy and Guidelines for Staff
- Trust Values
- SUI
- Safeguarding of Vulnerable Adults and Children

- Bullying and Harassment

Appendix A: Trust Board Contacts (Level 3)
Executive directors

- Sir Ron Kerr, Chief Executive
- Dr Ian Abbs, Medical Director
- Eileen Sills CBE, Chief Nurse

- Amanda Pritchard, Chief Operating Officer
- Ann Macintyre, Director of Workforce
- Steve McGuire, Director of Capital, Estates & Facilities Management
- Martin Shaw, Director of Finance

Non Executive Directors

- Sir Hugh Taylor, Chairman *(chairs the Remuneration Committee and the Strategy and Estates Committee).*
- Rory Maw, Vice Chairman *(chairs the Finance and Investment Committee)*
- David Dean (Chairs Audit Committee)
- Mike Franklin *(chairs the Workforce Committee)*
- Jan Oliver
- Girda Niles
- Diane Summers

King's College Hospital NHS
NHS Foundation Trust

Policy on Raising Concerns (Whistleblowing)

Document Information			
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Author(s):	Marion Lorman, Associate Director Reward & Policy Development		
Responsible Director:	Angela Huxham, Director of Workforce		
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Consultation distribution (before ratification)

Sent to	Version	Date	Actions taken as a result
JCC	2.0	April 2011	UKCC changed to NMC
Staff Committee Chairs	2.0	April 2011	Adult safeguarding statement added

Reviews and updates

Date	New version no.	Summary of Changes	Major change/s (must go to KE) or minor change/s	Author of change/s
June 2004	1.0	New Policy	Major	Marion Lorman
April 2006	1.0	Updated	Minor	Marion Lorman
December 2007	1.1	1st Revision	Minor	Marion Lorman
May 2011	2.0	Three yearly review Policy updated to reflect guidance in Policy on Policies	Minor	Gemma Glanville
January 2012	2.1	NHS Whistleblowing Helpline Number Added	Minor	Gemma Glanville

Dissemination schedule (after ratification)

Target audience(s)	Method	Person responsible
All staff	As only minor changes, will be stored on a Trust wide drive	Gemma Glanville

1. INTRODUCTION

1.1 This Policy has been developed in response to the Public Interest Disclosure Act 1998, and brings together existing guidelines to set out the responsibilities of staff and other workers and the procedures to be used when raising particular issues of concern. Its purpose is to enable staff to raise concerns about malpractice and to ensure that they are promptly and properly investigated and dealt with appropriately.

1.2 The Policy complements various professional or ethical guidelines and codes of conduct or freedom of speech and is not intended to restrict the publication of clinical or scientific research findings, although the Trust expects it to be made clear that any comments in this respect represent a personal view and not the views of King's College Hospital NHS Foundation Trust.

1.3 This Policy should be read in conjunction with other Trust policies and procedures and in particular the Adverse Incidents Policy and Media Handling Policy. Further advice on other relevant guidelines and policies is given at the end of this document

1.4 This Policy does not apply to accredited Trades Union or Professional Association representatives undertaking duties within the industrial relations guidelines and agreed procedures.

1.5 This Policy is intended to address concerns where the interests of others or the Trust itself are at risk. It is not designed for raising every day concerns with management and it does not address individual or collective issues which are more properly dealt with under the Trust's Staff Complaints (Grievance) Resolution Procedure.

2. PURPOSE AND PRINCIPLES

2.1 The Trust is committed to encouraging a policy of openness and participation in all aspects of our work and services. However, this must be exercised with proper regard to individuals' rights to confidentiality in all matters personal to themselves, and to the proper use of appropriate channels of communication. It must also take full account of the requirements of patient confidentiality.

2.2 As part of the Trust's commitment to a policy of openness, we will support members of staff raising a genuine concern under this Policy.

2.3 The Trust expects individuals to respect this commitment by observing the appropriate procedure for raising such concerns and guidance is offered in this document.

2.4 When a member of staff raises a concern they should disclose any personal interest they may have in the matter, or in the particular concern, from the outset.

2.5 If a member of staff acts in good faith and reasonably believes their concern to be true, it does not matter if they are subsequently found to be mistaken. Therefore, staff should feel able to raise genuine concerns without a fear of retribution.

2.6 To obtain protection under the Public Disclosure Act 1998 staff must demonstrate that they have acted reasonably and responsibly, genuinely believing that a wrongdoing has occurred, is occurring or is likely to occur again.

2.7 The Trust also recognises that there may still be situations where staff wish to raise a concern in confidence. If a member of staff asks for their identity to be protected, the Trust will not reveal it without their consent. However, there may be situations where the Trust cannot proceed any further without doing so, and staff may not unreasonably refuse to co-operate in this respect.

2.8 Whilst the Trust acknowledges that some individuals may wish to remain anonymous when raising concerns it may make it much more difficult to investigate the matter if their identity is not revealed and this may impact on public or staff safety. Whilst anonymous reports will be looked into, this Policy does not therefore apply in such circumstances.

2.9 Staff will not be at risk of dismissal or any other form of retribution as a result of raising genuine concerns. This assurance does not cover those who raise a matter through malicious intent and/or which they know to be untrue, and formal disciplinary action may be taken in such circumstances.

2.10 Staff are reminded of their duties of confidentiality and loyalty to the Trust. Whilst areas of concern may be raised with external bodies without first raising them with the Trust, if it is not justified under the Public Interest Disclosure Act, this could be regarded as a breach of duty and may lead to disciplinary action. Staff are encouraged to raise concerns in line with this Policy.

2.11 Deterring someone from using this Policy, or victimising someone who does, will be regarded as a disciplinary issue.

2.12 It is important that when raising concerns, all NHS staff remember they have a duty of confidentiality to patients. Unauthorised disclosure of personal information about any patient may be regarded as breach of confidentiality and managed in line with the Trust Disciplinary Policy. Staff raising concerns should anonymise details so that patient identifiable information is not released. Staff can contact the Caldicott Guardian for advice.

3. SCOPE

3.1 WHO MAY RAISE CONCERNS UNDER THIS POLICY?

- All employees of the Trust whether temporary or subject to fixed term contracts, whether full-time or part-time, including trainees, and research staff
- NHS Professionals or Bank Staff

- Agency workers working at the Trust whether under contracts with, or employed by, the Trust or an Agency
- Any other workers who undertake work for the Trust but who are not necessarily employed by the Trust, such as contractors and their staff, or those holding honorary contracts

Although the Act does not specifically cover volunteers and independent consultants, we would encourage individuals to raise any concerns with a relevant employee of the Trust should they have cause to suspect, or evidence of, any malpractice.

3.2 WHAT ISSUES OF CONCERN DOES THIS POLICY COVER?

- Health care matters including suspected mistreatment or abuse of patients and/or issues relating to the quality of care provided
- Health and safety issues which affect patients, visitors or staff
- Suspicion or knowledge of theft, fraud, corruption, bribery or other financial malpractice
- Concerns about the professional or clinical practice or competence of colleagues or other members of staff
- The treatment of other staff, including suspected bullying, harassment or discrimination
- Employment standards and/or working practices
- Concern that the environment is, or is likely to be, endangered
- Failure to comply with any other legal obligation
- Information which may show that any of the above matters is being, or is likely to be, deliberately concealed
- Concerns about staff exploitation by extremists or radicalisers

4. PROCEDURE FOR RAISING CONCERNS

4.1 WHEN SHOULD I RAISE CONCERNS?

4.1.1 All staff have a duty to raise any concerns which they may have as soon as possible, as any delay could result in something happening again and/or make investigations more difficult. Examples of concerns which should be discussed are shown in Section 3.2.

4.2 TO WHOM SHOULD I TALK?

4.2.1 You should initially raise any concerns with your immediate line manager if you are employed or managed by the Trust. If you feel unable to do this for whatever reason you should discuss your concerns with your Departmental Head/Divisional Manager/Clinical Director, as appropriate. Junior Medical and Dental staff should raise any concerns with their Consultant, their Clinical Director or their Educational Supervisor. Nursing staff should speak with their Service Manager or appropriate Professional Head. However, concerns relating to potential fraud must be raised with the Trust's Counter Fraud Specialist on telephone extension 6110 in the first instance,

4.2.2 If you have spoken to these people and your concerns still continue, or if you feel that you would prefer to talk to someone outside your department, this is acceptable (see Section 5).

4.2.3 If you are an employee of a contractor you can contact the Chief Executive, Chief Financial Officer, or the Executive Director of Workforce Development to raise your concerns.

4.2.4 Staff may also choose to raise concerns through their local representative of an accredited trades union or professional association.

4.3 WHAT WILL HAPPEN WHEN I HAVE SPOKEN TO SOMEONE?

4.3.1 It is the responsibility of managers and senior clinicians to ensure that they are accessible to staff wishing to express their concerns, which should be dealt with thoroughly, fairly and promptly.

4.3.2 The Trust recognises that raising a concern can be a difficult experience. Genuine concerns will be listened to and taken seriously by managers and senior clinicians. Once a concern has been raised, the Trust will:-

- Respond to you in writing summarising the issues which you have raised.
- Consider it fully, fairly and sympathetically, and assess what steps need to be taken.
- Ensure that the matter is investigated as appropriate to the situation.
- Inform the individual raising the concern of the name of the person handling the matter and how they can be contacted.
- Provide feedback to the individual as far as is reasonable. The Trust is not able to disclose information, or details of the precise action taken, where this would infringe confidentiality owed to others, such as other staff or patients.
- Consider what further assistance you may be able to provide with the investigation.

4.3.3 Although it is important that reasonable time is allowed for a full investigation, it is expected that managers will consider the issue and respond to the person raising the concern as soon as possible, and within 10 working days of the matter being brought to their attention. Where this is not possible they should contact the member of staff to give reasons and an expected date for reply.

4.3.4 Where concerns are raised about an employee's conduct, the manager will bring this to their attention at the earliest opportunity.

5. WHAT CAN I DO IF I REMAIN DISSATISFIED?

5.1 Where local discussion has not allayed your concerns or resolved the issues staff should seek further help and guidance:-

Medical Staff should approach the Executive Medical Director or Executive Director of Operations (if they have not already done so).

Other Clinical Staff should approach their appropriate professional head.

Other Staff should approach the Head of their Directorate or Division..

5.2 **All Staff** are free to approach any member of the Trust's Executive or Board, the relevant specialist adviser(s) or any member of the Human Resources Department where they have been unable to address their concern through normal channels, or would prefer not to do so.

6. EXTERNAL CONTACTS

6.1 This Policy is intended to provide reassurance that matters raised internally will be dealt with swiftly and appropriately. Whilst the Trust would encourage you to raise your concerns through the internal process, you may also contact the following:-

6.2 Professional, Representative and Regulatory Organisations

All staff retain the right to consult, seek guidance and support from their professional organisation or trades union, and from statutory bodies such as the NMC or the GMC. Staff are encouraged to consult with the appropriate body if an issue seems likely to remain unresolved locally, and have an obligation to comply with the codes of practice of their relevant professional body.

6.3 The Health Service Ombudsman

The Ombudsman may look into complaints by staff on behalf of a patient, provided that they are satisfied that there is no-one more appropriate to act on a patient's behalf, such as the immediate relative. Information leaflets about the Ombudsman's role and the procedures for reference are available from the Patient Liaison Office or The Parliamentary and Health Service Ombudsman, Millbank Tower, Millbank, London, SW1P 4QP. Website http://www.ombudsman.org.uk/

6.4 NHS Fraud and Corruption Reporting Line

Employees can also call the NHS Fraud and Corruption Reporting Line on freephone 0800 028 40 60. This provides an easily accessible route for the reporting of genuine suspicions of fraud within or affecting the NHS. It allows NHS staff who are unsure of internal reporting procedures to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so. .

6.5 The National Clinical Assessment Service (NCAS)
For medical and dental staff concerns.

☎ 020 7062 1620 (switchboard) OR ☎ 020 7062 1655 (advice line)
💻 http://www.ncas.npsa.nhs.uk/

6.6 Public Concern at Work

This Charity also operates a confidential service who will advise you about raising concerns externally. Their Helpline number is 020 7404 6609.
Website http://www.pcaw.co.uk/ or email helpline@pcaw.co.uk

6.7 NHS Whistleblowing Helpline, (provided by Royal Mencap Society): 08000 724 725. The helpline provides confidential advice to individuals on how to report. It operates on weekdays between 08.00 and 18.00 with an out-of-hours answering service available at weekends and on public holidays.

6.8 Other External Contacts

Whilst there are other external contacts who may be approached, the Trust would expect you to raise your concerns in accordance with this policy before doing so. It may not necessarily be reasonable to disclose a matter to external parties if internal channels have not first been used. In any event you are advised in all cases to consult in confidence a member of the Human Resources department before raising any concerns outside the Trust.

7. RAISING CONCERNS ABOUT YOURSELF

7.1 You may have anxieties about your own work performance or conduct. These may stem from concerns, for instance, about:

- Your health.
- Events in your home life.
- A drink, drugs or other substance habit.
- Lack of confidence about your ability to do the job in the manner or to the standard required.
- Mistakes, errors or near misses for which you feel a responsibility.
- Inability to get along with one or more work colleagues.

The Trust would encourage you to share these concerns with an appropriate person, who will help you resolve the source of your concern.

7.2 Who should I raise my personal concerns with?

Depending on the nature of your concerns, you should raise the matter with your immediate supervisor or manager, who may wish to involve professional help, through Occupational Health, the Education and Development Team or Human Resources Departments. This is particularly important if the safety of patients or other staff is at risk.

If you feel uncomfortable about raising your concerns with your line manager, then you are free to self-refer yourself to Occupational Health, a professional counsellor within Occupational Health, your Human Resources manager or even your manager's manager.

You can get support and guidance from Workplace Options on 0800 243 458 or by email: assistance@workplaceoptions.com, via the website: www.workplaceoptions.com - Log in: KCH password: employee (needed if entering the website outside of the Trust) or on +44(0)208987 6550 (outside of the UK) . MINICOM 020 8987 6574.

7.3 Will I be jeopardising my employment by raising such issues?

The Trust will respect the fact that you have volunteered your concerns and will do everything practical to assist you resolve these in ways that protect your employment with the Trust. In dealing with the particular issues, you may wish to seek the support of a friend or trade union colleague or prefer to deal with the matter in a low-key, informal way. The Trust will respect your wishes on this matter.

In determining the best way to deal with the issues, appropriate Trust policies and procedures will be followed wherever appropriate.

8. GENERAL STATEMENT

King's College Hospital NHS Foundation Trust has in place a range of policies, procedures and protocols to support and encourage staff to raise concerns, which may include concerns about themselves. These include a process for individual performance appraisal and policies to encourage reporting of untoward incidents. Policies are also in place to allow staff to raise concerns around bullying and harassment, as well as issues relating to their personal capability and/or difficulties such as health, or alcohol and substance abuse. Staff are advised to access the relevant policy for detailed guidance, all of which are available in the human resources x-drive folder.

The Trust will provide support and advice to staff involved in traumatic or stressful incidents, including cases in which staff are subject to allegations of unfair or inappropriate treatment from patients, colleagues or managers. Line managers will listen carefully to concerns; will provide advice and indicate additional sources of support. The Occupational Health Department has a key role in providing support to help staff get through difficult periods. Managers should be sensitive to either the need to refer staff to the Occupational Health Department or alternatively to the need to suggest staff self refer to either Occupational Health or the Trust's staff counselling service. For more information please see Trust guidance on The Role of Occupational Health in Supporting Staff during times of difficulty.

9. MONITORING ARRANGEMENTS

Measurable policy objectives i.e. what will be monitored	Monitoring/ audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to groups/committees, inc responsibility for action plans
Monitor via grievance cases, disciplinary's and ET's for cases reported under Public Disclosure Act	Monitor ER cases through the annual ER data	Annual	Associate Director of Human Resources	JCC Workforce Diversity Group HR Department

10. REFERENCES

Adverse Incidents Policy
Alcohol & Drugs Policy
Children's Safeguards
Capability Policy and Procedure - Medical & Dental Staff
Clear Sexual Boundaries Between Healthcare Professionals and Patients
Counter Fraud and Corruption Policy
EL(93)51 - Guidance for Staff on Relations with the Public and Media
EL(95)42 - Code of Practice on Openness in the NHS
EL(95)60 - Detailed Guidance on Code of Practice on Openness in the NHS
GMC Guidelines on Confidentiality
Intimate Care and Sensitive Situations
Media Handling Policy
NAHAT "Protecting Patients" - guidelines for handling staff complaints about patient care – 1985
NMC Code of Conduct
Public Interest Disclosure Act 1998
Sickness Absence
Staff Complaints (Grievance) Resolution Procedure.

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Service/Function/Policy Raising Concerns (Whistleblowing)	**Directorate / Department** Human Resources	**Assessor(s)** Gemma Glanville	**New or Existing Service or Policy?** Existing	**Date of Assessment** March 2011

1.1 Who is responsible for this service / function / policy?
Human Resources Department (Marion Lorman/Gemma Glanville)

1.2 Describe the purpose of the service / function / policy? Who is it intended to benefit? What are the intended outcomes?
It is intended to benefit all staff, and also temporary staff and contractors working at the Trust. The policy puts in place a framework and guidance which sets out the responsibilities of staff and other workers and the procedures to be used when raising particular issues of concern. Its purpose is to enable workers to raise concerns about malpractice and to ensure that they are promptly and properly investigated and dealt with appropriately. It also includes some appropriate external bodies who may provide advice and support.

1.3 Are there any associated objectives? E.g. National Service Frameworks, National Targets, Legislation
No. Provide guidance in line with Public Interest Disclosure Act.

1.4 What factors contribute or detract from achieving intended outcomes?
(1) Awareness of policy. (2) Staff aware of responsibilities and obligations, and their willingness to raise matters of concern.

1.5 Does the service / policy / function / have an impact in terms of race, disability, gender, sexual orientation, age and religion? Details: [see Screening Assessment Guidance]
No. Anyone may raise concerns and will be properly supported. Policy reassures that staff will not be victimised or experience less favourable treatment.

1.6 If yes, please describe current or planned activities to address the impact.

1.7 Is there any scope for new measures which would promote equality?
Make policy readily accessible to all staff via X drive and knowledge of policy discussed at local induction.

- Ensure all managers and staff are aware of their responsibilities within the policy.

Promote policy changes via HR Brief and KWIKI/KingsWeb.

1.8 Equality Impact Rating [low, medium, high*]:
Race □ **Age** □ **Disability** □ **Gender** □ **Religion** □ **Sexual Orientation** □
If you have rated the policy, service or function as having a high impact for any of these equality dimensions, it is necessary to carry out a detailed assessment and then complete section 2 of this form

1.9 Date for next review: 2014

South London and Maudsley NHS
NHS Foundation Trust

MHOA &D (CAG)

Cha Power
Deputy Director

115 Denmark Hill, LONDON
SE5 8AZ

0203 2281624
cha.power@slam.nhs.uk
www.slam.nhs.uk

July 8th 2013

Julie Timbrell
Project Manager
Scrutiny Team
160 Tooley Street
London
SE1 2QH

Dear Julie

Re: Home Treatment Team and update for the Overview and Scrutiny Committee

You requested more information on :

The length of treatment times that service users receive

On average currently it is 22 days
The longest a patient under the home treatment service has been 12 weeks and the shortest has been only a day where someone mental health deteriorated and required an admission to hospital.

The outcome of the review into the times of service operation

This was reviewed in our last reference group and has been discussed with the team on a number of occasions. Generally work from 9am to 9pm has meant us offer a comprehensive to our service users. Staff on occasion have worker later and longer. At week-ends the working 10am to 6pm seems to have provided sufficient cover. We have had no negative feedback from service users , carers or partnership agencies regarding our operating times. This will be further reviewed when the pilot comes to an end in September.

A statistical breakdown into the extent of drug prescribing for service users

Only one patient has had no prescribed medication while under Home Treatment service. Most patients taken on by the service would be on

medication for both physical and mental health issues before the are referred to the service.

The service is continuing to expand into Lewisham and currently we are recruiting staff for new posts. There will be a formal evaluation in September 2013 which I will ensure you get a copy.

.

If there is any queries or need any further information please do not hesitate to contact me .

Yours sincerely

Cha Power
Deputy Director, MHOA&D CAG

Agenda Item 10

NHS Southwark Clinical Commissioning Group

Health, Adult Social Care, Communities and Citizenship Overview and Scrutiny Sub-committee

15th July 2013

Update on consultation: Improving health services in Dulwich and the surrounding areas.

Between 28th February and 31st MAY 2013 NHS Southwark CCG undertook a formal consultation under S242 of the 2006 NHS Act asking local people about future health service provision in Dulwich and the surrounding areas. People were asked to comment on a proposed service model for health services in community settings and two options for how these might be delivered.

The consultation plan was agreed with the Health, Adult Social Care, Communities and Citizenship OSC, and was also quality assured by the Consultation Institute. The management of the survey design, data collection and two deliberative events was run by an external organisation (Opinion Leader) with specialist expertise in the field to ensure objectivity. They were also responsible for the analysis of the data and the production of a report.

NHS Southwark CCG also, as part of this process, held 74 stakeholder events to broaden the engagement and to offer alternative ways of submitting views to the consultation. The outputs from these events were also fed into the analysis and the report.

Part of the preparatory work for the consultation was the commissioning of an Equalities Impact Assessment (EqIA) from an external organisation with experience and expertise in the field (Verve) so that there was also an impartial view on whether there were particular communities who might be differentially affected by the proposals. The recommendations from the EqIA fall into three categories: those which should be implemented as part of the consultation phase, those which should be considered at the project implementation phase and those which had wider implications across the work of the CCG. The recommendations for the consultation phase were all implemented.

As a result of the EqIA some stakeholder events were specifically targeted at particular communities in the area to ensure that their views were represented.

NHS
Southwark
Clinical Commissioning Group

At its meeting on the 11 July 2013, the Dulwich Programme Board will present the final draft of the Consultation Report to the Governing Body for formal receipt and noting prior to the development of any recommendations for local services informed by that consultation.

The Consultation Report outlines the process, the results of the consultation and an analysis of the information received. It also draws some conclusions based on that analysis.

Attached for information are the Consultation Report and the Equalities Impact Assessment.

NHS
Southwark
Clinical Commissioning Group

Improving Health Services in Dulwich and the Surrounding Areas Consultation

Report prepared by Opinion Leader

4th July 2013

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Contents

1. Executive summary

1.1 Introduction

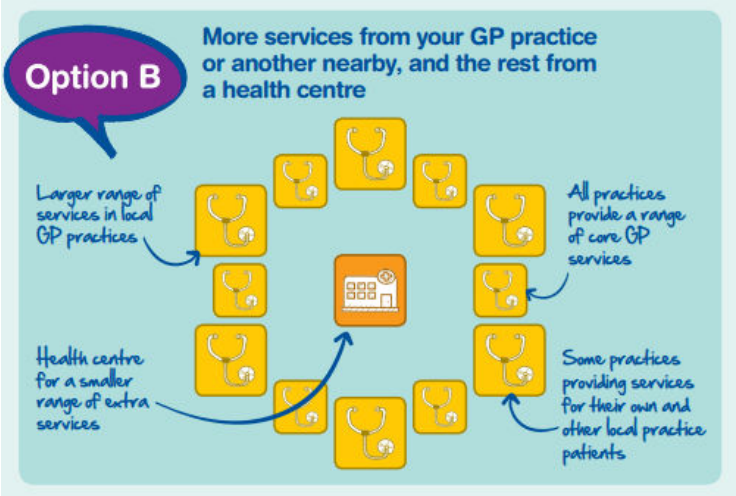
In spring 2012, NHS Southwark CCG organised a public engagement exercise that sought to uncover the health needs of the population of Dulwich and the surrounding area. It identified particular demand for providing healthcare to cater for:

- The area's ageing population;
- The area's unusually high proportion of young families;
- A high prevalence of cardiovascular disease and cancer;
- Preventive treatment;
- Helping people to look after themselves and manage their long-term health conditions;
- Improving the availability of GP appointments;
- Providing healthcare closer to home in the community.

Consequently NHS Southwark CCG developed a model of healthcare and two proposals for the way primary and community health services might be delivered to address each of the above points:

- Option A would involve delivering more primary and community health services than at present from a health centre (that is likely to be located on the Dulwich Community Hospital site) and only core services being delivered by GP practices.

- Option B would involve delivering more primary and community health services from GP practices dependent on each practice's skills, capacity and space, and a smaller range of specialist community health services from a health centre that would be likely to be located on the Dulwich Community Hospital site.



This approach and these proposals formed the basis of a thirteen-week consultation, held between the 28th February and the 1st June 2013. Residents or individuals that currently received or may receive healthcare in the Dulwich, Nunhead, Herne Hill, south Camberwell and south Peckham areas were invited to take part. There were a number of ways in which individuals could respond to the consultation: through a questionnaire (available online and on paper); by submitting written responses via post or email; through deliberative events open to all members of the public; or through meetings organised by NHS Southwark CCG with key stakeholder groups.

Opinion Leader was commissioned to design the consultation questionnaire, observe and record two deliberative events, manage queries and responses to the consultation on a daily basis, and collate, synthesise and analyse all responses via the questionnaire and meetings organised by NHS Southwark CCG with members of the public and stakeholders. Opinion Leader worked with the Consultation Institute to ensure that the materials used in administering the consultation met good practice guidelines.

The number of individuals that participated in the consultation is detailed below:

- An estimated 667 people attended public meetings (including council meetings) in which the consultation was promoted, documents were distributed and there was an opportunity for questions to be asked of NHS Southwark;
- 568 people engaged in discussion meetings and events organised by NHS Southwark CCG;
- 215 people responded to the formal consultation questionnaire;
- 6 letters or emails from members of the public commenting on the proposals ('white mail');
- 14 stakeholder organisations sent a written response to the consultation;
- 60 people attended round-table public events, the purpose of which was to discuss and explore the proposals in depth.

This report provides an account of all responses to the consultation through the channels listed above. Responses to the questionnaire and 'white mail' are reported on in the form of charts and percentages; responses provided through public meetings are also described throughout as well as being detailed in a dedicated section of this report.

It is also important to note that, as with any public consultation, the findings in this report cannot be extrapolated to make claims about the wider population. Respondents to the questionnaire, those that provided other written responses, and those that chose to attend a deliberative event were self-selecting members of the public rather than a representative sample of the population of Dulwich and the surrounding area. In addition, NHS Southwark CCG approached some stakeholder groups on the basis that they may be disproportionately affected by the proposals; or that they might not be able to participate or provide a response in another way. The opinions reported on in this document, therefore, reflect only those who chose to take part in the consultation.

The profile of respondents to the consultation incorporated individuals from a range of backgrounds. The stakeholder groups that were specifically targeted by NHS Southwark CCG and with whom meetings were arranged included older residents, people with physical or learning disabilities, mental health service users, members of the Lesbian, Bisexual, Gay and Transgender community, and people from a range of ethnic backgrounds. A detailed breakdown of respondents to the consultation questionnaire is later in the report.

1.2 Key findings

A) Respondents were supportive of the proposed approach to delivering healthcare

Overall, respondents were supportive of NHS Southwark CCG's approach in putting together the two proposals to deliver healthcare in a community setting, and seeking to address the health needs of the local population as listed above – 80% of respondents to the questionnaire were **in agreement with the overall model of delivering healthcare in the community** compared with just 4% that were opposed. Support for this approach was also high amongst individuals that attended the deliberative and stakeholder meetings, with the exception of those who objected to the case for change more generally (moving care out of hospitals into the community, locating health services closer to people's homes, and modifying some GP practice buildings). Thinking about NHS Southwark CCG's case for change, respondents generally were supportive, particularly with regard the sentiment that healthcare should be delivered in a more **accessible setting in the community rather than in hospital**. This, respondents felt, would empower people to **manage their own health problems themselves independently.** Having **health services delivered locally** was the most important issue for some individuals, whilst the importance of providing **preventive care** was stressed at various points in the questionnaire and in deliberative and stakeholder meetings.

There was slightly less certainty that improvements or changes ought to be made to the delivery of health services from some GP practices and GP practice buildings. Here, questionnaire respondents as well as those attending meetings organised by NHS Southwark CCG acknowledged the variation in experience of patients across the area. There was a higher degree of **sensitivity amongst some respondents as far as modifying their GP practice was concerned** compared with other potential ways in which healthcare might be delivered in the area in future. **GP services were the most commonly used health services** in the area, especially for consultations, health checks and children's health services. For a large number of health services, GP practices were also rated as **the preferred location** for these services to be delivered; additionally even respondents who stated they had no preference as to where health services were delivered (in a health centre or GP practice) seemed to want to **preserve the current system** and keep the configuration of health services within GP practices as it is at present.

Whilst respondents were generally in favour of the overall approach, some commented that it was difficult to arrive at any firm opinion about either of the proposals in the absence of a **cost analysis of both Options**, and greater **detail about the configuration of services and the locations in which these would be delivered** under either of the Options.

B) The preferred option

Overall, **Option A was the preferred Option:** this feeling was concentrated most heavily amongst respondents to the questionnaire, with 60% in favour of it and 19% opposed, and also responses from stakeholder organisations and attendees at stakeholder meetings arranged by NHS Southwark CCG. This contrasted with Option B, where 46% of respondents to the questionnaire were in favour and 27% were opposed. Arguments in favour of Option A included the perceived **enhanced quality of healthcare** as it is delivered from a centralised point with concentrated expertise and equipment to treat specialist community health problems; **improved availability** of health services that might formerly have been offered in GP practices; and **decreased waiting times** to receive healthcare that might formerly have been offered in GP practices. All of these things would, in the view of some respondents, reduce some of the strain that GP practices currently face, and help to overcome the difficulty respondents commonly cited of making an appointment to see their GP.

The sorts of health services that respondents felt should be offered in a health centre included those relating to **more serious conditions** (like minor surgery, chest disease and neuro-rehabilitation stroke team, as well as more **complex services** like complex contraception and mental health support). Opinion seemed to be split where maternity and children's health services were concerned where responses from those completing the survey as well as those attending meetings highlighted the need for some groups, expectant mothers in particular, to have joined-up and personalised care.

Having said that, there were some respondents that were **strongly in favour of Option B,** largely for reasons of **accessibility and services being located closer to home**. Respondents' views on this varied depending on **where they lived and the type of healthcare they required**. Age was less of a driver of opinion here, with respondents to the questionnaire aged 18-24 more inclined to think that accessibility was more important than those aged over 65. There were concerns that the Dulwich Community Hospital site (the intended site for a new health centre) was **not always easily accessible by public transport** and would create longer travel times for patients who might no longer be able to obtain treatment from their local GP practice. Some stakeholder groups also favoured Option B from an accessibility perspective for more **vulnerable service users.**

The main argument some respondents (particularly those that preferred Option A) made against Option B was the inability of GP practices to deliver health services under this model. Some were disparaging of the **quality of their GP services** currently; another common complaint was **oversubscription of GP practices** and the difficulties this created in making an appointment. It was felt that these **problems would be exacerbated under Option B** and some respondents had genuine doubts about the feasibility of this Option in practice.

Having said that, individuals felt there were potential problems to overcome with regard to both Options. Discussions at the deliberative events open to all members of the public demonstrated a range of views among attendees and whilst participants may be more in favour of one Option over another, the priority for many of those in attendance was to ensure any Option that was taken forward did not have a detrimental effect on the quality of care available. Another concern raised with regard to both Options was ensuring **equality of access for residents across the area**, both to a health centre and to the GP practice

offering the care required. Access was repeatedly raised by respondents across all channels, and was rated as the most important feature of a new health centre by respondents to the questionnaire.

C) Other considerations

There were a number of other considerations that were raised by respondents irrespective of the Option that was pursued in the future. The first of these was ensuring that healthcare was **joined up across the different channels** that a patient might receive treatment. Specifically respondents and participants at deliberative events and stakeholder meetings identified the fact that **GPs, hospitals, any new health centre, pharmacists and social services** should all have access to current medical notes about each patient so that the healthcare – and the personal service – that patients require is delivered appropriately.

Some respondents' distrust that this could be implemented effectively in practice led them to question the feasibility of NHS Southwark CCG's approach and Option B in particular, which it was felt would **fragment the care individuals receive** across Dulwich and the surrounding area. This fragmentation, and the fact that some GP practices would offer some specialist community services whilst others would not was not felt to be fair or ensuring health services were of sufficient quality to patients across Dulwich and the surrounding area. This debate highlighted a tension in responses to the consultation between **offering patients choice** as to where they obtain their healthcare and **centralising services for the perceived sake of quality and continuity of care**.

Another general concern was the provision of **out-of-hours care**. **Evening and weekend opening times** were the second highest priority for a new health centre for respondents to the questionnaire, with 92% of respondents rating this as important, and this was also a priority for some of those at the deliberative events, particularly where they had bad experiences in the past. For respondents more generally, if more services were to be delivered from a health centre or from various GP practices, accessibility and flexibility of these services – particularly for people that work – was a concern.

At the forefront of some respondents' minds was the overarching necessity of having high quality healthcare. For these respondents, they hoped that NHS Southwark CCG would not simply work within the confines of the existing system, but that it would aim for the **ideal model of healthcare**.

1.2 Conclusions

There was strong support for the CCG's overall direction, with important caveats about cost and accessibility. There was particular support for delivering preventive care in the community but some individuals had concerns about the location of these services.

Option A is preferred to Option B overall, the variable standard of GP services being the driving factor. Other benefits individuals mentioned with regard to Option A was the concentration of expertise, the potential for care to be joined up for key groups like pregnant women, the elderly, and mental health service users, and for coordination with other health and social care providers.

GP services are well regarded overall, however, the standard is variable. There is some sensitivity about the capacity of GPs to take on additional services, but some individuals are keen to ensure they do not have to travel further or see multiple healthcare professionals to receive health services out of their GP practice.

Concerns about potential fragmentation of care and decrease in quality and accessibility due to the new approach to healthcare delivery need to be allayed. This point was raised irrespective of the Option that NHS Southwark CCG might go on to pursue.

2. Introduction

This consultation, *Improving Health Services in Dulwich and the Surrounding Area,* was launched by NHS Southwark Clinical Commissioning Group (CCG) following a period of public engagement in Spring 2012. This period of engagement sought to understand the health needs of the local population, and their priorities in terms of healthcare provision in the area. *Improving Health Services in Dulwich and the Surrounding Area* also took place as the NHS in the area came under increasing pressure to make efficiencies and work with reduced budgets.

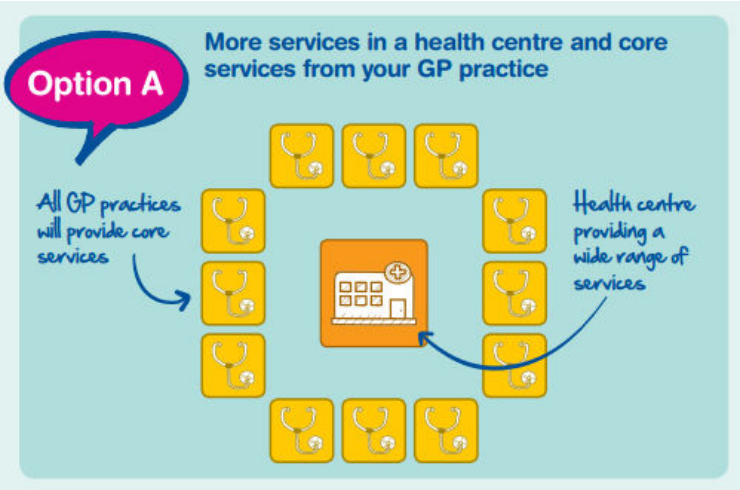
With both of these things in mind, NHS Southwark CCG had a number of considerations to carry forward into potential options for the delivery of healthcare in Dulwich and the surrounding area.

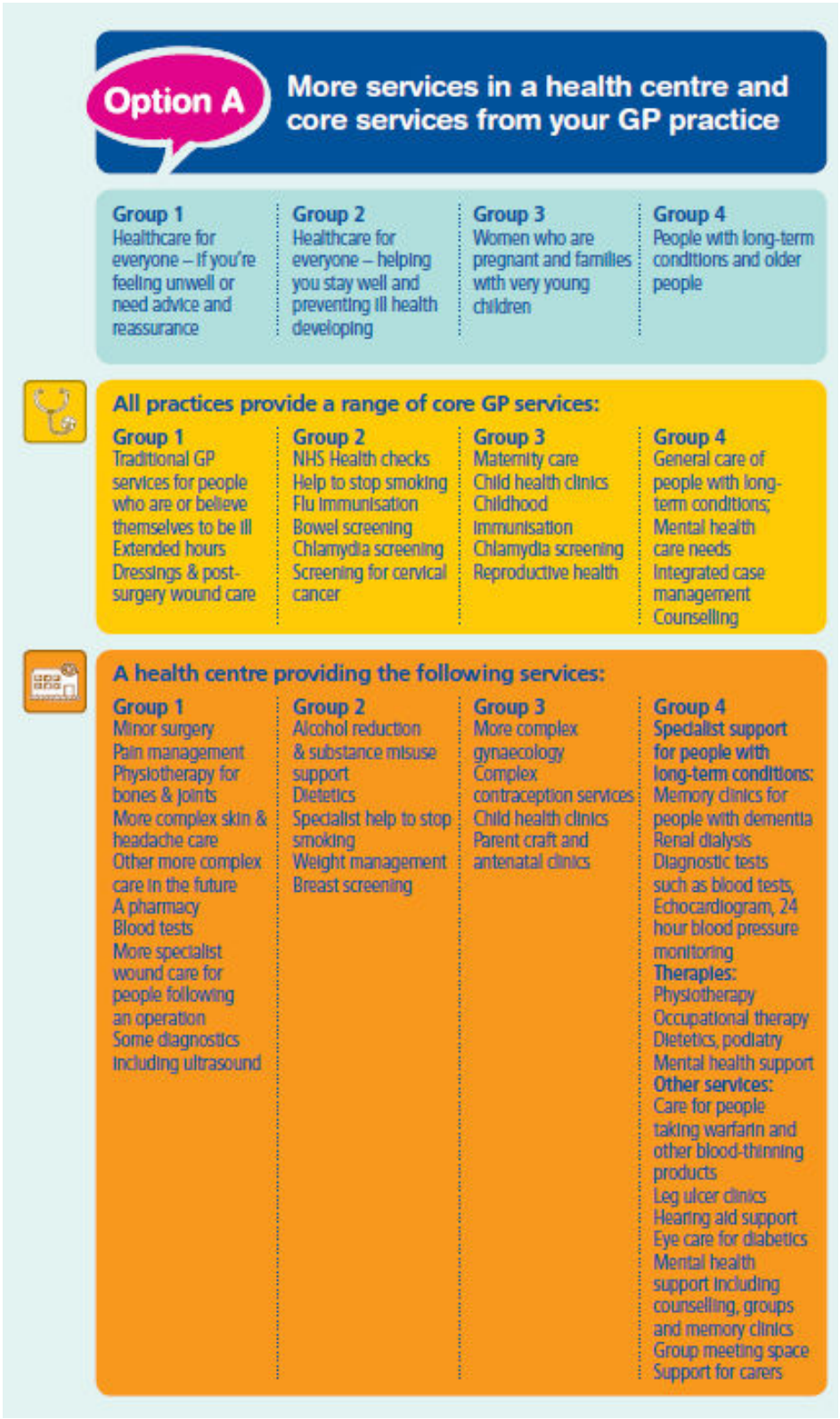
- The Southwark population had an increasing number of older people and very young children.
- Diseases such as cardiovascular disease, cancer and other long-term health conditions were especially prevalent in the area.
- Previous public engagement exercises had highlighted residents' priorities, including:
    - The need for more preventive healthcare in the area;
    - Assistance for residents with long-term health conditions;
    - Improvements to the availability of GP appointments;
    - The provision of more healthcare in the community.

As a result, NHS Southwark CCG devised two proposals for ways in which primary and community healthcare might be delivered in the Dulwich area in the future.

Configuration of health services under Option A

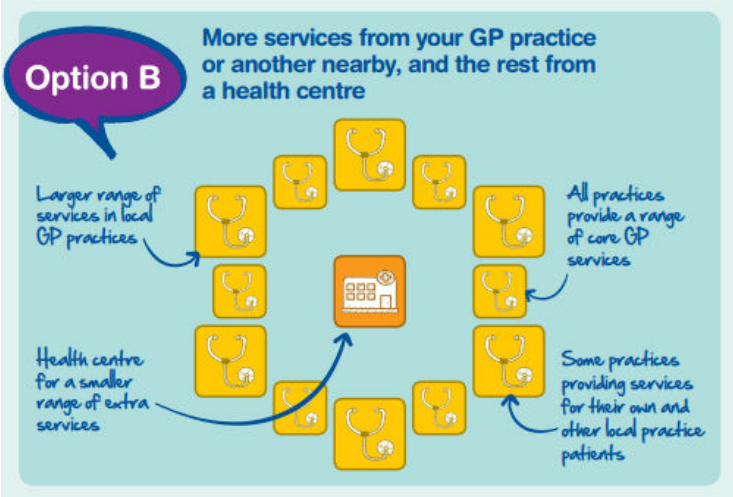
- Option A would involve delivering more primary and community health services than at present from a health centre (that is likely to be located on the Dulwich Community Hospital site) and only core services being delivered by GP practices.




Option A
More services in a health centre and core services from your GP practice
Group 1
Healthcare for everyone – if you're feeling unwell or need advice and reassurance
Group 2
Healthcare for everyone – helping you stay well and preventing ill health developing
Group 3
Women who are pregnant and families with very young children
Group 4
People with long-term conditions and older people
All practices provide a range of core GP services:
Group 1
Traditional GP services for people who are or believe themselves to be ill
Extended hours
Dressings & post-surgery wound care
Group 2
NHS Health checks
Help to stop smoking
Flu immunisation
Bowel screening
Chlamydia screening
Screening for cervical cancer
Group 3
Maternity care
Child health clinics
Childhood immunisation
Chlamydia screening
Reproductive health
Group 4
General care of people with long-term conditions;
Mental health care needs
Integrated case management
Counselling
A health centre providing the following services:
Group 1
Minor surgery
Pain management
Physiotherapy for bones & joints
More complex skin & headache care
Other more complex care in the future
A pharmacy
Blood tests
More specialist wound care for people following an operation
Some diagnostics including ultrasound
Group 2
Alcohol reduction & substance misuse support
Dietetics
Specialist help to stop smoking
Weight management
Breast screening
Group 3
More complex gynaecology
Complex contraception services
Child health clinics
Parent craft and antenatal clinics
Group 4
Specialist support for people with long-term conditions:
Memory clinics for people with dementia
Renal dialysis
Diagnostic tests such as blood tests, Echocardiogram, 24 hour blood pressure monitoring
Therapies:
Physiotherapy
Occupational therapy
Dietetics, podiatry
Mental health support
Other services:
Care for people taking warfarin and other blood-thinning products
Leg ulcer clinics
Hearing aid support
Eye care for diabetics
Mental health support including counselling, groups and memory clinics
Group meeting space
Support for carers

Configuration of health services under Option B

- Option B would involve delivering more primary and community health services from GP practices dependent on each practice's skills, capacity and space, and a smaller range of specialist community health services from a health centre on the Dulwich Community Hospital site.




Option B
More services at your local GP practice or one nearby and a health centre for a smaller range of extra services
Group 1
Healthcare for everyone – if you're feeling unwell or need advice and reassurance
Group 2
Healthcare for everyone – helping you stay well and preventing ill health developing
Group 3
Women who are pregnant and families with very young children
Group 4
People with long-term conditions and older people
All practices provide a range of core GP services:
Group 1
Traditional GP services for people who are or believe themselves to be ill
Extended hours
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Group 2
NHS Health checks
Help to stop smoking
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Chlamydia screening
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Child health clinics
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Reproductive health
Group 4
General care of people with long-term conditions;
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Counselling
Some practices provide services for their own and other local patients
Group 1
Minor surgery
Pain management
Physiotherapy for bones & joints
More complex skin & headache care
Other more complex care in the future
Blood tests
More specialist wound care for people following an operation
Group 2
Alcohol reduction & substance misuse support
Dietetics
Group 3
More complex gynaecology
Group 4
Memory clinics for people with dementia
Counselling for stress & anxiety (IAPT)
A health centre providing the following services:
Group 1
A pharmacy
Minor surgery
Physiotherapy for bones & joints
Some diagnostics including ultrasound
Group 2
Specialist help to stop smoking
Mental health support including counselling, groups, memory clinics
Weight management
Breast screening
Group meeting space
Group 3
Complex contraception services
Child health clinics
Parent craft and antenatal clinics
Group 4
Specialist support for people with long-term conditions:
Diagnostic tests such as blood tests, Echocardiogram, 24 hour blood pressure monitoring
Therapies:
Physiotherapy
Occupational therapy
Dietetics, podiatry
Mental health support
Other services:
Care for people taking warfarin and other blood-thinning products
Leg ulcer clinics
Hearing aid support
Eye care for diabetics
Renal dialysis
Support for carers
Mental health support including counselling, groups and memory clinics

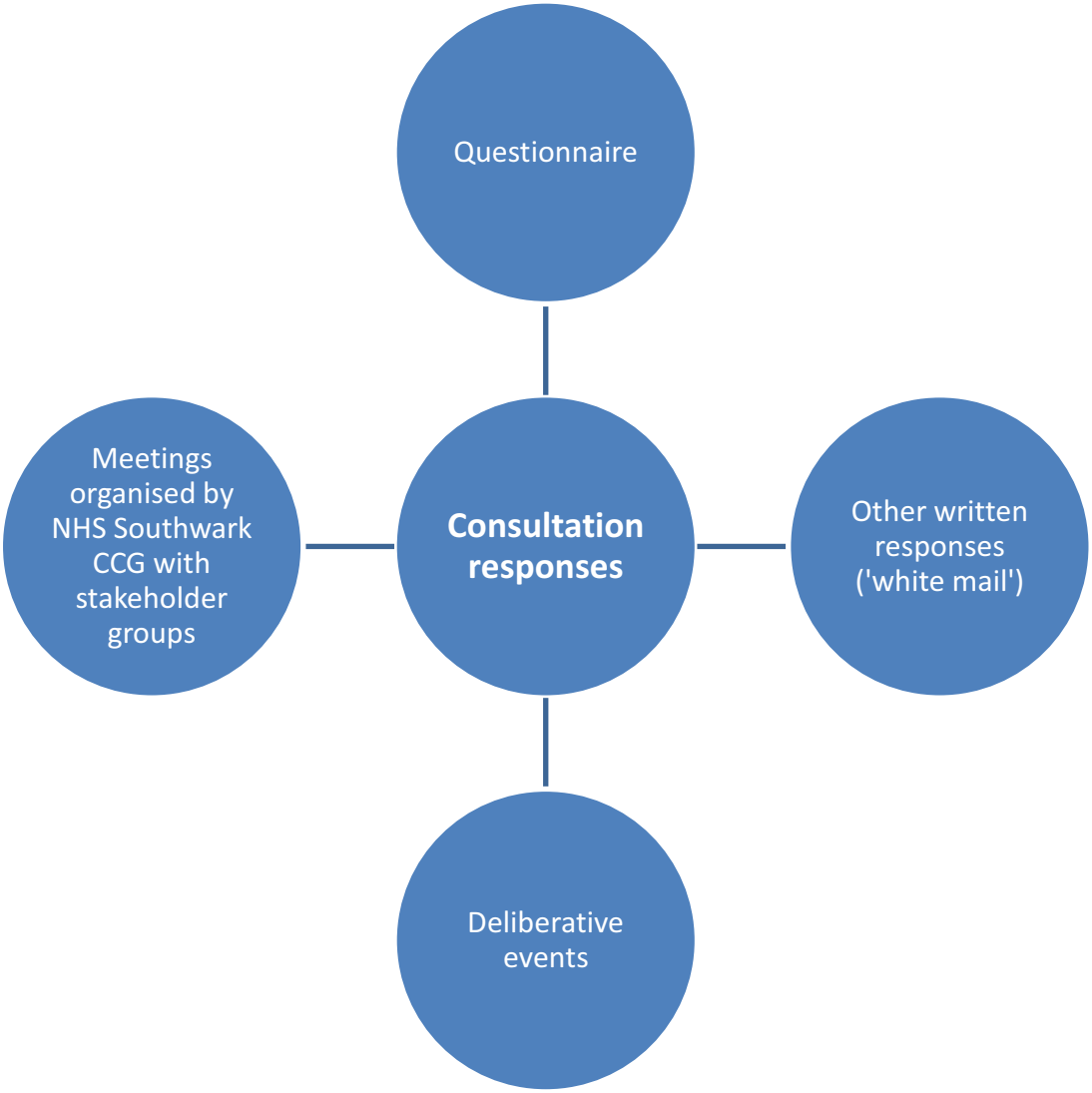
Option A and Option B formed the basis for public consultation.

NHS Southwark CCG commissioned Opinion Leader to administer and evaluate responses to the consultation, which took place over 13 weeks between 28th February and 1st June 2013. The report that follows synthesises and conveys public views on the proposals put forward for the future of health services in the Dulwich area.

2.1 Methodology

The consultation was aimed at any individual or organisation with an interest in the delivery of health services in the Dulwich area. This included individuals that lived, or received healthcare in, the area. No postcode or area boundaries were applied to assess eligibility for responding to the consultation, although NHS Southwark CCG acknowledged that the proposals would probably be most relevant to residents in Dulwich, Nunhead, Herne Hill, south Camberwell and south Peckham.

Respondents were able to participate in the consultation in a number of ways, and responses via all these channels have been considered equally in the reporting of findings in this document:



A) The consultation document and questionnaire

NHS Southwark CCG designed a 60-page consultation document to assist residents in arriving at an informed view of the proposals. The document included:

1. Details of the healthcare options that would be available in the community if the proposals were to go ahead as well as specific details of both of the proposals and the sorts of things NHS Southwark CCG had taken into consideration when designing the two options.
2. The case for change (including the financial case) and for changing the model of healthcare delivery in the area based on the local population's needs.
3. Details of how individuals could provide feedback on the options. A Freephone telephone number and a Freepost address were also included, directing queries and responses to the consultation to Opinion Leader who would independently log and handle them.

The consultation document and questionnaire were available on the NHS Southwark website[1] as well as in paper and easy read versions, to ensure residents could access this information through a range of channels. The consultation document was also available through GPs' surgeries, libraries and public access buildings. Opinion Leader also distributed copies of the document and questionnaire to residents that requested one. Other versions of the document in different formats and languages were also available on request.

Various activities were undertaken by NHS Southwark CCG throughout the consultation to advertise the consultation and encourage people to respond.

Actions taken to spread awareness and encourage engagement included:

- Distributing 2,000 copies of the consultation document and 100,000 copies of the summary document to every GP surgery, dentist, pharmacy & optician in Southwark including some in Lambeth and Lewisham where they bordered the core area.
- Distributing 45,000 (estimate) summary documents to 300 high street and community-based outlets- including libraries, community centres, shops, cafes and restaurants.
- Door to door distribution of 30,000 summary documents to most households in south Southwark.
- On-street distribution of consultation documents on Lordship Lane, Dulwich, Rye Lane, Peckham and Sainsbury's supermarket on Dog Kennel Hill.
- Advertising the consultation in South London Press and SE21&22 magazines.
- Advertising the consultation in Southwark News.
- Advertising the consultation in an exhibition at the Dulwich Community Hospital site
- Sending a copy of the consultation to 800 organisations/groups including all GP practice patient participation groups, dentists, pharmacies & opticians, nurseries, primary and secondary schools inviting them to participate and offering to visit them
- Providing 150 community and voluntary sector organisations working in the health and social care field with a hard copy of the document via Community Action Southwark.
- Two public deliberative events.
- Seventy-four meetings with stakeholder groups.
- Five drop in events.

[1] When NHS Southwark Primary Care Trust became NHS Southwark Clinical Commissioning Group, the document and questionnaire were made available on the new website.

The link to the online questionnaire was highlighted in the consultation document as well as leaflets that were distributed to all houses in the Dulwich area.

Opinion Leader worked closely with NHS Southwark CCG and the Consultation Institute to design the questionnaire, which was identical across both online and postal channels. The Consultation Institute provided an assurance throughout that questionnaire met good practice guidelines.

It was essential that the questionnaire met the following requirements:

- Relevant to the consultation topic;
- Objective;
- Written in plain English so that lay people could clearly understand the questions and were able to provide a clear and informed response;
- Unambiguous;
- Quantitative and qualitative in nature.

The questionnaire consisted of a mixture of closed and open questions. Closed questions with pre-coded responses sought to measure levels of support or opposition to different elements of the proposals whilst at open questions respondents were encouraged (but not obliged) to explain their answers and also put forward other ideas or considerations that NHS Southwark CCG ought to bear in mind.

The questionnaire was organised into the following sections:

1. **Use and preferred location of health services in the Dulwich area:** this included most recently used services as well as services respondents felt were not adequately referenced in the proposals.
2. **Thoughts on the model of community health care:** specifically gauging levels of support or opposition for providing local facilities for primary care, diagnostic services, mothers and young children, and support for older patients and those with long-term health conditions.
3. **Thoughts on Option A and Option B:** including levels of support or opposition, feelings about the availability and accessibility of healthcare specifically, key things that NHS Southwark CCG ought to bear in mind for each of these proposals and asking respondents for any additional ideas for the delivery of healthcare in the area. Respondents were also asked to rate the importance of the various features that a health centre might embody, for example, being open at the weekends and early evenings.
4. **Thoughts on the case for change:** gauging levels of support or opposition with the premise that local health services needed updating; that care in the community was more beneficial in some cases than care in hospital; and that some GP practice buildings needed improvement.
5. **Overall views:** so that respondents could add any further comments.

The questionnaire also contained a series of demographic questions for the purposes of analysis and to identify service user groups. These included postcode, age, gender, ethnic group, sexual orientation, occupation and disability.

As well as being available publicly online in order to obtain as many responses as possible the questionnaire was also sent directly to a research panel of respondents living in the following postcodes (within the areas listed above): SE5, SE14, SE15, SE19, SE21, SE22, SE23, SE24, SE26, SE27. Questionnaire links were sent separately to 150 community groups in the Dulwich area via Community Action Southwark, and NHS staff. The questions asked of respondents were identical across both online and postal channels, and across members of the public, panel respondents, community groups and NHS staff. The online questionnaire that was designed for panel respondents, community groups and NHS staff signposted respondents to information differently than the standard questionnaire and contained more detailed explanations of the

proposals contained alongside some of the questions so that respondents need not look at the consultation document separately.

Before launch, the questionnaire was tested with five members of the public that had used primary healthcare services in the Dulwich area in the past year. Participants were supplied with a draft of the consultation document and also the questionnaire. Firstly, they were asked to read the document and familiarise themselves with the proposals as well as highlighting any areas where they felt the information was unclear or sparse. They were then asked to go through the questionnaire and answer the questions as they might if they were responding to the consultation, timing how long it took them to do so. Finally, participants went through the questionnaire a second time, thinking about what sorts of things they had taken into consideration when answering the question and the reasons why they had responded in a particular way. They were then interviewed via telephone by an Opinion Leader researcher, to talk through their experience and thoughts on the questionnaire. Feedback from the cognitive interviews was then collated and given to NHS Southwark CCG for consideration and subsequent changes were made to the questionnaire.

In total, there were 215 responses to the questionnaire online and via paper. The breakdown of responses received online via the various channels described above includes:

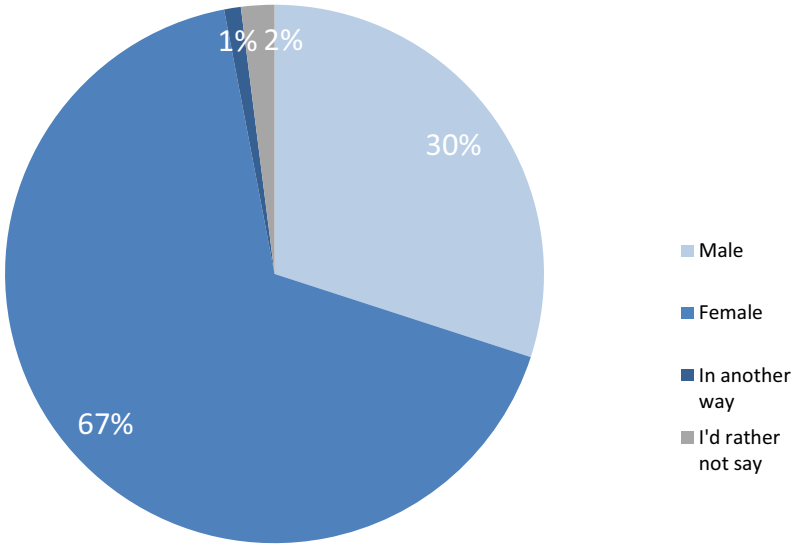
- 122 self-selecting members of the public
- 89 panellists
- Two community group respondents
- One member of NHS staff

Of the responses to the questionnaire, 59 were received via paper and 156 online.

Respondents to the questionnaire came from a range of demographic backgrounds, a breakdown of which can be found in the charts below.

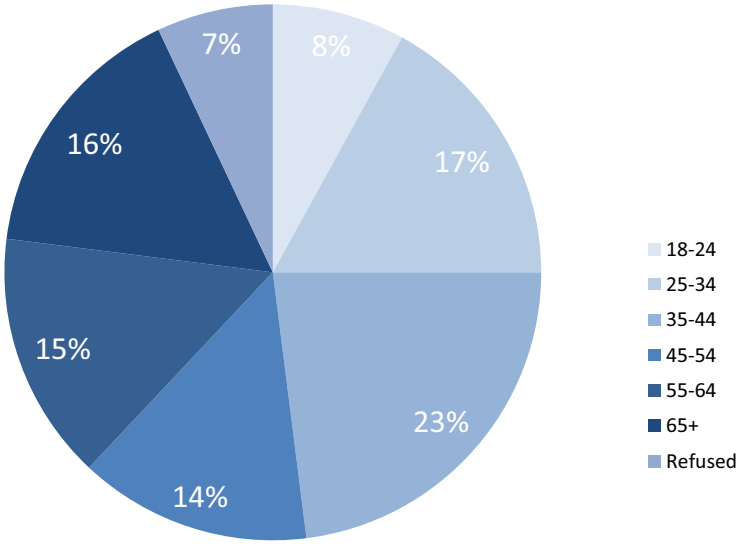
The proportion of female respondents to the questionnaire to men was roughly two to one.

Question 14. Which of the following best describes how you think of yourself?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



There was a spread of responses to the questionnaire across age groups. Younger respondents tended to come from the panel rather than self-selecting members of the public (16% versus 2%) as were 25-34 year olds (27% versus 11%). Older respondents tended to be self-selecting members of the public, with 22% of those aged 65 or older opting to take part in the survey compared with 8% of those responding from the panel. This was also true of respondents in the 55-64 age group, of whom 20% were self-selecting members of the public and 7% responded from the panel.

Question 13. What was your age on your last birthday?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



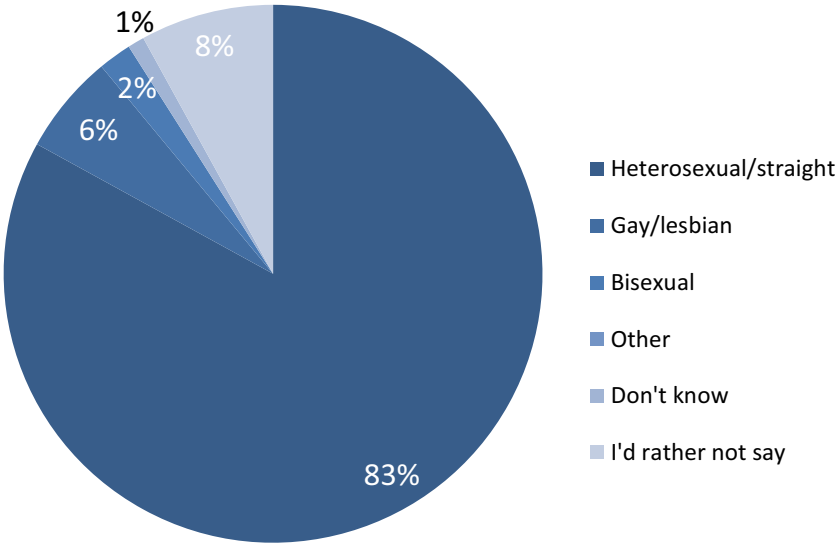
The majority of respondents to the questionnaire (74%) came from White backgrounds. The remaining quarter of respondents to the survey were spread over a number of other categories. The proportion of respondents from non-white groups tended to respond via the panel (36% versus 26%) and were more likely than self-selecting members of the public to come from Black or Chinese groups. As already mentioned, NHS Southwark CCG separately approached a range of stakeholder groups representing individuals from a number of ethnic backgrounds.

Question 15. Which of these groups do you consider you belong to?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Health service	% respondents
White British	65
White Irish	1
Other White	8
Mixed White and Black Caribbean	3
Mixed White and Black African	1
Mixed White and Asian	1
Other Mixed	2
Asian or Asian British Indian	2
Asian or Asian British Pakistani	*
Asian or Asian British Bangladeshi	*
Other Asian	0
Black or Black British Caribbean	4
Black or Black British African	5
Other Black	1
Chinese	1
Any other ethnic group	1
I'd rather not say	4

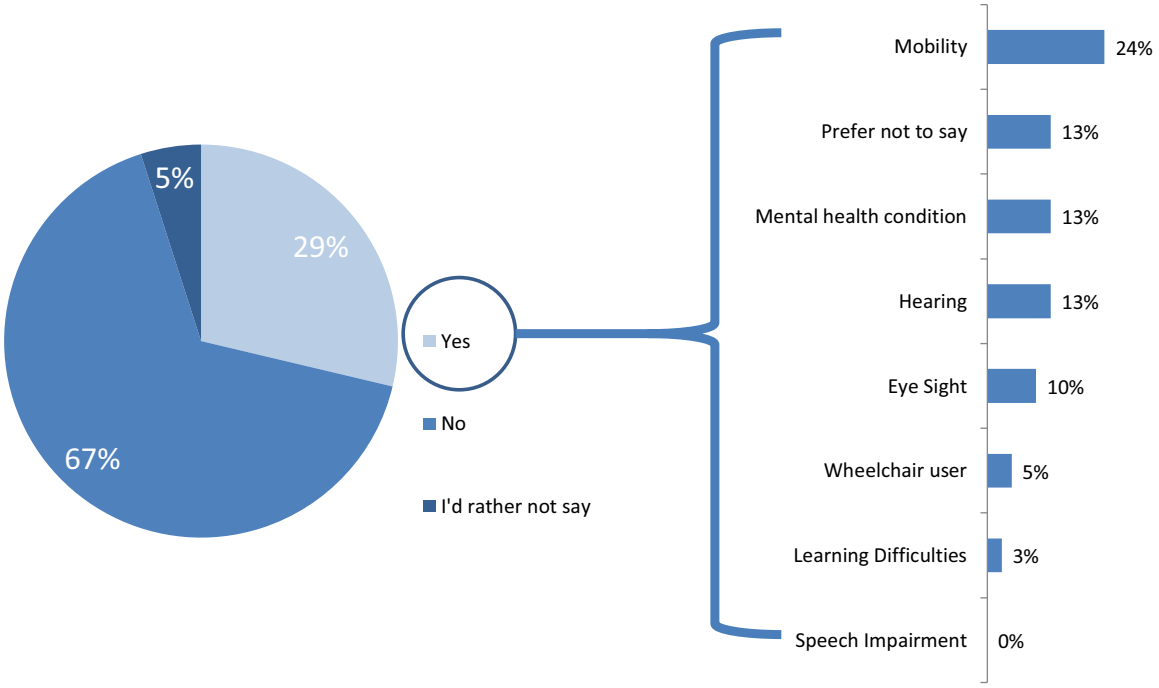
Eight per cent of respondents to the questionnaire came from Lesbian, Bisexual, Gay or Transgender groups, with little variation amongst self-selecting respondents and those responding via the panel.

Question 16. Which of these options best describes how you think of yourself?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



Almost one-third (29%) of respondents to the questionnaire reported having a disability. This was more common amongst self-selecting members of the public (32%) than amongst respondents from the panel (25%). The most commonly reported disabilities amongst those that had a disability were related to mobility (24%), mental health (13%) and hearing (13%). As part of its work to speak with stakeholder groups, NHS Southwark CCG also involved groups representing people with physical and learning disabilities, as well as people with mental health considerations, to take part in the consultation via informal meetings.

Question 18. Do you have a disability or long term illness?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



Responses to the questionnaire came from the following postcode areas:

Postcode	Postcode area	Number of respondents to the questionnaire
SE1	Bankside, South Bank, Southwark, Bermondsey, Vauxhall	4
SE5	Camberwell, Denmark Hill, Peckham	22
SE8	Deptford, Evelyn	1
SE11	Kennington, Vauxhall	1
SE12	Lee, Grove Park, Chinbrook,Hither Green , Eltham , Horn Park, Blackheath	1
SE13	Lewisham, Hither Green, Ladywell	1
SE14	New Cross	7
SE15	Peckham, Nunhead	41
SE17	Walworth, Newington	1
SE19	Upper Norwood, Crystal Palace	8
SE21	Dulwich, Dulwich Village, West Dulwich, Tulse Hill, Sydenham Hill	8
SE22	East Dulwich, Peckham Rye, Loughborough Junction, Herne Hill	69
SE23	Forest Hill, Honor Oak, Crofton Park	12
SE24	Herne Hill, Tulse Hill	10
SE26	Sydenham, Crystal Palace	6
SE27	West Norwood, Gipsy Hill	10
SW2	Brixton, Brixton Hill, Streatham Hill, Tulse Hill, Clapham Park, Balham	1
SW16	Streatham, Norbury, Thornton Heath, Streatham Park, Furzedown, Streatham Vale, Mitcham Common, Pollards Hill	1
Other/not stated		11

Organisations responding to the questionnaire included:

Organisations responding to the survey
WPF Therapy
East Dulwich Primary Care Centre
Guy's and St. Thomas' Therapies
Mind
Lambeth, Southwark and Lewisham Local Pharmaceutical Committee
Acorn and Gaumont House Surgery
SLAM SUCAG Service User and Clinical Academic Group
Concordia Melbourne Grove and Parkside Medical Centre

B) White mail

In addition we received six pieces of 'white mail' from members of the public. We have classified 'white mail' as an individual's written response to the consultation in the form of a letter or email that did not take the form of the questionnaire. Responses of this nature have been incorporated into the data contained in this report (more details below). No petitions were received over the course of the consultation. One other response to the survey was submitted in the form of a report, details of which are outlined here:

- Opinion Leader received a 17-page report from a Dulwich resident on the 29th May 2013. At the beginning of the consultation, NHS Southwark CCG outlined its process for responding to recommendations for delivering healthcare in the area outside of its current proposals. Consequently, NHS Southwark CCG has responded to this report separately. Further details about this can be found in the appendices to this report. A summary of the key points contained in the report can be found below:

    - A request for an integrated health and care set of services on the Dulwich Community Hospital site to be created.
    - A request for the consultation to focus on the ageing population of Dulwich, as they consume a great deal of heath care money.
    - An assertion that, as older people cost £124million pounds of expenditure on acute activity annually, there is a need for a solution that diverts this expenditure into more productive healthcare models for older people, and reduces admission and re-admission into the acute sector.
    - A claim that primary/community care will not address these needs.
    - An assertion that the solution or model should not be a separation between primary/community care and emergency care, but a move towards a more integrated model, that includes social care and health care.
    - A proposal that the 'A++' model or option for future healthcare in Southwark is:
        - 'A 24 hour, 7 days a week, dedicated National Centre of Excellence for the medical treatment, care and social care of over 65's and their older carers resident in Southwark and accessible parts of Lambeth and Lewisham and other South East London.
    - Suggestions on where to go to fund this proposed model.
    - A strong request to keep the Dulwich Community Hospital site, as the site is prime real estate and 'once lost to health, will never again be reclaimed for health'.

Formal responses from stakeholder groups and organisations

A total of 14 formal responses were received from stakeholder groups and organisations, most of which had a medical or healthcare remit. Due to the breadth and detail of these responses, they are detailed in a dedicated section later in this report. The full list of stakeholder organisations that provided a formal response is below:

Community Action Southwark (CAS) and Healthwatch Southwark (HWS)
Southwark Council
NHS Lambeth Clinical Commissioning Group
NHS Lewisham Clinical Commissioning Group
Guy's and St Thomas' NHS Foundation Trust
King's College Hospital NHS Foundation Trust
King's Health Partners
Southwark and Lambeth Integrated Care (SLIC)
South London and Maudsley NHS Foundation Trust
NHS England
Rt Hon Dame Tessa Jowell MP
Southwark Local Medical Committee
Local Pharmaceutical Committees (LPCs)
The Chartered Society of Physiotherapy

Where the content of these responses resonated with other responses to the consultation, we have indicated this throughout the report.

C) Deliberative events

As part of this consultation, two public meetings in the form of deliberative events were held in St Barnabas Church, Southwark – one on Tuesday the 30th of April at 7pm and one on Wednesday the 22nd of May at 2pm. The purpose of these events was to provide a brief summary of the case for the consultation and details of the two options to attendees before more focused round-table discussion could take place where those in attendance could voice their feelings and concerns about the proposals and, more broadly, ways in which healthcare might be delivered across Dulwich and the surrounding area in the future. In total, 60 individuals attended these meetings.

The first event was independently moderated by Verve Communications and was chaired by Clive Caseley, a director at Verve Communications. Representatives from NHS Southwark included Malcolm Hines, Chief Financial Officer of NHS Southwark CCG, Rosemary Watts, Head of Membership & Engagement, Rebecca Scott, Programme Director for Dulwich and Colin Beesting, Communications and Engagement Manager. Two GPs were present (Dr. Roger Durston and Dr. Femi Osonuga) as well as two senior nurses, Barbara Hills, Directorate General Manager, Children's Community Services, and Gwen Kennedy, Director of Client Group Commissioning.

Those who attended the meeting were given an introductory presentation by Rebecca Scott outlining the objectives of the consultation, the case for change and the proposals outlined in the consultation. After the presentation, a series of round-table discussions ensued. For the discussion, the room was split out into four tables of groups with a moderator from Verve Communications and a healthcare specialist on each table, who provided points of information and clarification where necessary as the discussions progressed. The discussion was split out into four main themes: primary care, preventive care, young family healthcare, and healthcare for the elderly and long-term conditions. Each table of participants had fifteen minutes to discuss each topic with their table and the relevant healthcare specialist before moving onto the remaining three topics in turn. The discussions explored participants' views on the services included in the proposals; participants' feelings towards the proposals (Option A and Option B in particular) in the provision of these health services; and additional comments and considerations that ought to be borne in mind when planning healthcare across Dulwich and the surrounding areas in the future.

The second event was chaired by Clive Caseley, a director at Verve Communications. Rosemary Watts, Head of Membership & Engagement, Rebecca Scott, Programme Director for Dulwich and Colin Beesting, Communications and Engagement Manager, Malcolm Hines, Chief Financial Officer of NHS Southwark CCG and the same two GPs, Dr. Roger Durston and Dr. Femi Osonuga were present once more and an introductory presentation was delivered by Rebecca Scott. During the presentation, a number of questions arose outside of the formal Q&A session held at the end of the discussions. They are outlined in greater detail in the summary report at the end of this document. The room was once more spilt out into table discussions structured according to the same four main themes: primary care, preventive care, young family healthcare, and healthcare for the elderly and long-term conditions.

Feedback provided by attendees at these deliberative events was rich with detailed comments on each of the proposals, additional suggestions, and the personal experiences and preferences of those in attendance. Details of this feedback are captured throughout the report as well as in a dedicated section later in this report.

D) Meetings organised by NHS Southwark CCG with stakeholder groups

NHS Southwark CCG invited over 350 stakeholder groups to discuss the proposals and obtain feedback on how healthcare ought to be delivered across Dulwich and the surrounding area in the future. In order to speak with individuals spanning a broad cross-section of the local population, including those who might be disproportionately affected by the proposals and those who might not be able proactively to take part in a consultation of this nature. This included targeting groups of older residents, individuals with a physical or learning disability or mental health service users, members of the Lesbian, Bisexual, Gay and Transgender community, and residents from a range of ethnic backgrounds. This also included five public drop-in sessions in the following locations:

- Dulwich Community Hospital, Friday 15th March, 2pm-4.30pm
- Cambridge House, Camberwell, Tuesday 19th March, 10am-12.30pm
- Peckham Library, Friday 22nd March 2pm-4.30pm
- Gaumont House Surgery, Peckham Wednesday 1st May, 10am-12.30pm
- Dulwich Community Hospital, Wednesday 8th May, 6pm-8pm

In total 74 meetings (at which there were 568 attendees) were arranged with various interest groups, the full list of which is below:

1. African Caribbean over 50s club
2. Service users at Southwark Resource Centre
3. Nunhead Residents Association AGM
4. South Southwark Locality Commissioning Group
5. SELDOC
6. Dulwich Hospital League of Friends
7. Community Action Southwark voluntary sector event
8. Maternity Services Liaison Committee - GSTT & Kings
9. Copleston Church Centre
10. LGBT Forum meeting
11. DMC Crystal Palace Road – Patient Participation Group
12. Carers group at Nunhead Surgery
13. Southwark Local Medical Committee
14. Forest Hill Assembly
15. Father's Group - East Peckham Children's Centre
16. Acorn & Gaumont Surgeries Patient Participation Group
17. Staff meeting at Forest Hill Road Practice
18. Elm Lodge Patient Participation Group
19. Drop in - Dulwich Hospital
20. South Southwark Locality Patient Participation Group
21. Travellers group - East Peckham Children's Centre
22. Dulwich Helpline - focus group
23. The Garden's Surgery baby clinic
24. Diabetes Focus Group - DMI
25. Drop In - Gaumont House Surgery
26. Briefing Labour councillors
27. Townley Road Baby Clinic
38. Camberwell Community Council
39. Peckham and Nunhead Community Council
40. Speaking up group (session 2)
41. Nunhead surgery Patient Participation Group
42. Lewisham Healthier Communities Select Committee
43. Parent meeting - Dulwich Hamlet School
44. Bermondsey Church
45. Briefing for Lib-Dem Councillors
46. The Garden's Surgery Patient Participation Group
47. The Vale Residents Association
48. Family Mosaic Learning Disability Group (1)
49. Bede – Learning Disability Group (1)
50. Family Mosaic Learning Disability Group (2)
51. South Southwark Locality Commissioning Group
52. GSTT Staff meeting
53. DPB Stakeholder briefing
54. Bede - Learning Disability Group (2)
55. Southwark Health Overview Scrutiny Committee
56. Sternhall Lane Patient Participation Group
57. Drop-in - Peckham Library
58. Southwark Pensioners Forum meeting
59. Melbourne Grove Surgery - Listening Exercise
60. Melbourne Grove Surgery - Listening Exercise
61. Dulwich Programme Board Meeting
62. Briefing Labour councillors
63. Drop In - Cambridge House
64. Southwark Engagement and Patient Experience Committee

28. Rae Sheppard's Monday Club
29. South Southwark Locality Commissioning Group
30. Dulwich Project Board
31. Herne Hill Forum
32. East Dulwich Primary Care Centre
33. Rye Lane Children's Centre
34. DMC Chadwick Road Patient Participation Group
35. Dulwich Community Council
36. Paxton Green Patient Participation Group
37. Dulwich Community Hospital - Staff meeting
65. Drop in - Dulwich Hospital
66. Briefing for Robin Crookshank-Hilton - Councillor
67. Older People's Partnership Board
68. CCG Staff meeting
69. The Vale Residents Association
70. Briefing for Catherine MacDonald, Cabinet Member for Health and Adult Social Care and Councillor
71. SLAM Involvement Group meeting
72. Forest Hill Road Practice Patient Participation Group
73. Hambledon Clinic Patient Participation Group
74. South Southwark Locality Patient Participation Group

The nature of these meetings varied according to the specific requirements of each group. In some instances, members of the NHS Southwark CCG project team gave a presentation about the proposals before providing an opportunity for questions; in others, a more unstructured discussion took place between members of the group and NHS Southwark CCG representatives.

Some of the feedback provided at these meetings was specific to the healthcare needs of the group in question and this is explored in detail in a dedicated section later in the report as well as being included throughout the report.

E) Handling queries

For the duration of the consultation, members of the public were advised to contact Opinion Leader via telephone or email if they wished to request a brochure, had any queries about the survey, or wanted more information about the consultation or proposals. Opinion Leader's contact details were supplied in the consultation document, and the leaflet that was distributed to households across Southwark. All interactions between members of the public and Opinion Leader were systematically logged and all queries were addressed either by Opinion Leader or, where appropriate, NHS Southwark CCG.

Opinion Leader received twenty five emails and calls over the course of the consultation. Of these 15 people had general enquires and comments, often relating to individuals' specific healthcare needs (mainly diabetes) and the impact of the proposals on themselves personally. Five individuals had queries specifically relating to the proposals, about the catchment area that would be affected if either Option were adopted, where resource would come from to facilitate either Option A or B, and asking for more information about the role of GPs under both of the Options. Two people wanted to check their eligibility for responding to the questionnaire. Eighteen people wished to request a copy of the consultation document and questionnaire. In total, 219 copies of the consultation document and questionnaire were requested via freepost, including one braille version.

2.2 Analysis and interpretation of the data

A) The questionnaire

All online and paper responses were systematically logged. Data from the pre-coded questions was collated into data tables which give both numeric and percentage results for each applicable question. Sub-group analysis was also shown for key groups in these tables. The free-text (open-ended) verbatim comments, answers and responses were coded. This involved compiling a list of themes based on the open ended responses for each question into a 'code frame', which was then used to statistically analyse the responses in much the same way as the pre-coded questions.

The code frame was initially developed early in the consultation process. The first 50 completed response forms were used to build the preliminary code frame and it was continually refined throughout the duration of the consultation process. The code frame itself was 'organic' in that the coding teams had the flexibility to raise new codes when it was felt that genuinely new issues or terminology were appearing, and re-visit other codes previously allocated to see if they should be re-allocated.

B) White Mail

The six 'white mail' responses (i.e. letters or emails that did not follow the questionnaire format or specifically answer the consultation questions) from individual respondents that could reasonably be matched to the general focus of the questions in the consultation questionnaire were also included in the analysis and coded at the most appropriate question in the questionnaire. We have indicated whether the charts contained in this report include white mail responses.

All pre-coded and open question data is 'unweighted' – i.e. the results are an exact reflection of the numbers / types of submissions received. Linked to this, the results cannot be extrapolated to represent 'public opinion' or any similar concept. **They are simply the collective views of those people responding to the consultation.** This principle reflects that for any 'self-selecting' sample. All data in charts in this report excludes those who chose not to answer a question, hence base sizes vary. Charts presenting free-text responses show actual numbers rather than percentages because of the low number of respondents providing each response. Furthermore the percentages cited have been rounded to the nearest whole number. All responses to the survey are available in a full raw data file.

C) Formal responses from stakeholder groups and organisations

Responses from these groups were often very specific in focus and could not be matched to an appropriate question in the questionnaire for coding. As such these responses have been analysed in a qualitative fashion, and the content is described throughout the report as well as in a dedicated section later in the report.

D) Deliberative events and meetings organised by NHS Southwark CCG with stakeholder groups

Another set of responses that is considered throughout the report that follows is that of the meetings organised by the consultation project team with stakeholder groups. Because of the diverse and detailed nature of the comments raised in these events, as well as the fact that these meetings were recorded in a qualitative way, they have been analysed in a qualitative fashion and therefore feedback through this channel is described throughout the report and in a dedicated section rather than being measured in a statistical sense.

Note on interpreting the data

It should be noted that the responses shown below cannot be used to extrapolate about the wider population's views of the proposals or the way in which healthcare might be delivered in the Dulwich area in the future. The Equalities Impact Assessment highlighted 'protected characteristics' groups that may be adversely affected by proposed changes to local health services and through the consultation the CCG team undertook specific activities to involve these groups. Analysis of the questionnaire responses showed little significant variation in the responses of those identifying as members of these groups and the responses given by any other respondent. In many cases, this was because the size of some of these subgroups were too small (i.e. less than thirty) to draw any firm conclusions from the data. Where there were significant differences in the responses provided by individuals identified in the Equalities Impact Assessment, we have highlighted this in the report.

The key advantage of a consultation over opinion polls or sample surveys is that the whole population are offered the potential opportunity to take part, making it more of a democratic tool. However, it is a less effective way of measuring how widely held particular opinions are in the population as the results of a consultation are comprised of those who chose to respond to the consultation – i.e. it may over-represent some demographic groups who were disproportionately likely to respond, and may also over-represent particular views in the same way. Therefore, as with any public consultation, the results cannot be used to generalise or extrapolate in the same way as a representative sample survey. Furthermore the fact that NHS Southwark CCG made additional effort to encourage responses from stakeholder and specific patient groups, as well as distributing the link directly to panel respondents, community groups and NHS staff may also have influenced the distribution of responses received.

Furthermore, consultation responses often consist of a brief **open response** to a lengthier proposal thus these responses are subject to a certain degree of interpretation. In particular, those who responded that they were in favour a proposal might well not have recorded their support for all the specific elements of the proposal, while opponents who cite one aspect of a proposal as their reason for opposing it cannot be assumed to be supporting of, or indifferent to, every other aspect purely because they did not mention it. Hence it is unlikely that a true measurement of opinions on particular details of the proposals, even of those who responded to the consultation, could be achieved merely by tallying the number of favourable and unfavourable mentions in participants' responses. Moreover, in this consultation many participants provided **a qualified response** to some open-ended questions – e.g. *I would be in support of x if NHS Southwark do y*, making it difficult to classify the response as 'in support of' or 'opposed to'.

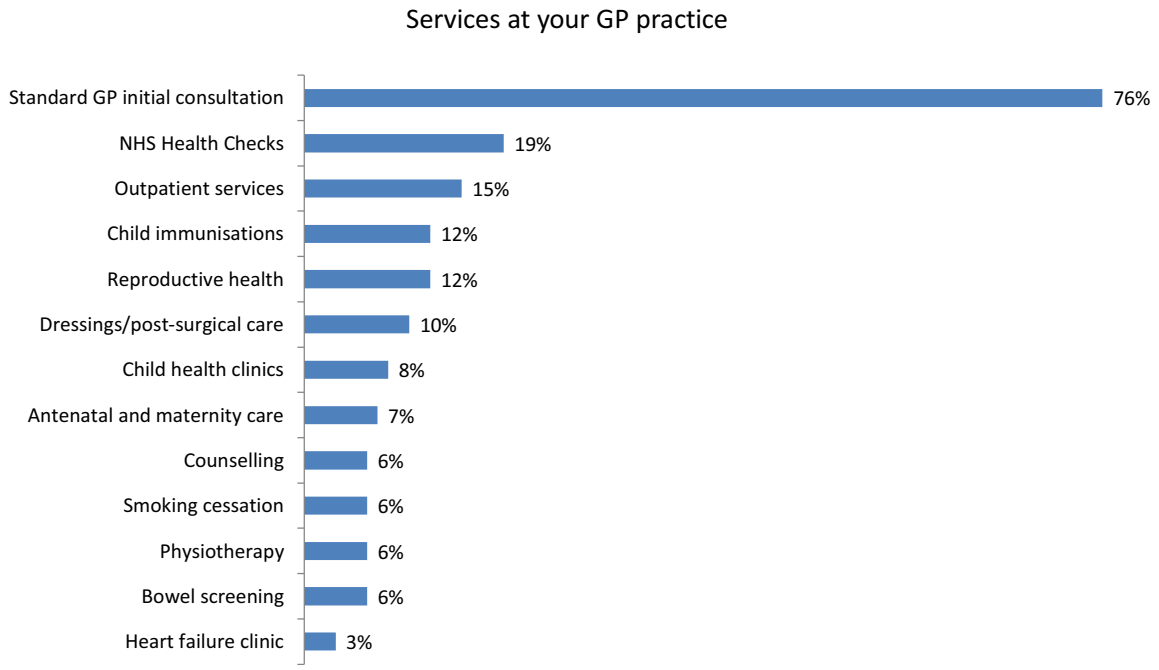
3. Main findings

3.1 Current and proposed health services across Dulwich and the surrounding area

In order to get a sense of the usage of community health services in the Dulwich area, a particular area of interest for NHS Southwark CCG was which NHS services individuals had used in the past twelve months.

The chart below displays the responses provided to this question in the questionnaire:

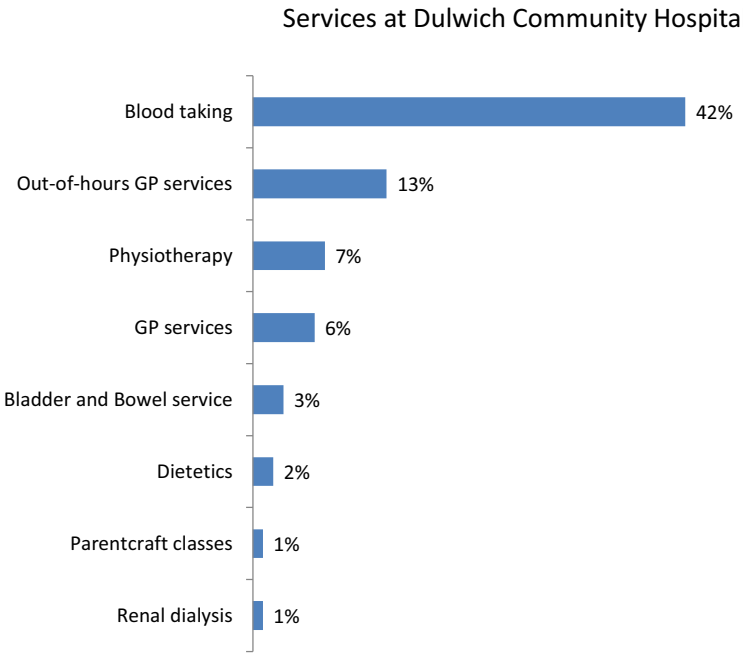
Question 1. Which, if any, of the following community health services provided by the NHS in Dulwich and the surrounding area have you used in the last 12 months?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



Almost nine-out-of-ten respondents (87%) had made use of health services at their GP practice in the past year and, as with individuals attending deliberative and stakeholder meetings, the most common of these was a standard consultation. This particular service was attended by 76% of respondents to the questionnaire, followed by NHS Health Checks (attended by 20%) and outpatient services (used by 15%). Children's health services and maternity care were also commonly used by respondents, which supports previous research undertaken by NHS Southwark CCG as to the healthcare needs of the population of Dulwich and the surrounding areas.

Some respondents had also used health services at Dulwich Community Hospital itself:

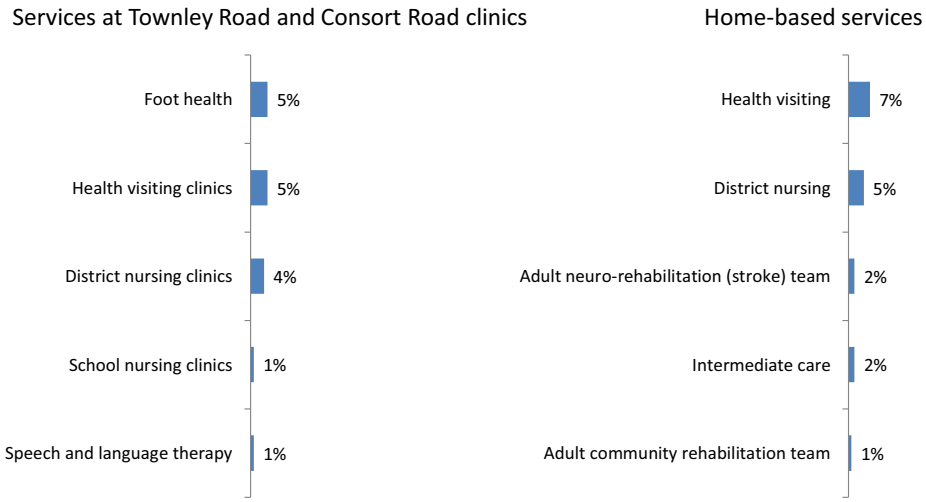
Question 1. Which, if any, of the following community health services provided by the NHS in Dulwich and the surrounding area have you used in the last 12 months?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



The proportion of respondents attending Dulwich Community Hospital was lower than for GP practices, with 53% of respondents having used the Hospital in the past year. The most common reason for going there was for blood taking (42%), whilst 13% of respondents had visited the hospital for out-of-hours GP services.

Use of health services at Townley Road and Consort Road clinics, as well as home-based services, was much lower overall.

Question 1. Which, if any, of the following community health services provided by the NHS in Dulwich and the surrounding area have you used in the last 12 months?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

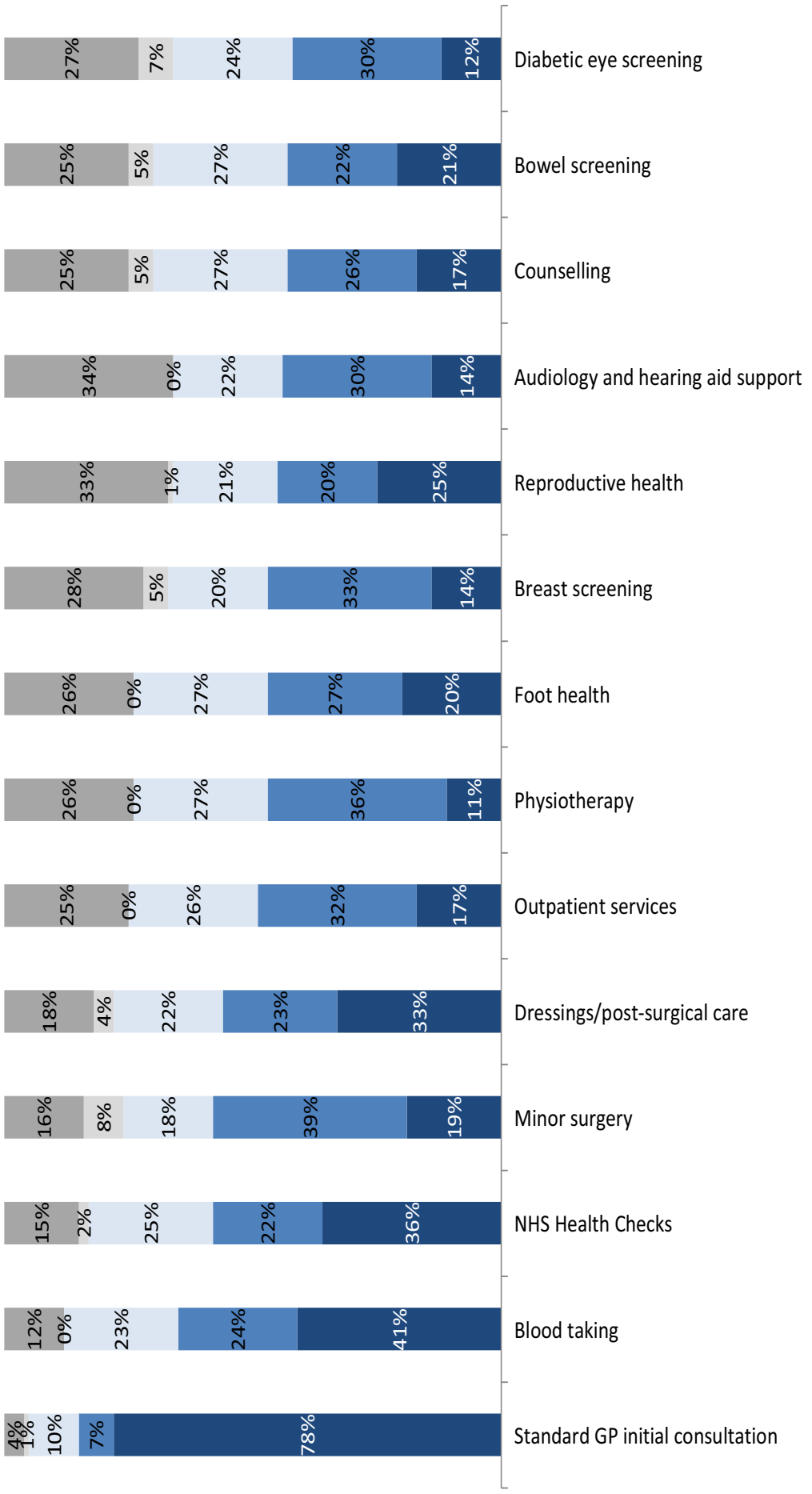


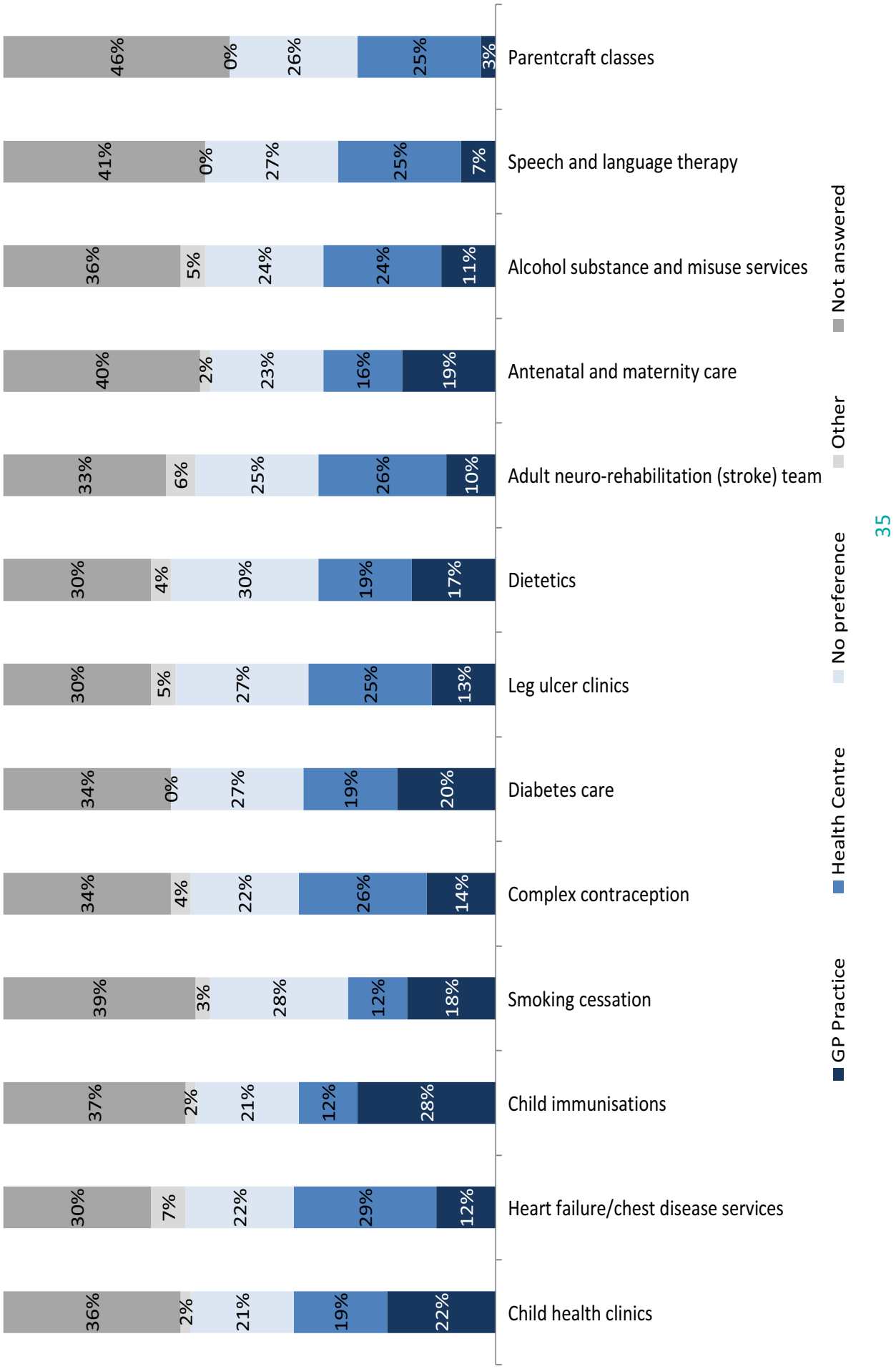
Use of services at both of these locations was higher for the 25-34 age groups, and those aged over 65: 18% of those aged over 65 had used services at Townley Road (predominantly foot health), and 19% of those aged 25-34 had received home-based services (specifically health visiting).

Next, respondents were asked where they would prefer to receive the health services they had used in the past twelve months: at their GP practice, in a health centre, or somewhere else.

Question 2. Thinking about the services that you currently use or anticipate using in the future, where would you prefer to receive those services?

Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)




Parentcraft classes
46% 0% 26% 25% 3%
Speech and language therapy
41% 0% 27% 25% 7%
Alcohol substance and misuse services
36% 5% 24% 24% 11%
Antenatal and maternity care
40% 2% 23% 16% 19%
Adult neuro-rehabilitation (stroke) team
33% 6% 25% 26% 10%
Dietetics
30% 4% 30% 19% 17%
Leg ulcer clinics
30% 5% 27% 25% 13%
Diabetes care
34% 0% 27% 19% 20%
Complex contraception
34% 4% 22% 26% 14%
Smoking cessation
39% 3% 28% 12% 18%
Child immunisations
37% 2% 21% 12% 28%
Heart failure/chest disease services
30% 7% 22% 29% 12%
Child health clinics
36% 2% 21% 19% 22%
Not answered
Other
No preference
Health Centre
GP Practice
35

For a number of services, when thinking from a personal perspective about the service they tended to use themselves, the preferred location respondents wished to receive healthcare was in a GP practice. Preference for the location of GP consultations was, perhaps unsurprisingly, in a GP practice with 78% of those that had used GP services in the past year saying so; blood taking was the next most popular option respondents felt should be delivered from a GP practice, with 41% saying so (versus 24% saying this should be delivered in a health centre); and dressings/post-surgical care was the next service respondents felt should be delivered from a GP practice (33% versus 23%). There was a slight preference for children's healthcare to be located at GP practices, particularly where immunisations were concerned (28% versus 12% saying these should be delivered in a health centre).

Having said that, there was feeling that some services – generally the more complex ones – might better be delivered in a health centre. Specifically these included minor surgery (39%), heart failure/chest disease (29%) and adult neuro-rehabilitation (stroke) team (26%). Other more specific health services were also felt to be better located in a health centre: whilst 25% of respondents answered that reproductive health should be located in a GP practice, a far smaller proportion (14%) felt the same way about complex contraception. Rather, support was greater for the delivery of complex contraception from a health centre (26%).

It was the case in some of the stakeholder meetings that attendees had concerns that GPs had the skills and training necessary to treat more specialist health problems. There was also the sense that providing specialist community healthcare in a health centre would increase the availability of appointments at GP practices and take some of the strain off GPs – an issue that was raised frequently at these meetings.

There were a number of services that a number of respondents had used and had no preference as to where they were located. This was the case for smoking cessation (28% had no preference) and diabetes care (27%) as well as antenatal and maternity care (23%). In these instances, opinion was also split between the GP practice and the health centre as the site for delivering these services.

In addition to the services listed in the consultation document and questionnaire, respondents were asked if there were any additional health services that ought to be incorporated into any local model of care. The following is a summary of the responses provided:

Question 3. Are there any specific health services that you think are needed locally that are not mentioned in this list?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

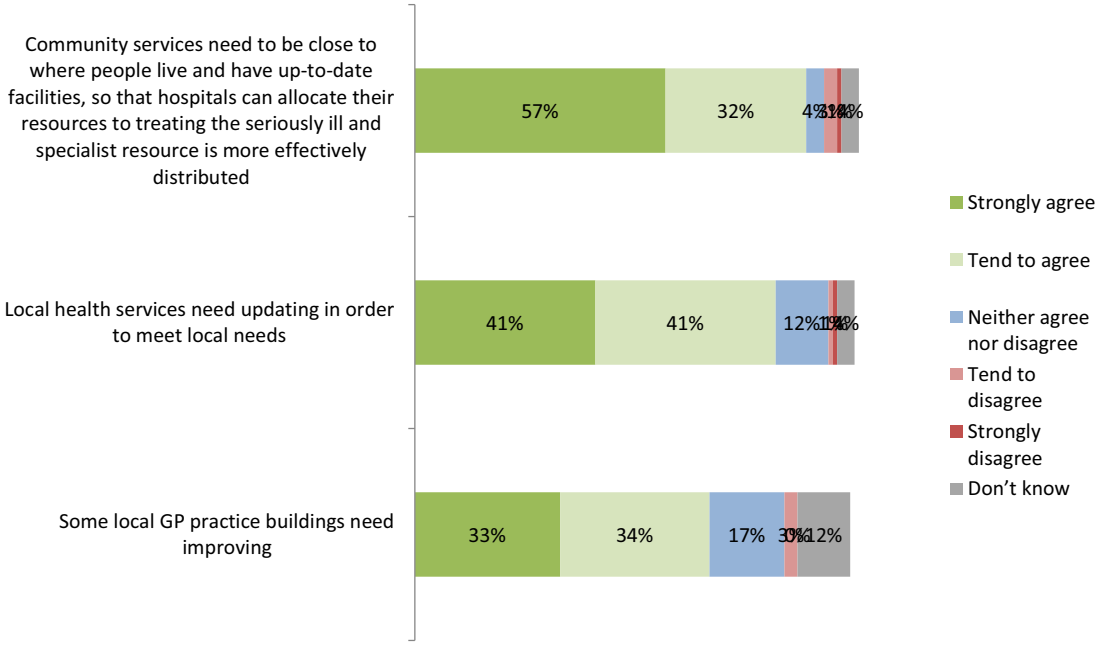
Health service	Number of mentions
GUM (Genitourinary Medicine / Sexual Health)	9
X-ray	6
Counselling, psychological support	5
Chest disease services	5
A&E/Minor injuries	5
Other screening services	5
Homeopathy	5
Dental	3
Gym/outdoor exercise facility	3
Cardiology	3
Mental health	3
Care for the disabled	2
Blood pressure	2
Minor ailments/preventive care	2
Orthopaedics – muscular/skeletal	1
Osteopathy	1
Rehabilitation services	1
Other	23

Responses from some stakeholder organisations also felt that further consideration ought to be given to services like minor surgery and urgent care. Additionally, the response from Guy's and St Thomas' NHS Foundation Trust advised that NHS Southwark CCG coordinate the delivery of specialist community health services with other community healthcare facilities in the surrounding area, for example, the Medical, Dental and Leisure centre in West Norwood.

3.2 Views on the case for change

The consultation document contained a section that explained to residents the reasons why the proposals were being put forward. These included a breakdown of the health needs of the local population in Dulwich and the surrounding areas accompanied with an argument for reconfiguring health services accordingly; delivering healthcare in the community so that healthcare was accessible for local residents and they did not need to visit hospital; and improving some GP practice buildings in the area to make them fit for purpose.

Question11a. Below are some statements which summarise the reasons why the proposals for delivering health services in Dulwich and the surrounding area above have been put forward now. For each, please state the extent to which you agree or disagree with them, if at all.
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



Strong support for accessibility of local health services

Support was greatest for the argument of delivering health services locally and out of hospitals, with 89% of respondents agreeing with this statement. Respondents aged over 65 were most in agreement (94%) with this statement. This argument was closely followed by the statement 'local health services need updating in order to meet local needs', where 82% of respondents agreed change was needed. There seemed to be more uncertainty as far as respondents were concerned as to whether local GP practice buildings needed improvement, although over two-thirds (67%) agreed with this statement overall.

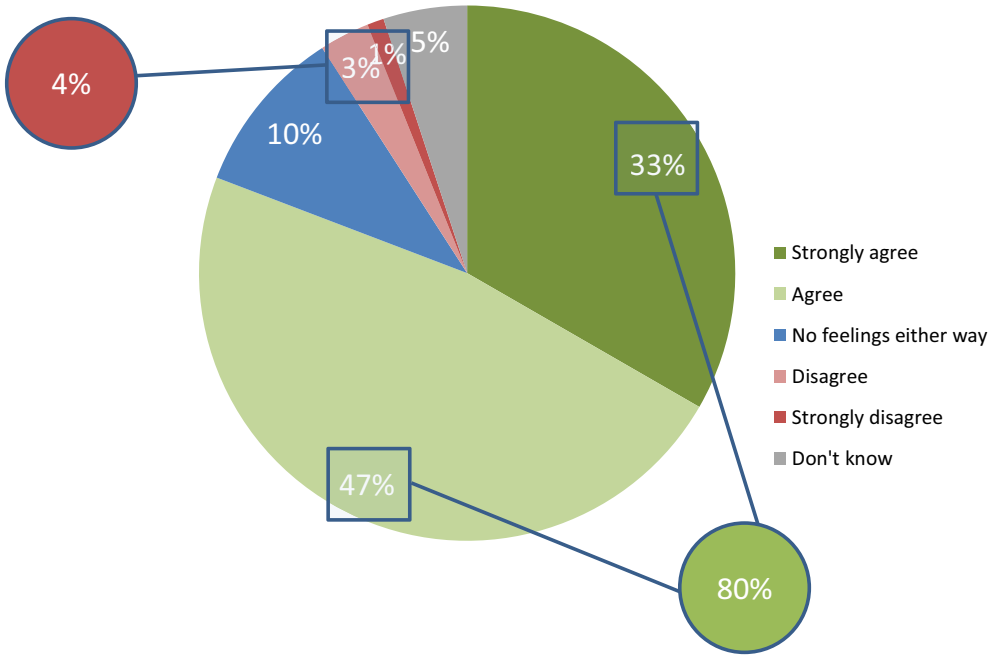
The fact that participants in deliberative and stakeholder meetings said that services such as intermediate care ought to be offered outside of hospitals, and repeatedly raised the importance of the accessibility of health services, further reinforces the importance of this to local residents. Attendees at these meetings also spontaneously mentioned that one benefit of introducing this change would be improvements to preventive care in the area.

It should be noted that, with regard to whether local GP practice buildings needing improvement, participants at meetings (both deliberative events and stakeholder meetings) reported varying levels of satisfaction with the facilities of their GP practice and this may have informed responses to this question.

3.3 Views on proposals for the delivery of health services across Dulwich and the surrounding area

NHS Southwark CCG also sought to find out the level of agreement amongst residents with the overall approach it had adopted in designing its proposals. This approach included offering advice and diagnostic services at multiple sites in the community; improving the availability of preventive healthcare; providing personalised local care for expectant mothers and young children; and helping older people with long-term health conditions to manage them independently.

Question 4. Overall, to what extent do you agree with this approach, as laid out in our proposals?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



Strong overall support for the approach to improving health services

Overall, support for this approach was high with 80% answering that they agreed or strongly agreed with this approach. Support for this approach was particularly high amongst respondents that agreed with the case for change (especially those who agreed that some GP practice buildings needed improving, of whom 88% were in support of NHS Southwark CCG's approach). Whilst 18-24 year olds were least positive about this approach, those aged 35-54 were more positive (85% of respondents in this age bracket agreed).

Stakeholder organisations were unanimously in favour of NHS Southwark CCG's overall approach to delivering health services in the community. There was particular support for bolstering preventive healthcare in the community, with organisations including the Chartered Society of Physiotherapy applauding the delivery of health services like physiotherapy in the community, thus enabling residents to manage their own health to a greater extent and not having to be admitted to hospital.

Respondents were then able to provide reasons for their answers:

Question 4b. Why do you say that?

Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey

Respondents' views on this approach were generally positive, for the reasons of accessibility and quality of healthcare delivered to local residents

Other thoughts on NHS Southwark CCG's approach to delivering healthcare in Dulwich and the surrounding areas in the future

Health service	Number of mentions
The plan is to promote privatisation	4
Concerned about the cost / insufficient funding	4
Happy with the current service	4
Too complicated / health centres add another layer of bureaucracy	4
Better for management of long-term conditions	3
Will result in a better service / better quality	3
Issues with GP appointment system / takes too long to get an appointment / want more flexible system	3
Want a greater emphasis on alternative medicines	2
GPs will have to extend opening hours / will have increased workload	2
Current GP service is variable in quality	2
This will effectively be subsidising GPs	2
Don't see how the plan would reduce waiting times	1
Too much information to absorb quickly / give a quick answer	1
Alternative proposal	1

The most common reason given by respondents for their answer was that it was better to have services closer to home, with 22 respondents saying this. Accessibility and location were mentioned by other respondents who felt it would result in less travelling (10 respondents). Some respondents also felt there were clinical benefits to delivering healthcare in this way, with 13 respondents saying this approach would help prevent disease in the first place and nine respondents saying this would allow practitioners to foster a closer relationship with their patients.

Preventive healthcare was also mentioned by attendees at stakeholder meetings as a priority and where more could be done to make healthcare as accessible as possible in the community – through measures such as drop-in services or health workshops.

"It doesn't matter where the service is based as long as it is of high quality, joined up with other services (e.g. make sure my records are accessible to all professionals helping me)."

Female, 35-44, SE15

"The proposals have the effect of placing the patient and his or her needs at the forefront of healthcare professionals' thinking, and will reduce the tendency for the condition to be separated as it were, from the patient. Medicine and therapies will be more holistic."

Male, 65+, SE24

There were some negative comments about this approach and also some advice from respondents about things to bear in mind if this approach were to be adopted. There were doubts amongst 10 respondents that the approach could be implemented in practice, especially considering the existing difficulties facing GP surgeries. This was supplemented by respondents' concerns to reduce waiting times to receive treatment, and that specialist centres of excellence remain (mentioned by eight and nine respondents respectively).

These views were commonly expressed at deliberative and stakeholder meetings, and were often stated as the priority for attendees at these meetings for improving community healthcare delivery.

Some respondents to the questionnaire (10) also felt that it should simply be the priority to deliver high quality healthcare through whatever approach was necessary.

This was a view that was commonly expressed at the deliberative events in particular: that the approach should not be confined within the current constraints of the system but should aim for the ideal model of healthcare delivery. For some of these individuals, the quality of care was felt to be more of a priority than location.

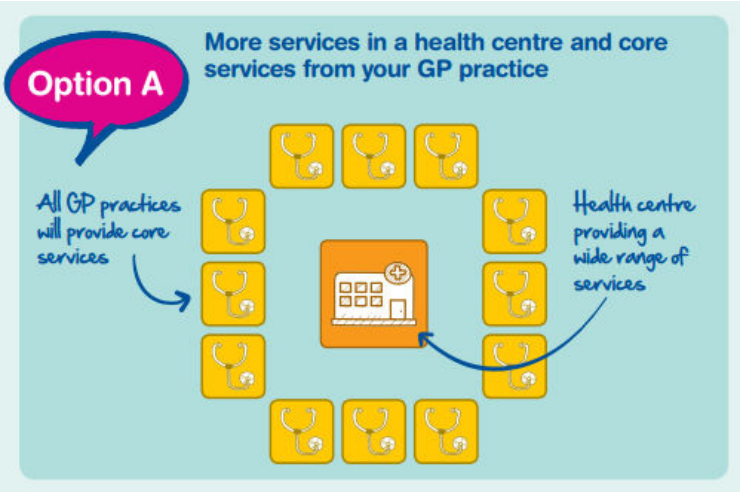
"On the surface what you are saying sounds very reasonable, however, what I am concerned about is that local hospitals are being quite seriously threatened e.g. the whole of Lewisham Hospital (not just the A & E department as publicised), so there is always a wider political context. That closure would have a massive effect on King's. Farming everything out to Health Centres and GPs may also overload them."

Female, 45-54, SE15

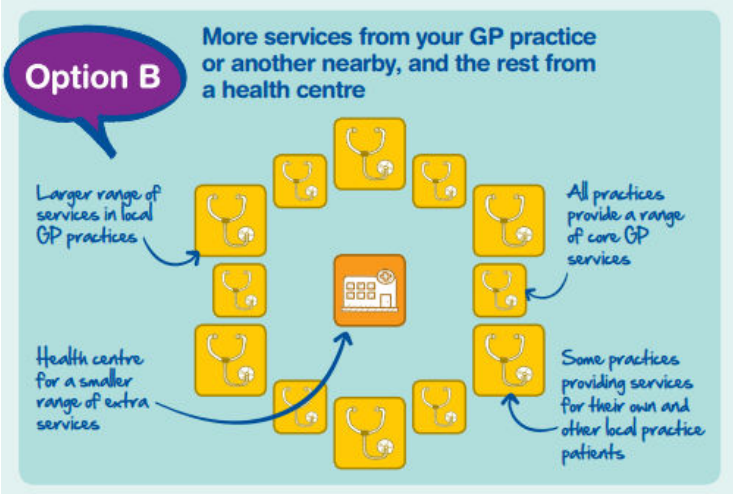
In addition, one person at this question felt that alternatives to this approach ought to be described by NHS Southwark CCG, and felt they could not comment on whether their proposed approach was a good idea or not if they did not know what other options were available.

Individuals were also asked to comment on both of the options being proposed by NHS Southwark CCG:

- **Option A** would involve delivering more primary and community health services than at present from a health centre (that is likely to be located on the Dulwich Community Hospital site) and only core services being delivered by GP practices;

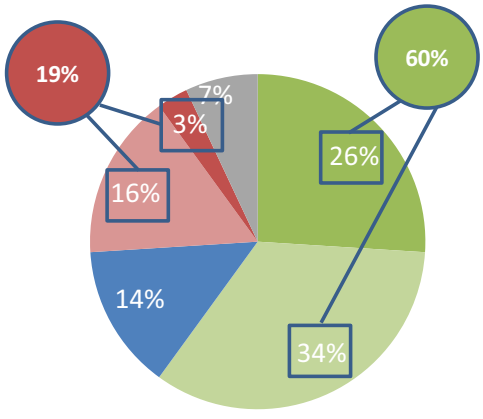


- **Option B** would involve delivering more primary and community health services from GP practices dependent on each practice's skills, capacity and space, and a smaller range of specialist community health services from a health centre on the Dulwich Community Hospital site.

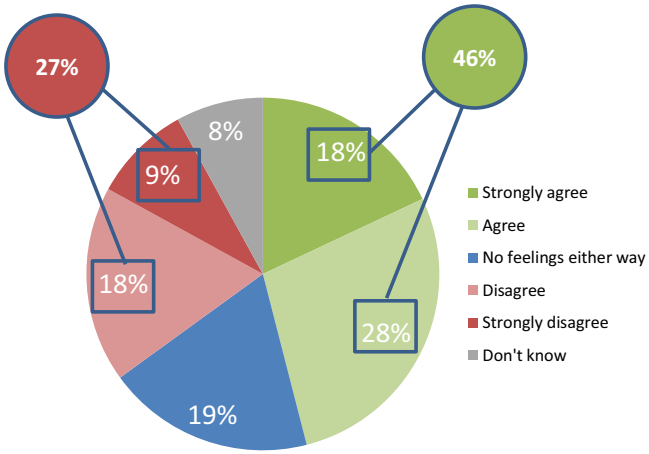


The following chart shows respondents to the questionnaire's levels of endorsement for each of these options:

Question 5. To what extent do you agree with the proposal for more services in a central health centre and core services being delivered from your GP practice as described in Option A?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



Question 7. To what extent do you agree with the proposal for more health services in GP practices and a health centre with a narrower range of services as described in Option B?
Base: 215 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)



More services in a central health centre and core services being delivered from GP practices is preferable to more health services in GP practices and a reduced capacity health centre

Respondents tended to prefer Option A to Option B, with 60% in favour of the former compared with 46% for the latter. Furthermore, a higher proportion of respondents actively opposed Option B (27%) than Option A (19%).

This matched the strength of opinion expressed at the deliberative and stakeholder meetings, and especially responses provided by stakeholder organisations.

Those most in favour of Option A fell in the 18-24 (71%) and 55-64 (75%) age brackets. Those that had attended Dulwich Community Hospital in the past twelve months were significantly more likely to be in favour of Option A than Option B (61% versus 49%). Generally those who would prefer to receive their health services in a health centre were more in favour of Option A particularly when thinking specifically about post-surgical care, counselling, phlebotomy, physiotherapy, foot health, chest disease and antenatal and child health services.

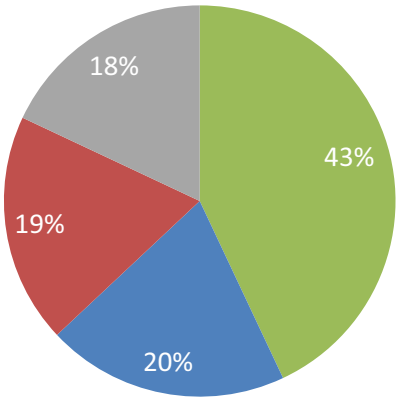
Unsurprisingly, support for Option B was higher almost across the board for respondents that preferred to receive healthcare in a GP surgery. More broadly, respondents that had used children's health or reproductive health services in the past twelve months were more likely to opt for Option B than Option A (of those in support of Option A, 10% had used child immunisation services in the past twelve months compared with 15% of those in support of Option B). Given that some respondents clearly wanted children's health and maternity care based in a health centre, there is no clear consensus as to where residents would prefer these services to be delivered.

As became evident in the deliberative and stakeholder meetings, feeling about having specialist community services provided in a GP practice tended to be dependent on individuals' personal experiences of care from their GP practice.

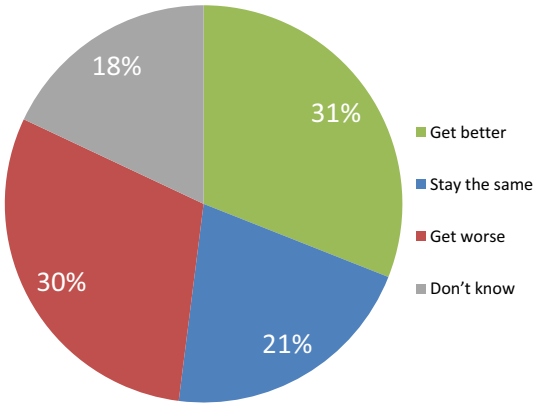
Respondents that claimed to have no preference as to where health services were delivered in the locality were also more likely to agree with Option B than Option A. As some participants at the deliberative events made clear, this may be because they had not experienced any problems with the delivery of health services at present, and therefore wished to preserve the status quo as far as possible.

Respondents were then asked to consider the potential outcomes of Option A and Option B on the availability and accessibility of healthcare. Respondents' views on Option A are presented below:

Question 6a. How do you think that this proposal might affect the following aspects of healthcare? The AVAILABILITY of the care you would receive would…
Base: 215 (public survey; panel survey; community group respondents; NHS staff)



Question 6b. How do you think that this proposal might affect the following aspects of healthcare? PEOPLE'S ABILITY TO GET TO PLACES where healthcare is delivered would…
Base: 215 (public survey; panel survey; community group respondents; NHS staff)



Most feel that for more services in a central health centre and core services being delivered from your GP practices will improve availability of care, but opinion is split on its impact on accessibility

Overall, respondents were more inclined to think that the availability of the care they would receive would improve than they were to think that the location of these services would be any more accessible than at present (43% versus 31%). The difference in feeling between those in favour of Option A and those in favour of Option B was marked: two-thirds (65%) of those agreeing with Option A were positive about the availability of healthcare under Option A compared with one-third (34%) of those in favour of Option B. Additionally those in the 45-54 (48%) age group and those aged 65 or over (50%) were more likely to hold the view that Option A would improve the availability of health services compared with the present.

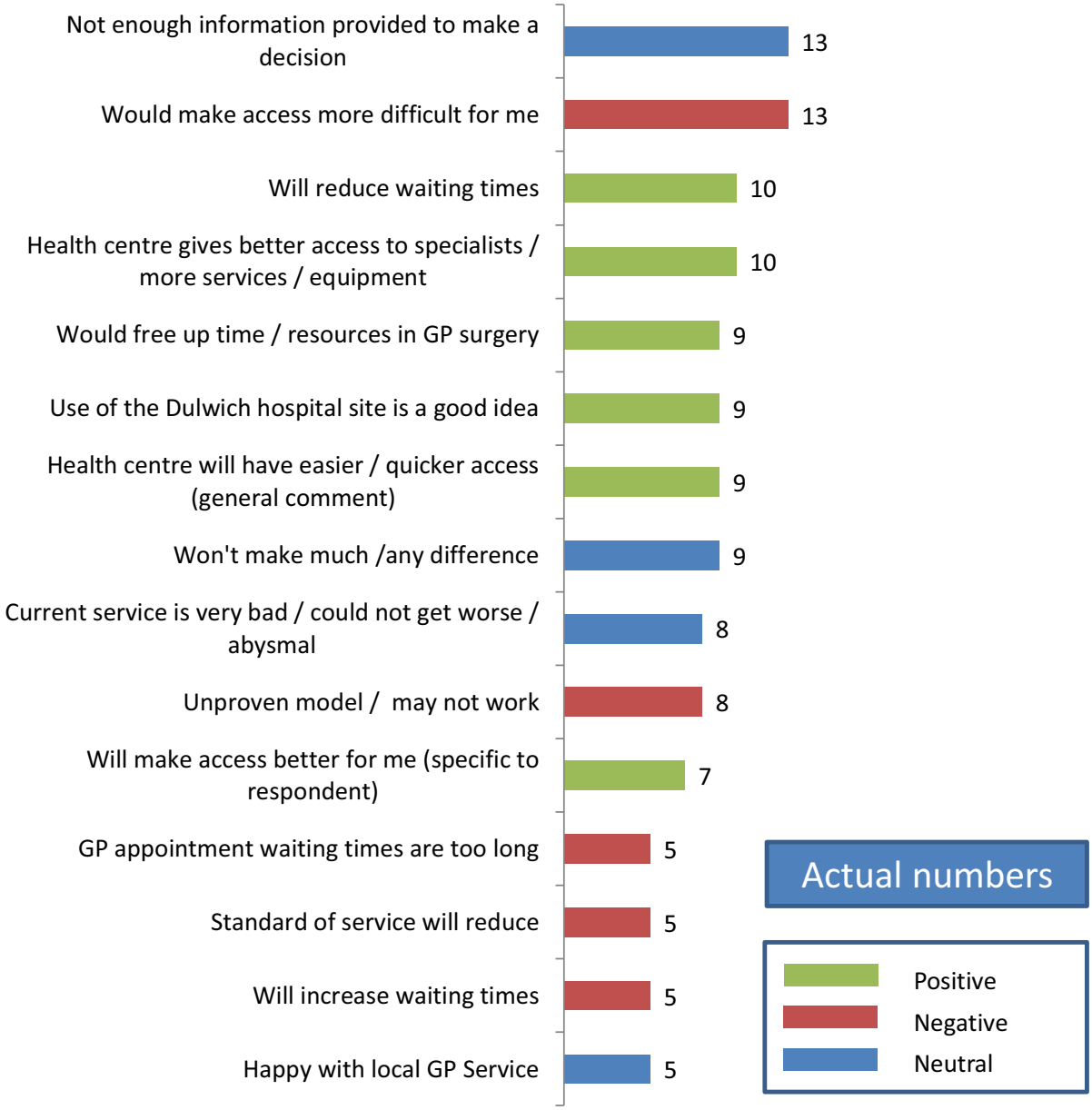
Those who disagreed with Option A more generally felt that availability and accessibility of healthcare under this option would decline (60% and 73% respectively) and those who disagreed with the case for change overall also tended to hold the view that these aspects of healthcare would get worse under Option A. The 35-44 age group were the group most actively voicing the view that both these aspects of healthcare would get worse under Option A.

With regard to the availability of healthcare, respondents to the questionnaire provided the following reasons for their answers:

Question 6ai. Why do you say that?

Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey



Some found it difficult to speculate how this would affect the services they currently receive, and there were mixed feelings about access

Other comments about the availability of health services under Option A

Response	Number of mentions
GP Service is variable / service will become postcode lottery	4
Option A is the correct approach	4
Agenda to direct patients away from hospitals / to fragment the service	3
GPs are already overloaded / have too big a role / lack capacity to expand	3
GP service is mediocre / not very good	3
No real difference between Option A and Option B / a false choice	3
Alternative proposal	2
Will lead to a decrease in hospital funding	2
A Necessary change / to cope with current demands	2
Commercial agenda / Back door to privatisation	1

Given that the proposals were not developed to the extent that the distribution of services across the area had been finalised, some respondents (13) found it difficult to know how the availability of health services would be affected by Option A. Additionally, respondents' feelings about this Option seem to have been influenced by their personal experiences of their GP practice and their location in relation to the Dulwich Hospital site. Consequently 13 respondents felt this Option would have a negative impact on the availability of health services for them, whilst nine respondents felt the opposite.

"For some people, i.e. middle class, mobile, this may improve their access to health care. I am concerned that for more vulnerable and deprived people this may not be the case. Also for people who typically fail to engage with services, I feel there are huge benefits for services being delivered in local surgeries by a team who work closely together with regular meetings and detailed knowledge of their vulnerable patients."

Female, 35-44, SE16

"It would be wrong to reduce the quality of GP care and I am concerned it would become less good and less joined up if more episodes of care took place elsewhere."

Female, 35-44, SE15

Some respondents saw benefits in centralising specialist community health services (and specialist community practitioners) on one site – what participants at deliberative and stakeholder meetings repeatedly described as having a 'centre of excellence' – and relieving pressure from GPs and GP waiting times. This was one of the most common complaints about the existing system and an area where residents argued for improvement to be made.

"Central provision of services would obviously mean more expertise."

Female, 65+, SE23

"There is a huge variation in the quality of GPs and care, centralising the resources and specialisms will help improve quality and cost effectiveness."

Female, 35-44, SE15

In particular, however, those attending meetings frequently cited family healthcare, care for the elderly (both health and social care) and care for mental health service users as areas of healthcare where

concentrated resource and expertise would be beneficial. Not only did individuals feel this would result in more joined-up and continuous care for patients, but allocate resource to best effect. Another argument that individuals at meetings commonly raised (as well as some stakeholder organisations) was that the health centre could act as a *"market place"* for the coordination of healthcare across a number of channels including district nursing, social services and voluntary groups.

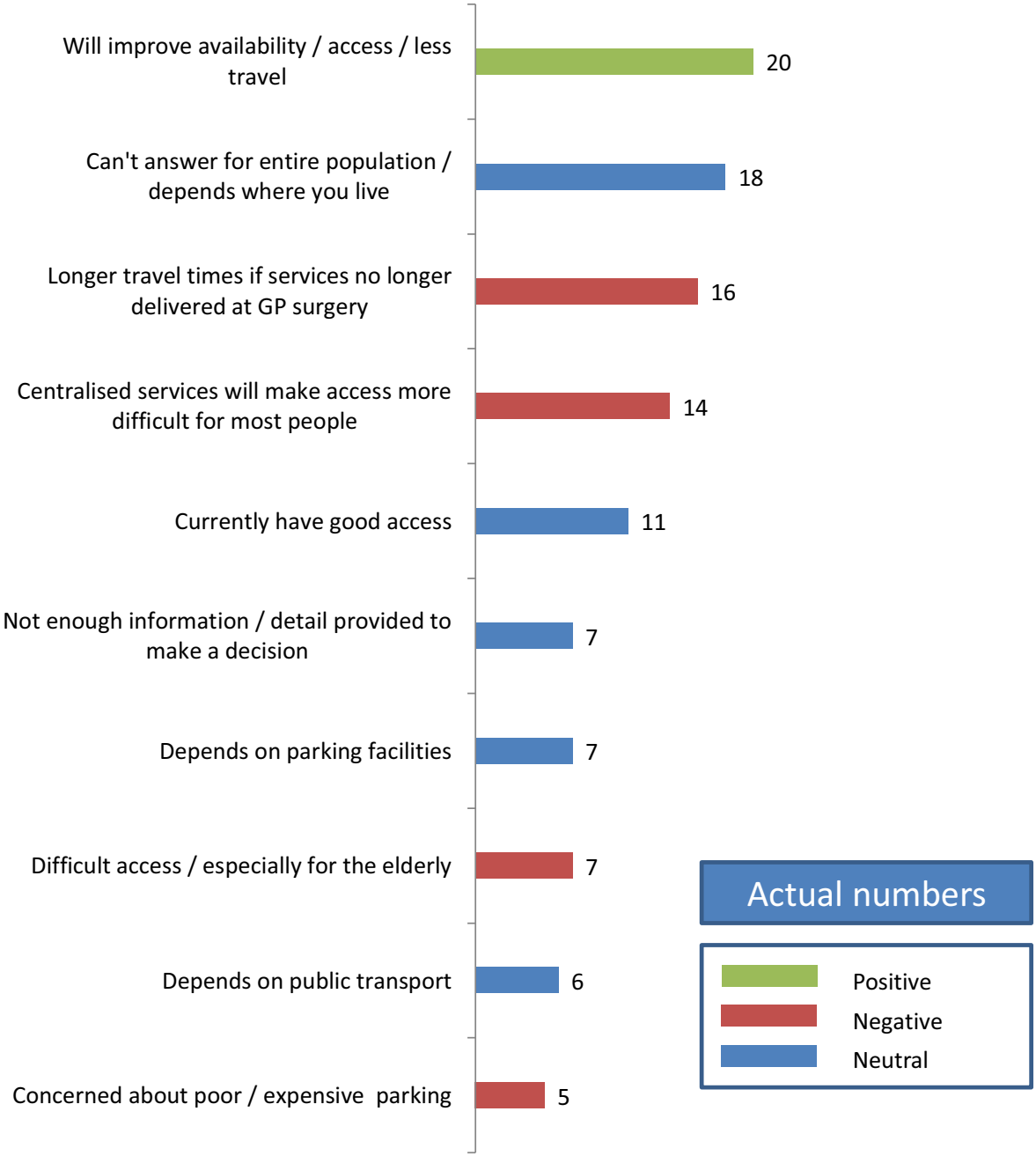
Another potential benefit that individuals attending meetings with NHS Southwark CCG raised (particularly at a Father and Toddler group meeting) was the potential for Option A to deliver what was described as *"opportunistic"* healthcare, where residents could drop into the centre and undergo a range of preventive procedures that they admitted they might not proactively seek themselves.

Respondents felt less positively about the accessibility of health services under Option A:

Question 6bi. Why do you say that?

Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey



Respondents' views on access of healthcare services under Option A were varied

Other comments on the accessibility of healthcare under Option A

Response	Number of mentions
GP surgery / Health centre are more local than hospital	4
Too many locations / too many journeys / too much travelling time	4
Likely to be easier to access with transport than GP surgeries	3
Prefer health centres / they go beyond the GPs	3
Agenda to direct patients away from hospitals / to fragment the service	3
Just moving things around / won't make much / any difference	3
Can strategically place heath centres at good locations for transport	2
Access more difficult for working people	2
Commercial agenda / Back door to privatisation	2
Alternative proposal	1
No real difference between Option A and Option B / a false choice	1
GP appointment waiting times are too long	1

Where accessibility was concerned, again there were a range of views as to what people felt the implications of Option A would be depending on their personal circumstances. For 20 respondents, the accessibility of this Option would be an improvement on the current situation whilst others were less sure of this, both for themselves and for the population of Dulwich and the surrounding area more broadly. Interestingly, respondents in the youngest age group (41% of 18-24 year olds) were most likely to think this aspect of service delivery would get worse under Option A. One participant at this question also put forward an alternative approach, in involving pharmacies more in the delivery of healthcare, thus making it more accessible for working people.

For those attending public meetings and stakeholder organisations (even those who tended to be in favour of Option A overall) accessibility was the main sticking point, particularly where vulnerable groups (individuals with disabilities, for example) as well as the elderly and expectant mothers/mothers with young children were concerned. Specifically, some older residents had concerns that waiting times for health services that were concentrated in just the one location would increase.

Another concern voiced by Local Pharmaceutical Committees was that if the distance patients had to travel was very much greater than at present (if, for instance, they were no longer able to obtain a particular service from their GP practice) this would simply result in an increase of residents simply dialling 999 to receive attention as quickly as possible.

"I can only assume that centralising services will make it less accessible for people."

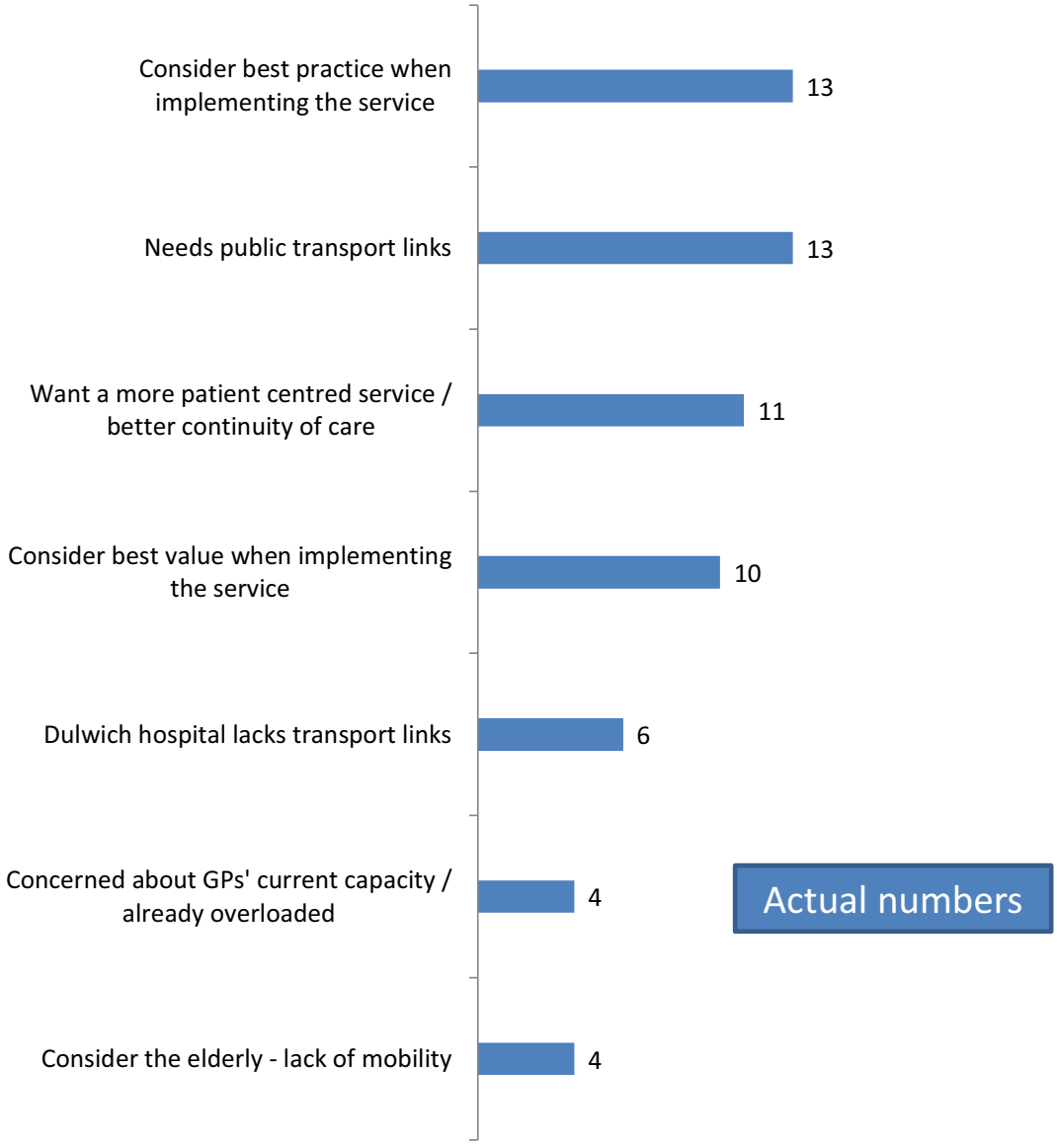
Male, 25-34, SE22

Finally, respondents were asked if there was anything else that NHS Southwark CCG should bear in mind with regard to this proposal and responses to this question are shown below:

Question 6c. Is there anything else that should be taken into account when thinking about this proposal [A]?

Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey



Respondents did not want NHS Southwark CCG to be constrained by the current system but to keep quality and cost efficiency at the forefront of their planning

Other comments on Option A

Response	Number of mentions
Commercial agenda / Back door to privatisation	3
Waiting times need to improve	3
Don't move services from the GP to the health centre	3
Concerned about GP's ability to deliver care	3
Alternative proposal	3
Improve consultation process / provide more information / make more people aware / consult at each stage	3
Dulwich hospital lacks resources	2
GP service is variable in quality	2
May be difficult to convince people / win them over	2
Ensure GPs are more accountable	1
Does not take demographics of Dulwich area into account, e.g. higher birthrates / more dementia patients	1
Consider other healthcare providers - pharmacy / dentist / optician	1

Respondents were most concerned that NHS Southwark CCG keeps best practice and best value in mind if proceeding with this proposal (mentioned by 13 and 10 respondents respectively). For 11 respondents this involved providing a patient-centred service and ensuring continuity of care across different locations.

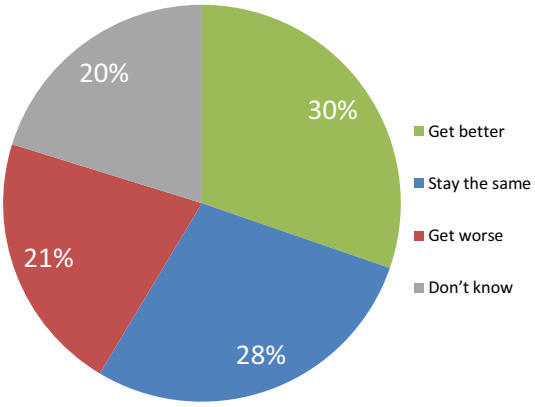
This was also mentioned in stakeholder meetings: here it was stressed that Option A could facilitate the delivery of a number of useful local health services and care in the community, but these agencies should all have an up-to-date understanding of the needs of a patient to ensure the delivery of personalised and effective care. Specifically, attendees at these meetings identified voluntary organisations and charities as potential partners for delivering healthcare through this channel. Furthermore, they suggested that the health centre become a base for delivering care in the community in the form of health visitors and social care.

Again, accessibility and transport were mentioned as particularly important things to consider (especially where the elderly were concerned). As described above, however, younger respondents were more likely than older ones to think accessibility would become an issue under Option A.

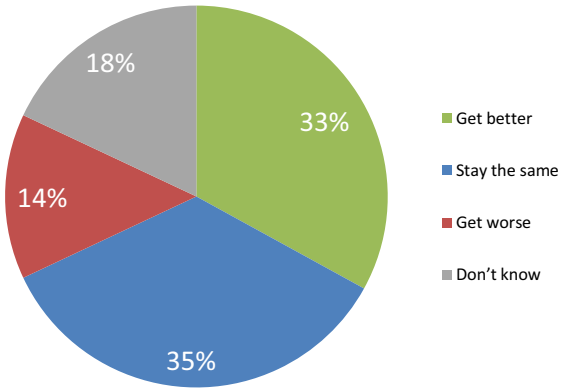
Three respondents at this question put forward alternative ways of delivering healthcare. One respondent said they would prefer for a new purpose-built centre to be used instead of the existing Dulwich Community Hospital building in order to deliver the types of healthcare services needed in the area at the moment; others suggestions included the model of Option A be transferred to GP practices, so they offered the additional services that the proposed health centre would; and another felt that the NHS should look at reducing demand or taking steps to cope with demand for health services in existing facilities rather than *"diverting them to another place"*.

Respondents were then asked for their expectations of the availability and accessibility of healthcare if Option B were pursued:

Question 8a. How do you think that this proposal might affect the following aspects of healthcare? The AVAILABILITY of the care you would receive would…
Base: 215 (public survey; panel survey; community group respondents; NHS staff)



Question 8b How do you think that this proposal might affect the following aspects of healthcare? PEOPLE'S ABILITY TO GET TO PLACES where healthcare is delivered would…
Base: 215 (public survey; panel survey; community group respondents; NHS staff)



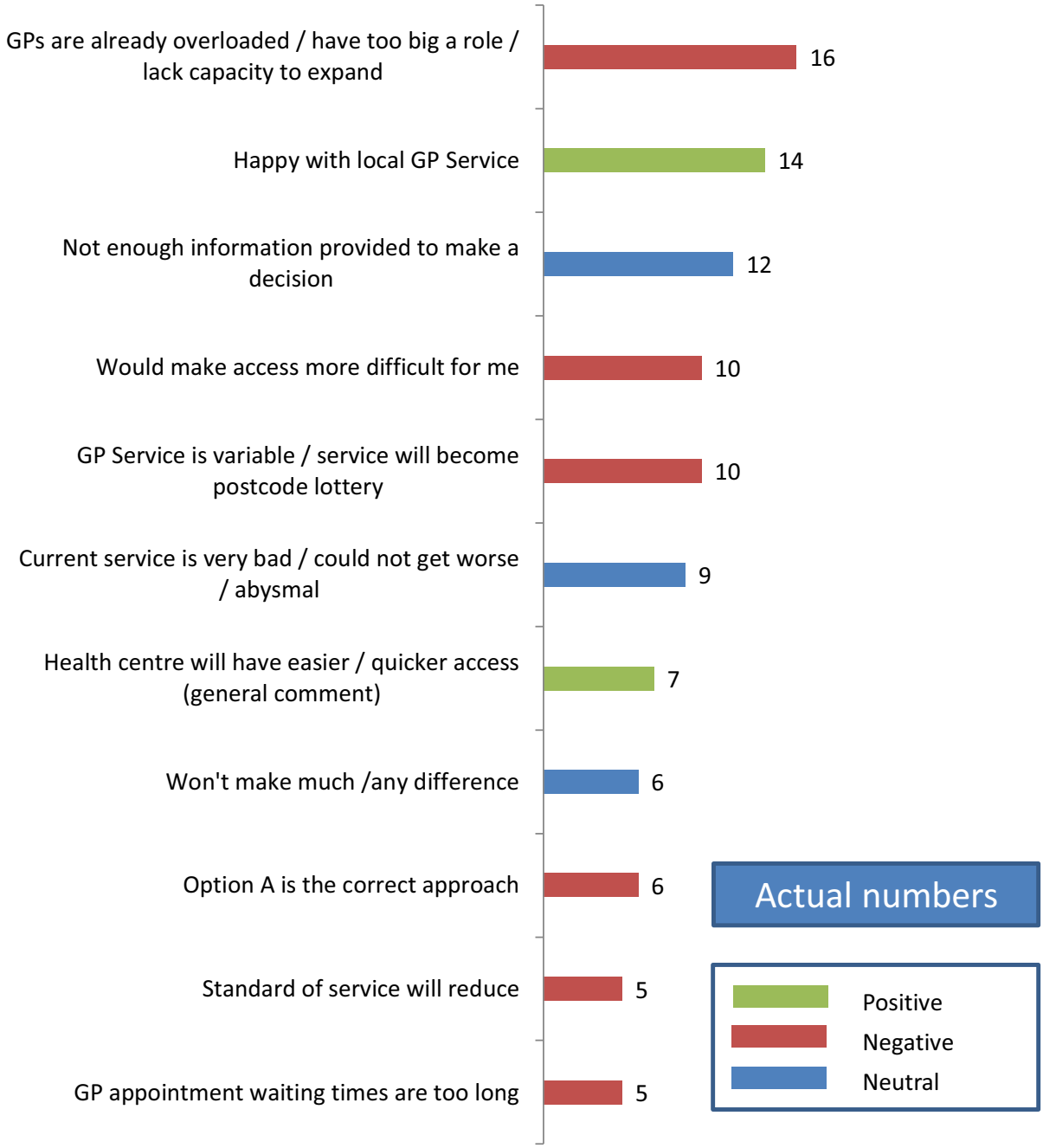
Opinion is split as to whether more health services in GP practices and a health centre with a narrower range of services will improve availability of care and most are unsure either way of its impact on accessibility

For both of these aspects of service, respondents were more likely than for Option A to think that the availability and accessibility of healthcare would remain the same, which would support other responses to the consultation that suggest respondents regarded this Option as less of a change to the status quo. Having said that, one-in-five respondents (21%) felt the availability of healthcare under Option B would get worse. This included respondents that were in favour of Option A (29%), and those aged 45-64 (29%). Some of the reasons provided for this are shown below:

Question 8ai. Why do you say that?

Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey



Some respondents had concerns about GPs' capacity to deliver additional services

Other comments about availability of health services under Option B

Response	Number of mentions
Service would be more efficient / streamlined	4
Health centre gives better access to specialists / more services / equipment	4
Alternative proposal	4
Will make access better for me (specific to respondent)	3
Will reduce waiting times	3
Agenda to direct patients away from hospitals / to fragment the service	3
Will increase waiting times	3
Will make GPs' role more focussed / not diluted with other responsibilities	2
GP service is mediocre / not very good	2
Commercial agenda / Back door to privatisation	2
No real difference between Option A and Option B / a false choice	1
Will lead to a decrease in hospital funding	1
Unproven model / may not work	1

For those supplying negative comments about Option B, the strain on GPs if this Option were pursued was mentioned by 16 respondents (plus nine who said their existing GP service was very poor), as was the distribution of services across some GP practices but not others (10 respondents).

For those attending deliberative and stakeholder meetings as well, this was an issue. Some had experienced poor quality care from their GP practice in the past and complained about how overstretched their GP was; others felt it would be unfair for specialist community services to be available in one area (to the benefit of local residents) but not in others.

Another point of view (mentioned by five respondents to the questionnaire as well as across a number of stakeholder meetings) was that offering specialist community healthcare across a number of GP practices would potentially fragment the care received by patients. Where expectant mothers, those with mental health considerations, and the elderly were concerned, attendees at meetings were more likely to think these groups as in particular need of consistent and personal care by the same healthcare professionals over time. This concern was also raised by stakeholder groups at which individuals with learning disabilities were in attendance, as well as a Lesbian, Bisexual, Gay and Transgender group, who commented that, further, there was a need for patients' health records to be up-to-date and available to the professional providing care for a patient at any given time.

"I strongly disagree with the proposal for only a small health centre as it would not ease the pressure on GP surgeries, nor the acute sector. However, a small one is better than none at all! Availability of care would be worse as increasing the range at surgeries would condense even further the space and time available for existing patients who are actually ill rather than needing e.g. counselling."

Female, 55-64, SE22

"This option has the inherent capacity to fragment care just when the current "direction of travel" is to be more holistic, more "one stop." It also has the capacity to incite unnecessary competition and perhaps jealousy between practices. Not all patients would get worse care, but this option runs the risk of making care in some areas or practices worse, when the intent to make the care much more uniform in quality, deliverability and accessibility."

Male, 65+ SE24

Some respondents (14) were happy with the service currently provided by their GP and felt this Option would ensure this service was continued.

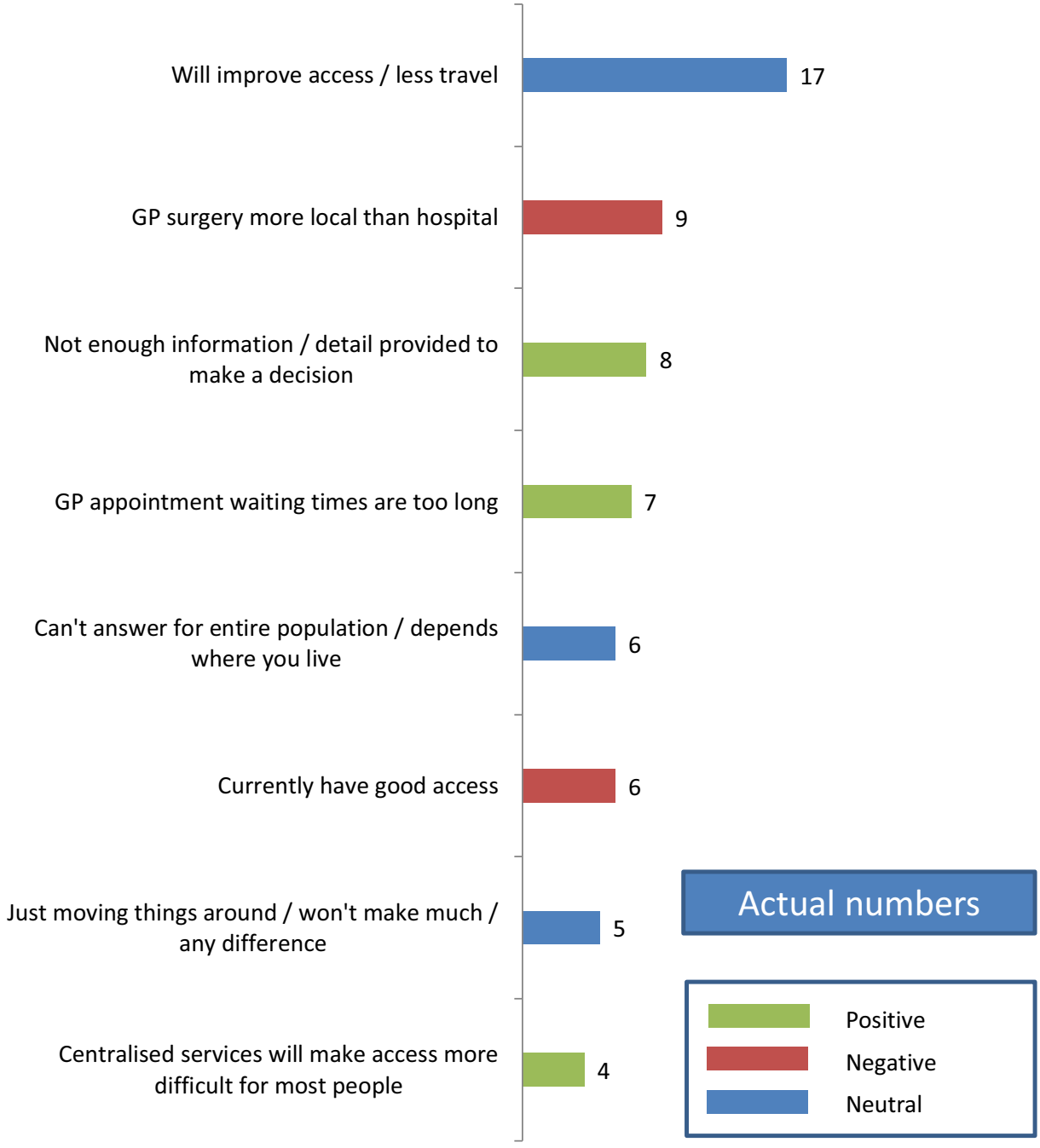
Four respondents had alternative proposals as far as the availability of community health services under Option B was concerned. The proposal to deliver health services from a pharmacy was raised once again by one respondent; another said they could not see a need to develop a new building and that existing hospital facilities should receive investment rather than more complicated redevelopment. Others felt that devolving increasing community health services to GPs would, in effect, make them into their own *"mini privatised"* hospitals, and that supervision of GPs and community health services more broadly should be conducted by a London-wide healthcare authority or hospital, a little like the King's College Clinics in the Community.

Respondents were slightly more positive about the accessibility of healthcare under this Option:

Question 8bi. Why do you say that?

Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey



Respondents felt this Option would mean health services were local and entail less travel

Other comments about the accessibility of healthcare under Option B

Response	Number of mentions
Can strategically place heath centres at good locations for transport	2
Depends on public transport	2
Same as for Option A	2
Alternative proposal	2
Access more difficult for working people	2
Concerned about poor / expensive parking	2
Agenda to direct patients away from hospitals / to fragment the service	2
Difficult access / especially for the elderly	2
Too many journeys / too much travelling time	2
Prefer health centres / they go beyond the GPs	1
Longer travel times if services no longer delivered at GP surgery / too many locations	1
Commercial agenda / Back door to privatisation	1
System too complicated / confusing	1
No real difference between Option A and Option B / a false choice	1

The most common responses to this question were positive, with improved accessibility/less travel being mentioned by 17 respondents and the locality of GP practices by nine. There was still some variability in opinion on accessibility, particularly where out-of-hours care was concerned (mentioned by two respondents). There was some concern (amongst seven respondents) that GP surgery waiting times would grow.

"If a wide range of services are offered in several locations, people will have more choice of where to go for their healthcare based on where they are able to get to conveniently."

Female, 18-24, SE5

"It doesn't matter where the services are delivered, it matters that people can access it and that it is high quality. There needs to be continuity of care. Unless there are more staff to deliver this care (including doctors, Nurses, HCPs and frontline/admin staff) people will be dealing with waiting times, difficulty navigating 'the system'."

Female, 25-34, SE22

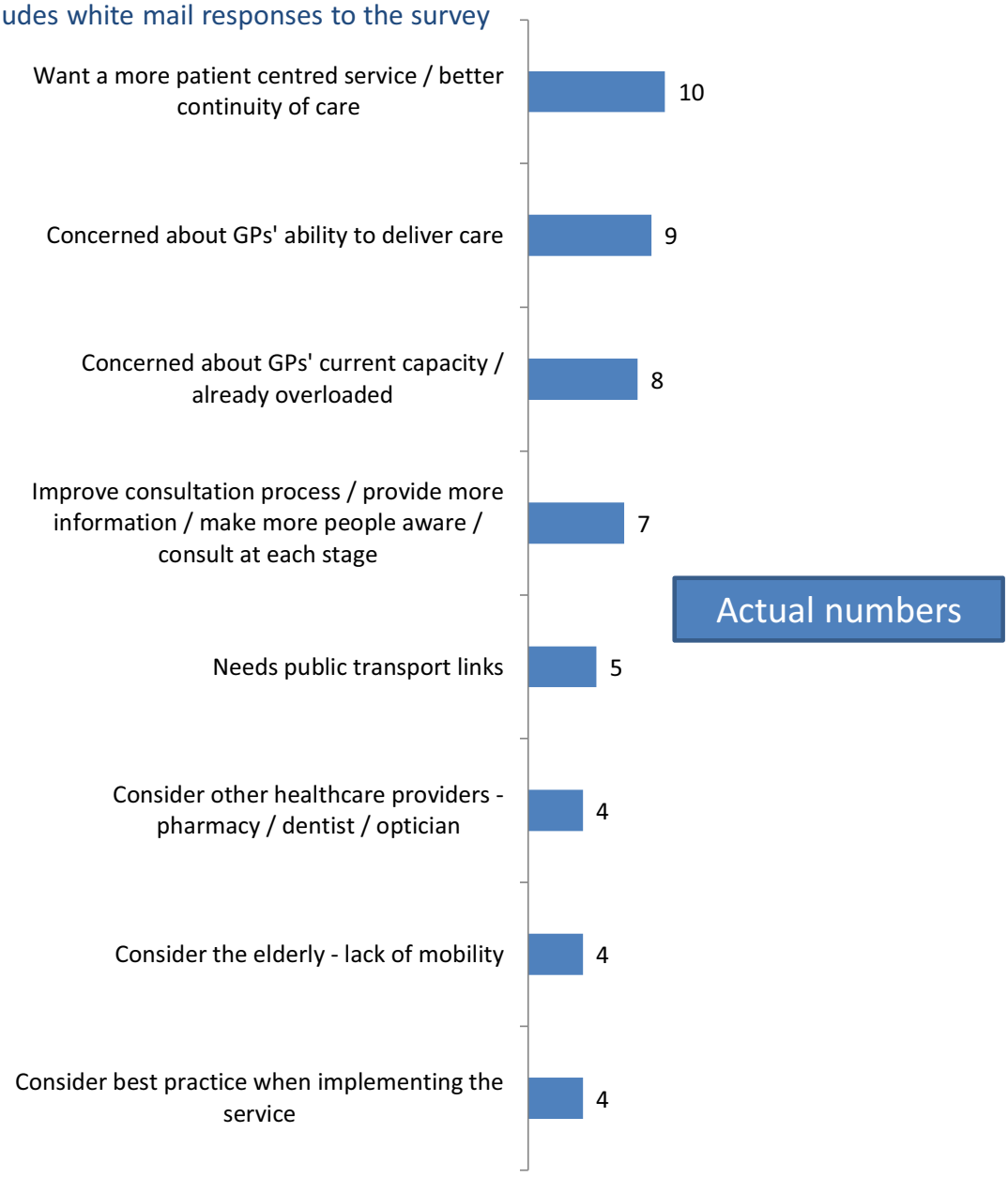
The option of delivering community healthcare services through pharmacies was another proposal raised by a respondent at this question.

As with Option A, respondents were asked what NHS Southwark CCG ought to bear in mind when considering Option B:

Question 8c. Is there anything else that should be taken into account when thinking about this proposal [B]?

Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey



Respondents' main concerns related to the capacity of GPs to deliver the quality of care to patients

Other comments on Option B

Response	Number of mentions
GP service is variable in quality	3
Commercial agenda / Back door to privatisation	2
More crowding in GP waiting rooms will increase infections	2
Ensure GPs are more accountable	2
Both models require adequate investment	2
Consider best value when implementing the service	1
Dulwich hospital lacks transport links	1
Waiting times need to improve	1
Don't move services from the GP to the health centre	1
No real difference between option A and option B	1
Alternative proposal	1
Would result in loss of land / buildings / would be expensive	1
Prefer option A	1

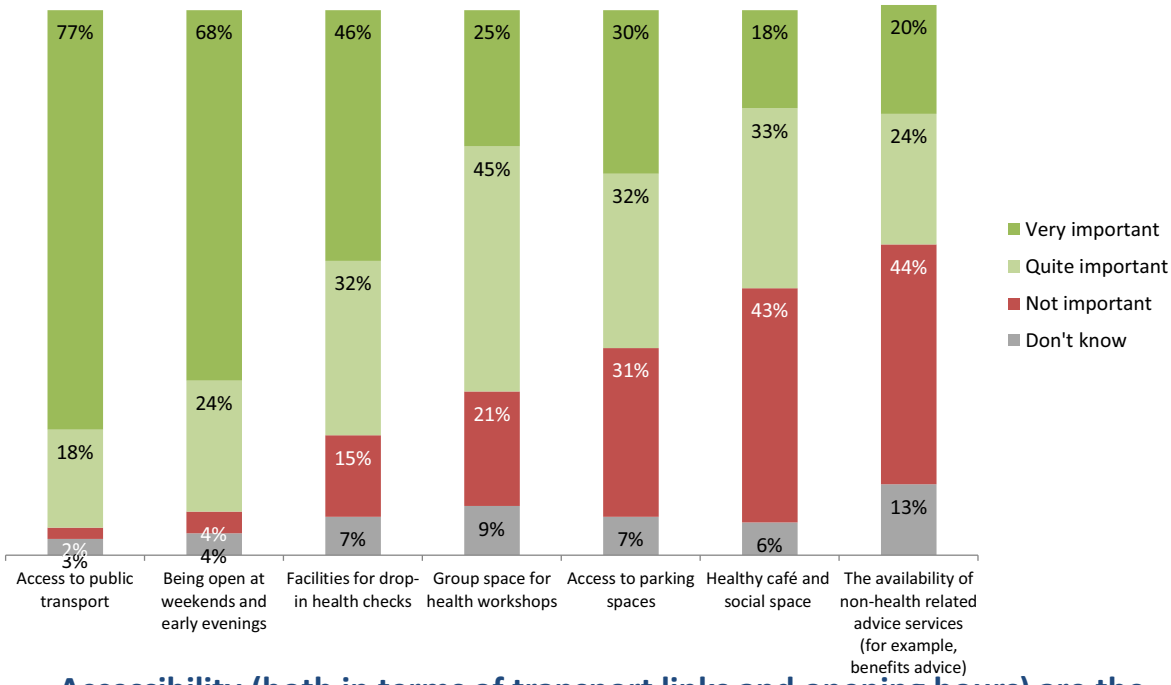
Respondents' concerns centred around the issue of the capability and capacity of GP practices to offer specialist community services under Option B. The most commonly cited point was that care would need to be patient-centred (mentioned by 10 respondents) followed by concerns about the clinical and practical implications of Option B (including waiting times). Having said that, one respondent stated that they did not want services to be moved from their GP practice to a health centre.

One respondent had an alternative proposal that entailed delivering a range of community health services from GP practices but also establishing a centre of excellence on the Dulwich Community Hospital site for providing healthcare for the very young and for the elderly.

One suggestion made through deliberative events and stakeholder meetings was that greater use could be made of pharmacists, dentists and opticians as part of this model. A general point of discussion at the deliberative and stakeholder meetings was the delivery of healthcare across a number of channels by a range of healthcare professionals. With regard to Option B, respondents seem to have mentioned this idea as a means of helping GP practices to cope.

In addition to aspects of service under each of the proposals, respondents to the questionnaire were also asked for their priorities in relation to the proposed health centre itself as part of either Option A or Option B.

Question 10. Thinking about the building for the proposed health centre set out in options A and B, which of the following is important to you?
Base: 215 (public survey; panel survey; community group respondents; NHS staff)



Accessibility (both in terms of transport links and opening hours) are the most important aspects for a proposed health centre

Perhaps unsurprisingly, accessibility featured highly in respondents' priorities as it has throughout other questions in the survey and at deliberative and stakeholder meetings. The most important aspect of a new health centre was that it was accessible by public transport, which was considered important by 95% of respondents. This was most important to respondents with disabilities (87% of respondents with a disability felt access to public transport was 'very important') and also those who were either opposed to Option A or in support of Option B (all respondents in these groups considered public transport to be important). Interestingly the 18-24 age group were the group that considered public transport to be most important (88% rated this as 'very important), closely followed by those aged over 65 (82%). Parking was less of a concern to respondents, however, with 62% rating this as important.

Accessibility in terms of opening hours was also something of great importance to respondents, and was another theme raised in deliberative and stakeholder meetings as well as in the questionnaire itself. Here, 92% rated being open at weekends and early evenings as important. This was consistent irrespective of whether respondents had a preference for Option A or Option B (94% in both cases). Again, it was the younger age groups (84% of 18-34 year olds) that considered this to be 'very important' in comparison with older age groups (just over half – 53% - of respondents aged over 65 felt this was 'very important'). Comments provided by attendees at a travellers' stakeholder group further highlighted the inflexibility of the existing system and a desire for high-quality out-of-hours care to be more readily available.

Parking, however, was not considered to be as important as drop-in health checks and group space for health workshops. Respondents that felt parking was 'very important' tended to be in the 45-54 age bracket, with two-in-five (42%) of this age group providing this rating. Additionally, respondents that had a disability were amongst those most likely to rate parking as 'very important', with 40% of this group saying so. Health workshops received much support from those who were in favour of Option A, which supports testimony provided at stakeholder meetings that this feature would be an attractive one for people to have multiple health problems addressed and advice obtained at one time.

Furthermore, stakeholder meetings highlighted support for the idea of 'drop-in' health services in a health centre, which might entice more residents to volunteer for screening programmes and take a more proactive approach to managing their health. Improving preventive care was spontaneously cited by attendees at stakeholder meetings as a major benefit of NHS Southwark CCG's overall approach, and indeed there was wider support from members of the public and stakeholder organisations alike for a health centre to support individuals' *"well-being"*.

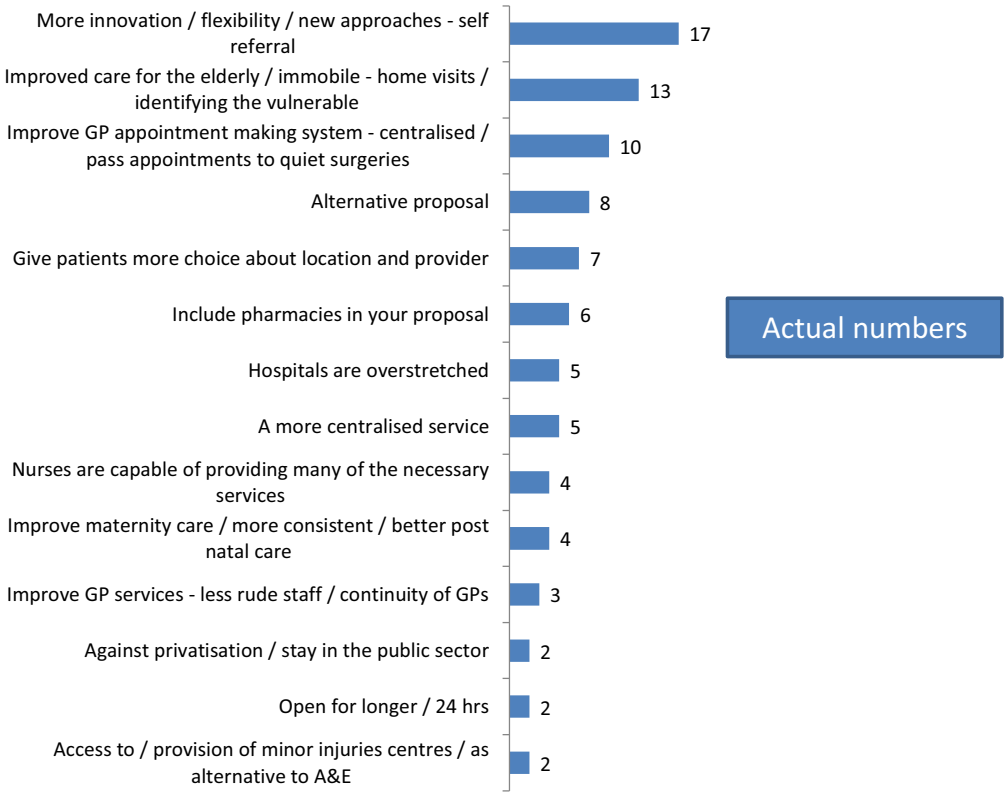
Aspects of the health centre that were not directly health-related, such as a healthy café and social space, and the availability of non-health related advice services, were prioritised to a lesser extent by respondents, with 51% and 44% respectively rating these as 'important' and a far greater proportion of respondents actively rating these things a 'not important' than for other features of a health centre.

Having said that, a suggestion made at a stakeholder meeting was that these more *"social"* sorts of features might encourage people to attend the health centre and would be useful from a preventive care perspective at improving the health of the local population.

3.4 Additional suggestions made by respondents

As part of the consultation process, respondents to the questionnaire and those attending deliberative or stakeholder meetings were asked for their suggestions for other ways in which health services might be delivered in Dulwich and the surrounding area, other than the two proposals put forward by NHS Southwark CCG.

Question 9. Are there any other ways in which health services in Dulwich and the surrounding area should be delivered?
Base: 221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)
Includes white mail responses to the survey



As some respondents mentioned at other points in the survey, there were calls for more innovative thinking from 17 respondents rather than working within the confines of the existing system.

"In the modern era, we need to get away from the old favoured solutions and institutions. GPs are a failed model."

Male, 55-64, SE22

The next most common point raised at this question by 13 respondents was for work to be done to improve the care provided to the elderly in particular.

Again, a point raised by participants at deliberative and stakeholder meetings was that the elderly required a more targeted and personalised standard of care, and the existing system did not cater effectively for vulnerable groups who required care at home. Maternity care was also identified as an area where more consistent care was required, mentioned by four respondents at this question and attendees at deliberative and stakeholder meetings also raising this as an issue that needed

addressing. Some attendees had personal experience where the care they had received prior to having a baby had been fragmented (both from their midwives and their GP), which had severe emotional implications.

There was also a split between respondents who advocated providing patients with more choice about where to obtain healthcare and including other parties like pharmacists in any proposals carried forward, and respondents who felt centralisation was the key to future healthcare delivery: seven respondents were in favour of greater patient choice of where they receive their healthcare and who they obtain it from; six said that pharmacists should be incorporated into a model of healthcare delivery; but five felt healthcare needed to be centralised.

This tension bore out in deliberative and stakeholder meetings as well: there were calls for pharmaceutical and charity medical professionals and social care providers, alongside demands that these individuals would need to receive adequate training, and concerns about the fragmentation of care. The nature of the audience receiving specialist community healthcare (new mothers, those with mental health considerations, and the elderly), and communications between healthcare professionals were key to those contributing to this discussion across the meetings.

There were a further eight different proposals for the delivery of healthcare in Dulwich and the surrounding area. These included the following:

- One suggestion was to invest in existing hospital services and safeguard the care provided in a hospital setting. One other suggestion echoed this sentiment by requesting that the existing system should be built on rather than replaced.
- One respondent felt there was also scope to develop a community health centre on the King's College Hospital site for residents who might find it difficult to travel to Dulwich.
- One respondent felt the role of health visitors was *"redundant"* and that the work they do (especially with mothers and children) could be carried out via GP practices.
- One respondent felt that better provision could be made under the proposals for the delivery of facilities for women in labour for non-complicated deliveries and for a midwife-led unit to be based there.
- There was one suggestion that emergency care to be provided at a community health centre as currently this is only available at a small number of sites in the area.
- One respondent asked whether the Fred Francis Centre in East Dulwich and Holmhurst in Herne Hill could be re-opened to deliver health and social care services.

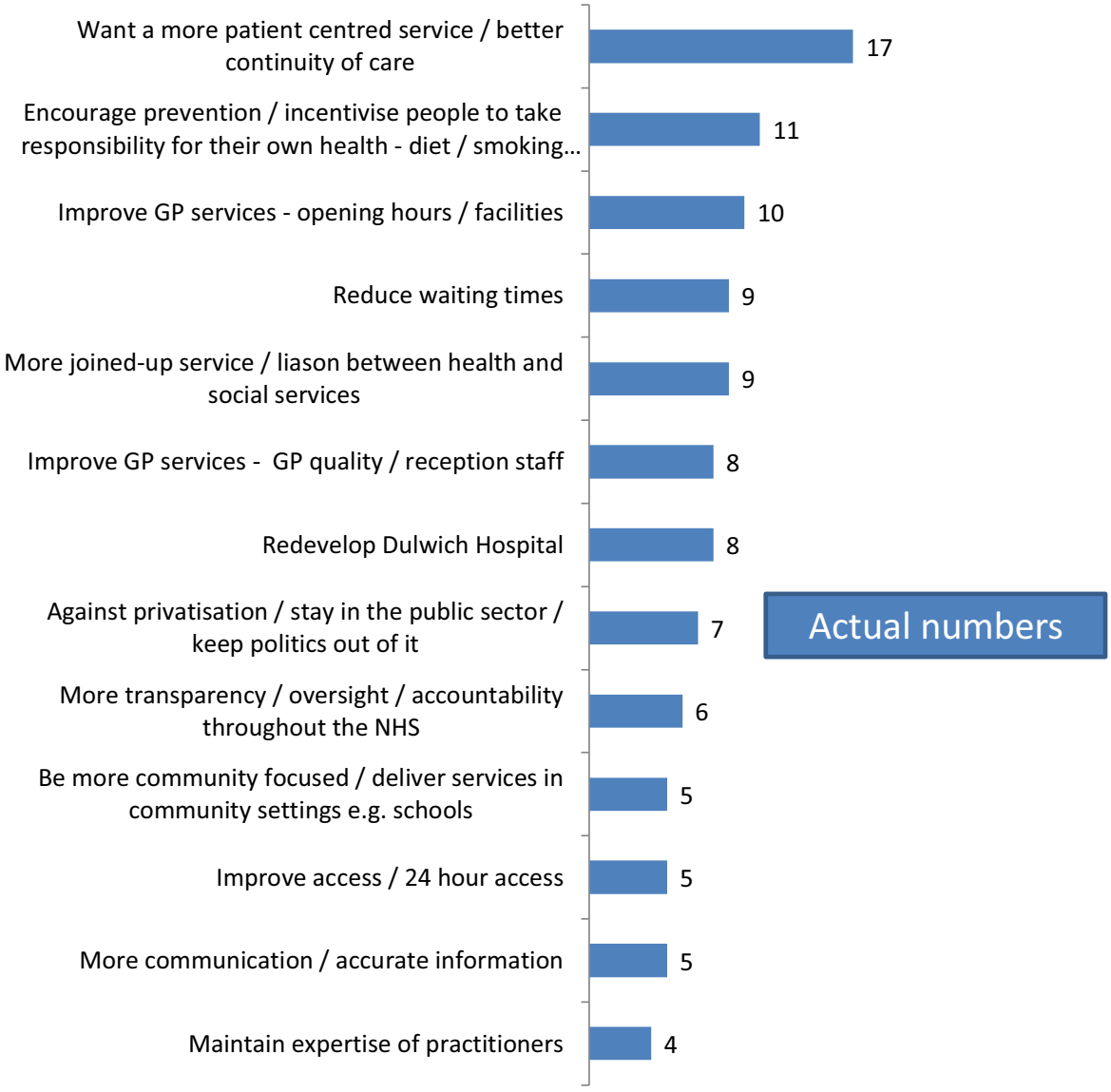
3.5 Overall views and comments

Finally, respondents were able to provide any other comments about the way health services might be delivered in Dulwich and the surrounding area.

Question 12. Is there anything else that you think NHS Southwark Clinical Commissioning Group should take into account when developing their proposals for how services should be delivered locally?

221 (122 public survey; 89 panel survey; 2 community group respondents; 1 NHS staff)

Includes white mail responses to the survey



Respondents took this opportunity to reiterate the importance of continuity of care and improving accessibility of GP services

Other additional views and comments

Response	Number of mentions
Location is a lesser concern than quality of service	3
Want alternative / complementary medicine to be a part of the NHS - e.g homeopathy / acupuncture, etc.	3
Alternative proposal	3
Agenda to direct patients away from hospitals / to fragment the service	2
Prefer option A	2
No real difference between Option A and Option B / a false choice	1

Unsurprisingly, 17 respondents to this question raised the issue of continuity of care, as had been mentioned at other questions and was a concern at deliberative and stakeholder meetings. Similarly, 10 respondents said that GP services needed attention, particularly out-of-hours care and the facilities available, and nine respondents said that work should be done to reduce waiting times. For those attending the meetings, these were amongst the priority areas that needed to be addressed irrespective of the Option pursued.

"Maintaining the quality of services and expertise of practitioners when spreading services more thinly across the area. No point providing services locally if of poorer quality."

Female, 45-54, SE15

Additionally, rather than advocating either of the Options, 11 respondents (plus some of those at stakeholder meetings) said that a priority ought to be to encourage prevention and enable people to take responsibility for their own health – which supports NHS Southwark CCG's overall approach to the delivery of healthcare in the future. This was mentioned with regard to screening as well as healthy eating and exercise, smoking cessation, and sexual health. Individuals felt this could be offered either at a health centre or by a mobile local unit in the community.

"It is better to prevent ill health and offer more preventive and early intervention services in the community and primary care as well as the care people need to manage a long term condition."

Female, 55-64, SW2

You need to screen people for health conditions that may be prevalent in the particular area e.g. in Nunhead call for people (campaign) to have health checks for cardiovascular disease and cancer as we know there are problems with this[…] More focus needed on working with children and young people on preventing ill health. Health services need to work more with social care services. More people should be taught/supported on how to self-care."

Female, 35-44, SE15

It should be noted that responses to this question more generally came from respondents irrespective of their levels of support for either Option A or Option B.

A further three proposals were raised by respondents: one that end of life care and hospice services should be provided as this would relieve pressure on healthcare resources; another respondent felt that there was scope for emergency healthcare to be provided outside of Accident and Emergency facilities (which should be reserved for the most severe emergencies); the final suggestion was that money need not be spent on developing a new health centre and simply "relabeling facilities".

3.6 Summary of themes from meetings arranged by NHS Southwark CCG

Throughout the consultation, the project team at NHS Southwark CCG arranged meetings for those who were interested in asking questions or gaining more information on the consultation, and to provide their views face-to-face.

1,295 members of the public were actively engaged in the consultation.

- 568 people participated in an in-depth discussion at a meeting or event;
- An estimated 667 people attended public meetings (including council meetings) in which the consultation was promoted, documents were distributed and there was an opportunity for questions;
- 60 people attended deliberative events, the purpose of which was to discuss and explore the proposals in depth.

The following describes the key themes drawn out from the deliberative events and meetings with stakeholder groups.

3.7 Deliberative events

Across the two events, a number of themes emerged in participants' views and comments. Some of these themes were also mirrored by responses to the questionnaire. There were additional queries made and some points were explored in greater depth. These will be outlined here.

Cost-efficiency

In both deliberative events, those present seemed unsure about which of the two Options would be most cost-effective based on the information provided in the consultation document. It was felt that in order to understand and make a decision between Option A and Option B, more information on finances was needed, as they were unable to make a strong judgement on which Option would be more beneficial for the NHS and their area without this knowledge.

Health services delivered by GP practices

A number of people across the two deliberative events questioned the feasibility of Option B, wondering how GP surgeries of different sizes and capacities could expand to provide a variety of healthcare services and meet the demand this would generate. Some participants were disparaging of the service they received from their GP at present and others acknowledged the variability in GP services across the area. They had misgivings, therefore, that this Option would be possible in practice. As has already been described, this point was raised by respondents to the questionnaire when thinking about Option B. More information on this – and the specific configuration of health services under the proposals – was requested by those who attended the events in order for them to be able to arrive at a decision about this Option.

In general, it was felt that Option B allowed for great accessibility of healthcare services and allowed for deeper relationships to be built up between patient and clinician.

No preference for Option A or Option B

There was no strong consistent preference for Option A or Option B. Individuals at both meetings asked the CCG to focus on the ideal version of healthcare, and to work toward an optimum solution, rather than entertaining only Option A or B. A suggestion made was to allow GPs or other healthcare professionals to specialise in a specific area and travel from GP surgery to GP surgery on different days, delivering that

healthcare service. Other suggestions included developing separate centres of excellence for elderly people and a centre of excellence for younger people.

Delivery of specialist community services

A significant area of consideration for those who attended was how specialist community services would be provided under Option A and Option B. Those present questioned whether specialists would be based within specified GP practices or would travel between them; whether new specialists would be trained up to meet demand in the community; and whether specialists and equipment would be sourced from King's College Hospital. Concerns around ensuring excellence of specialist training were raised: those present were eager to ensure that the quality of care would not decline were specialist community services to be provided locally as opposed to in a hospital. Frequently participants referred to the importance of having 'centres of excellence' for specialist health problems to be addressed effectively.

Joined-up care and communication amongst practitioners

Irrespective of the Option that would be implemented in the future, participants felt that it was essential for all practitioners delivering healthcare to communicate with each other to understand fully the situation and needs of each patient whether they were receiving care in a GP practice, a health centre, or elsewhere. This was a criticism levelled at the existing system (particularly where medical practitioners and social services were concerned) and participants felt it was essential to address this problem for either of the proposals to be effective. Some participants suggested that a new IT system to facilitate safe communication between healthcare services and store medical information about patients centrally was necessary. The need for this service was echoed by the medical specialists present at both deliberative events, and the issue of joined-up healthcare was present in the minds of some respondents to the questionnaire.

Accessibility of services

In both deliberative events, participants stressed the importance of designing a healthcare service accessible to all residents in the area. Some felt that for older people, and mothers or families with young children, having services located in local GP centres was preferable, to ensure ease of access (i.e. that the location was closer to home or was accessible by public transport). Others felt that providing services for older people and expectant mothers in a central location would be more efficient, and that this would reduce travelling time for older people with multiple conditions that require a number of appointments.

A number of people applauded the intended use of the Dulwich Community Hospital site but mentioned that this was inaccessible by public transport and asked that this issue needed to be addressed in future plans.

3.8 Stakeholder meetings

NHS Southwark CCG invited over 350 groups and organisations to meetings to discuss the proposals and put questions to members of the project team. In total, 74 were arranged, at which there were 568 attendees.

Overall, the views expressed at targeted stakeholder events were broadly similar to those expressed at all other events and so have been incorporated within the body of the report. However, these events did offer some helpful insights into the specific experiences of some groups that may inform implementation and delivery. Some of these have been outlined below.

- Some members of stakeholder groups with **learning disabilities** reported concern about the ability of primary care staff to communicate with them and understand their needs. One suggestion was that learning disability groups might be involved in delivering training events to help staff gain new skills and knowledge. Familiarity of environments, continuity of care – specifically with reference to seeing the same clinicians on an on-going basis – was also of particular concern.
- Some members of **traveller** stakeholder groups reported difficulties in accessing GP services at convenient times when juggling the conflicting demands of family life. This led some to use out-of-hours GP services as their default primary care service, rather than waiting for an appointment with their GP practice.
- Some members of stakeholder groups with severe **hearing impairment** raised concerns about their ability to quickly access interpreting services at their practice. This meant that it was difficult to access unplanned care services independently.
- LGBT respondents highlighted the need for those providing **mental health services** to have access to LGBT specific groups where appropriate. They also advocated for more comprehensive recording of data about patient's sexuality to help better identify the specific needs of LGBT service users in the future
- Whilst some respondents with **physical disabilities** which resulted in mobility issues highlighted the need for buildings to be fully accessible, in terms of location, most groups did not express strong opinions regarding location as they would access patient transport or use private transport to travel to services regardless of their location.
- There were no significant differences in the responses given by **BME groups** who engaged with the consultation. However, some BME participants were particularly interested in seeing an increase in the prevention services available in community settings.
- Some older participants (those over 60) highlighted a desire to access sexual health services in community settings and noted the reported increase in STIs amongst older people.
- The need to develop dementia friendly environments was also highlighted by some older people's groups.
- People using **mental health** services highlighted concerns regarding the knowledge and experience of GPs and other primary care staff to recognise, diagnose and manage mental health. They also highlighted the need to understand the inter-relationship between physical and mental health.
- Stakeholder groups representing carers highlighted concerns that carers still find it difficult to access carers' services available from the diverse voluntary sector organisations in Southwark and that there was a need to develop improved signposting mechanisms to support them.

The section that follows is a summary of the key questions that were asked, concerns that were voiced and comments that were made about the proposals. No clear preference for Option A or Option B emerged; preferences differed according to the area of healthcare that was being discussed and both options were felt to have positive and negative aspects.

Accessibility of services

Across the various groups, concerns about ensuring easy access to healthcare services under Option A were raised. Particular issues and suggestions included:

- For people living in parts of Peckham, the site at Dulwich hospital may be too far away – transport links would have to be available.
- Queen's Road Peckham station (which links directly to East Dulwich station, behind the site) is not very accessible so may cause issues for people with mobility issues.
- The route for the number 42 bus would need to be extended in order for people to travel to the Dulwich hospital site with ease.
- Parking facilities would need to be available close to the new centre on the Dulwich Community Hospital site (particularly for disabled people).
- The service on both the 37 bus from Rye Lane to East Dulwich Grove or the P13 service from Bellenden Road to Grove Vale was said to be poor. This would need to be addressed to open up ease of access to the healthcare centre.

Some older residents also had queries about waiting times if Option A were pursued and more services concentrated in one location. Consequently, some individuals felt that only particularly focused areas of community healthcare be delivered in a health centre, perhaps just catering for the elderly, for example, or for mothers and babies.

There was some positive feeling, however, towards the accessibility of health services in a health centre, particularly if they were drop-in services. In some groups it was mentioned that "opportunistic" healthcare, particularly screening and healthcare for males, would be taken up to a greater extent if provided in a drop-in manner. It was mentioned at one meeting with a Father and Toddler group that men were not likely to seek out preventive health services proactively and so having them in one location would increase take-up of these health services among this group. Additionally, if a health centre provided workshops or classes for people about various health problems, for example, exercise, they could obtain other health-related advice in the same visit, about mental health or counselling, for instance. This would support the delivery of preventive healthcare as part of NHS Southwark CCG's overall approach. Another suggestion made in one group was that the health centre could act as a 'hub' for care home residents to receive a range of healthcare services in one visit.

Another area of healthcare where it was felt more could be done in a preventive sense was sexual health, although there was some disagreement amongst the groups as to where this service ought to be delivered. At one group, providing treatment for individuals with sexually transmitted diseases across all age groups was most effectively delivered locally rather than at Camberwell Clinic as at present. For others, there were more negative views about sexual health treatment being delivered in a health centre alongside other family health services.

Availability of services

It was commonly remarked that waiting times for GP appointments and then referrals to hospital were long and that improvement was required. Opinion was split about whether Option A or Option B would most likely be able to deliver this improvement. Some felt that offering more services at a health centre and taking pressure away from GP practices would improve the availability of primary healthcare at GP practices; others felt that if specialist community healthcare services were offered in multiple locations (as under Option B), this would improve waiting times for specialist treatment.

It should be acknowledged, however, that the need for change was not accepted by everybody, and some did not feel that either of the Options would have a beneficial effect on the availability of services. In one

group, the health centre was described as an "unnecessary" additional layer of healthcare that carried a significant amount of expense and attempted to change a system that did not require it. Another view expressed by some individuals was that they were satisfied with their current GP practice's performance, and did not want to see health services distributed across the area as this would jeopardise not only the location of these health services but also the quality.

Quality of care

Another recurring theme that arose across these meetings was the importance of the quality of care – in some cases, more so than the location of health services.

Thinking about Option B, some individuals questioned whether GPs would have the necessary specialist training to deal with certain conditions. Mental health was cited as an area where this was especially important and within mental health, there was felt to be specialisms required for children's psychological health as well as the elderly.

Additionally some individuals felt that this joined-up delivery of healthcare should come from a range of healthcare professionals including pharmacists, and that in this instance it would be necessary to provide sufficient training so that the quality of care on offer was high.

Joined-up healthcare

A strong argument was made across these meetings for ensuring that future healthcare services would be designed with a holistic concept of healthcare in mind, regardless of the Option chosen. Greater links between social care, mental healthcare, and medical healthcare – be it primary, acute, specialist or preventive – were called for. A health centre was potentially a location from which community health care and health visits could be based and organised.

Suggestions for joined-up healthcare were also made at some of these meetings, including the recommendation that a centre be established solely for the purpose of delivering healthcare services for the elderly. Some also mentioned the possibility of partnering with voluntary and community groups to deliver healthcare services in the community for elderly residents, particularly after undergoing surgery. This follow-up care was felt to be an important part of a holistic model of healthcare delivery.

The point was also made that, currently, healthcare was not particularly joined up where pregnant women and young children were concerned. Some spoke of personal experiences where they had not been looked after by the same midwife over the course of the pregnancy, and their GP practice had not the capacity to provide midwife clinics. At a Father and Toddler group meeting, even where fathers said that the service provided by their GP was variable and not consistent with the performance of others in the area, they were reassured that their child received continuity of care from one professional who could become familiar with their case.

Some were concerned that, under Option B, continuity of care was under greater threat than currently or if Option A were pursued. Some people were uncomfortable with the idea of seeing potentially multiple GPs for different health problems. Not only did they worry that this would be detrimental to their healthcare in that the GP would be unfamiliar with their case, but some raised the importance of the GP-patient relationship and putting patients at ease about coming forward to speak to their GP about a health problem. Mental health was mentioned as an area where this was of particular concern. If Option B were pursued, healthcare services would be, in some individuals' view, fragmented across the area, meaning that patients might have to receive treatment in numerous locations, and there might also be greater strain on GP practices to cope with demand. This in turn would create more administrative work and, assuming information about patients was successfully communicated across GPs, put greater strain on GPs to deliver joined up and effective healthcare on a case by case basis.

Other concerns mentioned by groups

- Concern about the progressive dismantling of health services was raised and the NHS dentistry was given as an example of this.
- Some called for the Dulwich hospital site to be retained in its entirety.
- Some people wanted drug and substance misuse resources situated away from main healthcare facilities.
- Incorporating aftercare into the new models of healthcare.
- Providing interpreter services and other resources to facilitate communication of healthcare needs for people with disabilities.

3.9 Feedback from stakeholder organisations

A total of 14 stakeholder groups or organisations provided a formal written response to the consultation. These groups represented particular patient groups or associations of medical experts. A list of the stakeholder organisations who responded to the consultation is below:

Community Action Southwark (CAS) and Healthwatch Southwark (HWS)
Southwark Council
NHS Lambeth Clinical Commissioning Group
NHS Lewisham Clinical Commissioning Group
Guy's and St Thomas' NHS Foundation Trust
King's College Hospital NHS Foundation Trust
King's Health Partners
Southwark and Lambeth Integrated Care (SLIC)
South London and Maudsley NHS Foundation Trust
NHS England
Rt Hon Dame Tessa Jowell MP
Southwark Local Medical Committee
Lambeth, Southwark and Lewisham Local Pharmaceutical Committees (LPCs)
The Chartered Society of Physiotherapy

The following is a summary of the feedback provided across these groups, and also the comments they wished to make on behalf of their members/associates.

Preference for Option A

Stakeholders felt that Option A would deliver a centralised point within Dulwich where a range of different services could be provided. It was also felt that a centralised service would be a sustainable healthcare model, capable of delivering high quality healthcare services to Dulwich residents and facilitating an integrated healthcare service across different channels (for example, social care). South London and Maudsley NHS Foundation Trust felt Option A would be an effective way of delivering the care required by mental health service users and the elderly.

In addition, some stakeholder organisations felt Option A offered the most effective way of delivering preventive healthcare to residents across the area. The Chartered Society of Physiotherapy (CSP), for example, suggested that offering physiotherapy to patients in a health centre would offer a number of

benefits from a preventive healthcare point of view: firstly it would have capacity for classes to be held for the benefit of a number of patients at one time; it would allow the concentration of staff with subspecialist skills; and, if people could self-refer, this would reduce the amount of time individuals would have to wait to see the physiotherapy specialist.

Option A was also felt to be stronger in terms of efficiency of resources and cost. Guy's and St Thomas' NHS Foundation Trust said that Option A was a proven model of delivering sustainable healthcare whilst maintaining high quality standards and successfully integrating care with other providers. With this in mind, Guy's and St Thomas' NHS Foundation Trust suggested that there was scope for any new venture pursued by NHS Southwark CCG to be coordinated with similar community healthcare projects, for example, the recently created medical, dental and leisure centre at West Norwood.

Joined-up care

It was felt that in order to deliver high quality healthcare to the residents of Dulwich and the surrounding area, provision for an integrated healthcare service needed to be made. Stakeholder comments included:

- Inclusion of physiotherapy services in both Options by opening up access to physiotherapy in the healthcare centre and organising exercise classes.
- A comprehensive network of community services working across the boroughs of South London and included in the new healthcare system.
- Co-locating children's centres and adult social care services.
- Developing stronger working relationships with the Southwark and Lambeth Integrated Care programme, and with local beacons, such as the centre of excellence for people with dementia.
- Incorporating wider earlier intervention services such as the early help locality teams.'
- Incorporating overall 'well-being' into the new model of healthcare.
- Including voluntary services in the new model of healthcare.

The response from the Rt Hon Dame Tessa Jowell MP emphasised the need for personalised and tailored healthcare to be provided to pregnant women, and that this was lacking in the area at the moment. As well as considering the location of where these services ought to be delivered, she also stressed that staffing and resource needed to be scrutinised. Community Action Southwark and Healthwatch Southwark also supported this point.

Similarly, some stakeholder organisations felt Option A offered the most effective model of joined-up healthcare of the two Options. The Rt Hon Dame Tessa Jowell MP was amongst those of this opinion, commenting that this Option would reduce the fragmentation of health services across GP practices, allowing GPs to focus on delivering core services to a high standard.

Preference for locally-based care for vulnerable groups

Some stakeholders mentioned the importance of ensuring that maternity care and young family healthcare services were as accessible as possible for mothers and families. Option B, having healthcare services based in local GP practices, was felt to be preferable here.

Others mentioned the importance of ensuring equality of access to care for the elderly, the frail and other vulnerable groups, including those who might face difficulty with transport if Option A were to be pursued. Local Pharmaceutical Committees in particular mentioned the risk that, if the health centre were too far away for people to get to, they might simply dial 999 to ensure they receive medical attention quickly.

Other considerations

- Lambeth Clinical Commissioning Group commented that some further consideration ought to be given to urgent and out-of-hours care, whichever of the proposals were pursued. In addition, Local

Pharmaceutical Committees felt that some space at the health centre ought to be used for minor surgery.

- Community Action Southwark and Healthwatch Southwark asked that the impact on district nursing be taken into account.

4. Conclusions

Through responses to the survey, white mail, petitions and the various meetings arranged by NHS Southwark CCG, a number of themes have emerged where individuals would like reassurance, or for their concerns to be addressed if any of the proposals were to come into being. The following diagram summarises the key themes that may deserve particular attention and consideration by the NHS Southwark CCG consultation project team.

Strong support for the CCG's overall direction, with important caveats about cost and accessibility.

- The vast majority of respondents **support the overall model of delivering healthcare** in the community posited by the consultation document. Most buy into the CCG's 'case for change' too and subscribe to the view that **healthcare needs to be delivered in a more accessible setting in their community**, **rather than in hospital**. However, the CCG must also work to **allay concerns about the cost of delivering these changes and clarify their specific location** - these were key concerns among respondents and doubt or disagreement over these could quickly turn support into opposition.

Option A is preferred to Option B overall, the variable standard of GP services being the driving factor.

- **Option A** in the CCG's proposals is, on balance, the **preferred option among respondents**. Enhanced **quality** of healthcare, improved **availability** of health services and **reduced waiting times** are its key selling points. The main reason for preference over option B is a **worry that certain GP practices would not be able to deliver on the proposals in option B,** either clinically or logistically. However, if option A is to be selected, the motivations of those who chose option B need to be considered - namely that services would be more **accessible** if located closer to home, especially for the **most vulnerable patients**.**GP services are well regarded overall, however, the standard is variable.**

GP services are well regarded overall, however, the standard is variable

- Therefore ,for some, there is a **sensitivity about expanding their GP practice's remit** further for fear that GPs would not be able to deliver that service.**GP practices** are the hub of local healthcare provision - they are the **most commonly used** services and they also often came out as the **preferred location** for services to be delivered. However, there is a **good degree of variation in the experience of GP services across the area**, some are satisfied others less so. A consensus emerged that this variability ought to be addressed irrespective of the Option taken forward.

Concerns about potential fragmentation of care and decrease in quality and accessibility due to the new approach to healthcare delivery need to be allayed.

- Irrespective of the option chosen, there are concerns about the **potential implications of fragmenting services across different points of access** - services need to be joined up across the different channels that a patient might go through during their journey as a result of the changes, and key to this is **different providers communicating with each other**. The key messages that people will respond to are **quality and accessibility** - if they are assured that these will not be compromised, they will support change.

5. Appendices

i) Questionnaire

What do you think of our plans?

The consultation is open from the 28th February until the 1st June. The questionnaire should take around 20 minutes to complete (depending on how many questions you choose to answer). Please answer questions by ticking a box (as directed) or writing your answers in the spaces provided (these are optional).

Responses to this consultation are being received and evaluated by Opinion Leader Research on behalf of NHS Southwark Clinical Commissioning Group. All responses are confidential.

The questionnaire can also be completed online at www.southwarkpct.nhs.uk

If you have any questions about the consultation please contact Sarah Mulcahy on smulcahy@opinionleader.co.uk or Freephone 0808 178 9055.

YOUR DETAILS

BQ1. When you respond to this consultation are you doing so…
PLEASE TICK ONE BOX ONLY

As an individual	1
On behalf of an organisation (PLEASE SPECIFY _____)	2
On behalf of a group of organisations (PLEASE SPECIFY _____)	3

BQ2. Please provide your details below.

Name:

Postcode:

SECTION 1: CURRENT AND PROPOSED HEALTH SERVICES ACROSS DULWICH AND THE SURROUNDING AREA

Question 1. Which, if any, of the following community health services provided by the NHS in Dulwich and the surrounding area have you used in the last 12 months?
PLEASE TICK AS MANY AS APPLY

Services at your GP practice	
Standard GP initial consultation	1
Dressings/post-surgical care	2
Antenatal and maternity care	3
Child immunisations	4
Child health clinics	5
Reproductive health	6
Smoking cessation	7
NHS Health Checks	8
Bowel screening	9
Counselling	10
Physiotherapy	11
Heart failure clinic	12
Outpatient services	13
Services at Dulwich Community Hospital	
Blood taking	14
Physiotherapy	15
Renal dialysis	16
Out-of-hours GP services	17
GP services	18
Bladder and Bowel service	19
Dietetics	20
Parentcraft classes	21
Services at Townley Road and Consort Road Clinics	
District nursing clinics	22
Health visiting clinics	23
Speech and language therapy	24
Foot health	25
School nursing clinics	26
Home-based services	
Health visiting	27
District nursing	28
Intermediate care	29
Adult neuro-rehabilitation (stroke) team	30
Adult community rehabilitation team	31
Other (please specify)	98

Question 2. Thinking about the services that you currently use or anticipate using in the future, where would you prefer to receive those services?
PLEASE TICK ONE BOX FOR EACH SERVICE AS APPROPRIATE

	GP Surgery (1)	**Health Centre (2)**	**No preference** (3)	**Other (please specify) (98)**	**Don't** (99)
1. Standard GP initial consultation	1	2	3	98	9
2. Dressings/post-surgical care	1	2	3	98	9
3. Ante-natal, post-natal and 4. maternity care	1	2	3	98	9
5. Child immunisations	1	2	3	98	9
6. Child health clinics	1	2	3	98	9
7. Reproductive health	1	2	3	98	9
8. Smoking cessation	1	2	3	98	9
9. NHS Health Checks	1	2	3	98	9
10. Bowel screening	1	2	3	98	9
11. Counselling, psychological support, memory clinic	1	2	3	98	9
12. Dietetics	1	2	3	98	9
13. Outpatient services	1	2	3	98	9
14. Blood taking	1	2	3	98	9
15. Physiotherapy	1	2	3	98	9
16. Diabetes care	1	2	3	98	9
17. Parentcraft classes	1	2	3	98	9
~~18.~~ Speech and language therapy	1	2	3	98	9
~~19.~~ Foot health	1	2	3	98	9
20. Adult neuro-rehabilitation (stroke) team	1	2	3	98	9
21. Heart failure services	1	2	3	98	9
22. Chest disease services	1	2	3	98	9
23. Diabetic eye screening	1	2	3	98	9
24. Breast screening	1	2	3	98	9
25. Audiology and hearing aid support	1	2	3	98	9
26. Minor surgery	1	2	3	98	9
27. Complex contraception	1	2	3	98	9
28. Leg ulcer clinics	1	2	3	98	9
29. Alcohol substance and misuse services	1	2	3	98	9

Question 3. Are there any specific health services that you think are needed locally that are not mentioned in this list?
PLEASE WRITE IN YOUR RESPONSE (OPTIONAL)

SECTION 2: HOW WE WANT TO DELIVER HEALTH SERVICES ACROSS DULWICH AND THE SURROUNDING AREA IN THE FUTURE

The population of Dulwich and its surrounding areas has a variety of health needs. These include a high proportion of individuals with long term illnesses, cardiovascular disease and cancer in some wards; and a growing number of older people, expectant mothers and young children. We aim to improve the health of our population by providing the right kinds of care in the right places:

- Ensuring that individuals have access to healthcare advice and diagnostic services at a number of local sites including GP surgeries, pharmacies or at a health centre. This would reduce the length of time people have to wait for treatment and mean that, in many cases they do not need to go to hospital for treatment or advice. (See page 17 for examples)
- Detecting health problems early by improving the availability of screening, immunisation and prevention services in pharmacies, GP surgeries or a health centre, making it more convenient for people to use these services. (See page 18 for examples)
- Providing health services that are closer to home for expectant mothers and young children by providing more services in local community facilities so that care is personalised and tailored to people's needs. (See page 19 for examples)
- Helping older people and people with on-going health conditions to manage them and remain independent by ensuring care is provided in the community and is more joined up. (See pages 20-21 for examples)

Question 4. Overall, to what extent do you agree with this approach, as laid out in our proposals?

PLEASE TICK ONE BOX ONLY

Strongly agree	1
Agree	2
No feelings either way	3
Disagree	4
Strongly disagree	5
Don't know	6

Question 4b. Why do you say that?
PLEASE WRITE IN YOUR RESPONSE (OPTIONAL)

SECTION 3: PROPOSALS FOR THE DIFFERENT WAYS THAT HEALTHCARE SERVICES COULD BE DELIVERED ACROSS DULWICH AND THE SURROUNDING AREA

1. Option A: More services in a health centre and core services from your GP practice
Option A describes a central health centre providing a wide range of health services (which is likely to be located on the existing Dulwich site), and GP surgeries providing core services. This might mean that some GPs will offer fewer services than they currently do. This approach would mean patients could go to their

GP for routine check-ups as normal, and the health centre would provide a much broader range of extra services than are available at present, reducing the need to use local hospitals

Question 5. To what extent do you agree with the proposal for more services in a central health centre and core services being delivered from your GP practice as described in Option A?

PLEASE TICK ONE BOX ONLY

Strongly agree	1
Agree	2
No feelings either way	3
Disagree	4
Strongly disagree	5
Don't know	99

Question 6. How do you think that this proposal might affect the following aspects of healthcare? Please say in each case whether you feel that the proposal would make that aspect of healthcare in Dulwich and the surrounding area better, the same, or worse.

a) The AVAILABILITY of the care you receive would…

PLEASE TICK ONE BOX ONLY

Get better	1
Stay the same	2
Get worse	3
Don't know	99

i) Why do you say that?

PLEASE WRITE IN YOUR RESPONSE (OPTIONAL)

b) PEOPLE'S ABILITY TO GET TO PLACES WHERE healthcare is provided (with more services delivered from a health centre and core services delivered from GPs' surgeries) would...

PLEASE TICK ONE BOX ONLY

Get better	1
Stay the same	2
Get worse	3
Don't know	99

i) Why do you say that?

PLEASE WRITE IN YOUR RESPONSE (OPTIONAL)

c) Is there anything else that should be taken into account when thinking about this proposal?

Option B: More services at your local GP practice or one nearby and a health centre for a smaller range of extra services

Option B would involve the development of a health centre (offering a smaller range of extra services , and which is likely to be on the site of Dulwich Community Hospital) and GP surgeries, some of which would offer a wider range of services.

This approach would mean patients could go to their GP for routine check-ups as normal, either their own or another GP surgery for a much broader range of extra services than are available at present, and a health centre for more specialist services, reducing the need to use local hospitals.

Question 7. To what extent do you agree with the proposal for more health services in GP practices and a health centre with a narrower range of services as described in Option B?

PLEASE TICK ONE BOX ONLY

Strongly agree	1
Agree	2
No feelings either way	3
Disagree	4
Strongly disagree	5
Don't know	99

Question 8. How do you think that this proposal might affect the following aspects of healthcare? Please say in each case whether you feel that the proposal would make that aspect of healthcare in Dulwich and the surrounding area better, the same, or worse.

a) The AVAILABILITY of the care you receive would…

PLEASE TICK ONE BOX ONLY

Get better	1
Stay the same	2
Get worse	3
Don't know	99

i)

b) PEOPLE'S ABILITY TO GET TO PLACES WHERE healthcare is provided (with more services delivered from GP's surgeries and extra services delivered from a health centre) would...

PLEASE TICK ONE BOX ONLY

Get better	1

Stay the same	2
Get worse	3
Don't know	99

i) Why do you say that?
PLEASE WRITE IN YOUR RESPONSE (OPTIONAL)

c) Is there anything else that should be taken into account when thinking about this proposal?

Question 9. Are there any other ways in which health services in Dulwich and the surrounding area should be delivered?
PLEASE WRITE IN YOUR RESPONSE (OPTIONAL)

Question 10. Thinking about the building for the proposed health centre set out in options A and B, which of the following is important to you?

	Very important	Quite important	Not important	Don't know
1. Being open at weekends and early evenings	**1**	**2**	**3**	
2.Access to parking spaces	**1**	**2**	**3**	
3.Access to public transport	**1**	**2**	**3**	
4.Facilities for drop-in health checks (blood pressure machines)	**1**	**2**	**3**	
5.Group space for health workshops	**1**	**2**	**3**	
6.The availability of non-health related advice services (for example, benefits advice)	**1**	**2**	**3**	
7.Healthy café and social space	**1**	**2**	**3**	

SECTION 4: THE CASE FOR CHANGE

Question 11. Below are some statements which summarise the reasons why the proposals for delivering health services in Dulwich and the surrounding area above have been put forward now. For each, please state the extent to which you agree or disagree with them, if at all.

a) Local health services need updating in order to meet local needs.
PLEASE TICK ONE BOX ONLY

Strongly agree	1
Tend to agree	2
Neither agree nor disagree	3
Tend to disagree	4
Strongly disagree	5
Don't know	99

b) Community services need to be close to where people live and have up-to-date facilities, so that hospitals can allocate their resources to treating the seriously ill and specialist resource is more effectively distributed.
PLEASE TICK ONE BOX ONLY

Strongly agree	1
Tend to agree	2
Neither agree nor disagree	3
Tend to disagree	4
Strongly disagree	5
Don't know	99

c) Some local GP practice buildings need improving.
PLEASE TICK ONE BOX ONLY

Strongly agree	1
Tend to agree	2
Neither agree nor disagree	3
Tend to disagree	4
Strongly disagree	5
Don't know	99

SECTION 4: OVERALL VIEWS

Question 12. Is there anything else that you think NHS Southwark Clinical Commissioning Group should take into account when developing their proposals for how services should be delivered locally?
PLEASE WRITE IN YOUR RESPONSE (OPTIONAL)

ii) Summaries of the two deliberative events

Improving Health Services in Dulwich and the Surrounding Areas
30th April 2013, at St. Barnabas Church

The meeting at St Barnabas Church had around 30 attendees from Dulwich and the surrounding area. Attendees from NHS Southwark CCG included Rebecca Scott, Rosemary Watts, Colin Beesting and Malcolm Hines, Chief Financial Officer of Southwark CCG. Dr. Femi Osonuga and Dr. Roger Durston were also present as well as two senior nurses, Barbara Hills, Directorate General Manager, Children's Community Services, and Gwen Kennedy, Director of Client Group Commissioning.

The following is an account based on observations made by Opinion Leader, who attended and recorded the proceedings in their entirety. For the event, a recorder captured the beginning of the meeting, the presentation, the questions asked at the beginning of the event and the Q&A section at the end. An individual from Opinion Leader was present at each of the two tables for the discussions.

The meeting began with an introduction on how the public meeting at St. Barnabas Church fitted into the consultation process and what the overall objective of the consultation was; that being to glean insight from the people in the area on the subject 'Improving Healthcare Services in Dulwich and the Surrounding Area'.

After the presentation, a series of round-table discussions ensued. For the discussion, the room was split out into four tables of groups with a moderator from Verve Communications and a healthcare specialist on each table, who provided points of information and clarification where necessary as the discussions progressed. The discussion was split out into four main themes: primary care, preventive care, young family healthcare; and healthcare for long-term conditions. Each table of participants had fifteen minutes to discuss each topic with their table and the relevant healthcare specialist before rotating and moving onto the remaining three topics. The discussions focused on participants' views on the services proposed; their feelings towards the proposals (Option A and Option B in particular) in the provision of these health services; and additional comments and considerations that ought to be borne in mind when planning healthcare across Dulwich and the surrounding areas in the future.

Key themes from the discussions

1. **System for logging Medical Records**
    a. It was strongly felt that for Option A and Option B, a system to log each patient's medical records across all healthcare services was essential to their success. Individuals stressed the importance of their records being joined up across the potential healthcare centre, hospital, pharmacies and GP surgeries. This would both free GPs up from time-consuming paperwork and allow for safe, quality healthcare services for each patient in the area.

2. **Information on Cost-Saving element of Proposals**
    a. Those at the public meeting felt it was important to understand which option would save more money, as without that information, it was difficult for them to understand why the changes were being made and which one would be more beneficial for the NHS and their area.

3. **How can GP surgeries be expanded to realise Option B?**
    a. A number of tables asked this question, wondering how GP surgeries of different sizes and capacities could possibly accommodate a variety of healthcare services.

4. **Accessibility**
    a. Both Option A and Option B raised concerns around accessibility. Details on this are given below.

Group 1: Primary Care – Dr Roger Durston, GP

Two of the core services most commonly used were blood tests and ultrasound services. Some individuals felt that there was no mention of district nurses and their role in delivering primary care across the area.

Group 2: Prevention – Gwen Kennedy, Nurse and Director of Client Group Commissioning (Southwark CCG)

Some individuals noted that physiotherapy was not included on the list of prevention services.
Another point raised was the question of whether or not GPs would be specialised enough in different areas of healthcare if they are to be responsible for all specialised services in each GP surgery.

This was informed by the 'centre for excellence' model, something that cropped up in a number of tables. The optimum scenario agreed upon by participants was to have a number of GPs with specialised knowledge in specific areas of healthcare, which would cover all healthcare needs in the area.

A suggestion made was to allow GPs or other healthcare professionals to specialise in a particular area of healthcare, and mobilise around the area, from GP surgery to GP surgery. This would allow for them to deliver good quality healthcare and it would also improve accessibility as residents could plan their appointments around times that GPS were visiting their local surgery.

Group 3: Young Family Healthcare – Barbara Hills, Nurse and Directorate General Manager, Children's Community Services (Southwark CCG)

Allergies and audiology services were mentioned by some as missing on the list of services for young family healthcare.

Some felt that family healthcare services, particularly maternity services, should be located in the health centre, as they were very specific services requiring specialist materials/staff.

That said, a number of women felt it was important to have these services locally, so that while pregnant/trying for a baby/using contraception they could develop a rapport with their Doctor and their children would also develop familiarity with their GP.

A number of people mentioned the importance of having fixed, accurate appointment times for children, to ensure that they were not waiting too long.

People also mentioned that, to date, they felt their maternity care/the care received by people they knew was fragmented. This was something they wanted to see changed, as they felt it was important that all healthcare specialists seeing them throughout their pregnancy be aware of their condition and their needs as an individual.

A number of people mentioned the fact that sexual health/contraception services were currently located in a building separate to GP clinics. They felt that this set-up made service users feel uncomfortable, and asked that these services become more integrated, either through GP surgeries or the Health Centre.
At least one person strongly felt these services should be kept separate from other health care services.

Group 4: Long Term Conditions – Dr Femi Osonuga, GP

Opinion was split on whether or not Option A or Option B was more preferable. Option A was appealing as people felt it would free up GP appointments.

It was also felt that Option A might be a more efficient system for keeping joined up records on each patient in the area.

The Centre of Excellence point was raised again here, and whether Option B would allow GPs to become specialised enough to deal with specific areas.

It was felt that it might be appropriate for one healthcare Centre of Excellence to exist for the very old, and one for the very young.

It was mentioned that some services could be facilitated by pharmacies and pharmacists, if proper training was provided. An example given was phlebotomy.

Accessibility was a key concern within this group (and a key theme overall). For the Health Centre, people mentioned that there is currently only one bus that goes there and, despite there being a train station nearby, it was relatively difficult to access the building directly from the train station.

Questions and Answers Section

Attendees then reconvened for a questions and answers session (with each table submitting two questions each). A panel consisting of Southwark CCG representatives and two healthcare specialists, Dr. Femi Osonuga and Dr. Roger Durston answered two questions put forward from each table.

Q1. The fewer people that use hospitals, the more resources will be provided for the local healthcare CCG. Does this mean that healthcare services are more expensive to provide in hospitals than in the community?
A1. In many cases, yes, that is because of the infrastructure, the land and the equipment that hospitals need. Some services need to be in hospitals because of the equipment etc. and they are not the sort of services the CCG looking to move. (Rebecca Scott) Every visit to hospital costs £250; costs for community care visits are substantially less than that. (Malcolm Hines)

Q2. Once the consultation is completed and the CCG has decided what they're going to do, what is the timeline to move on from the decision to the new range of services?
A2. Roughly about three years, although there may be changes in the interim. (Rebecca Scott)

Q3. Is Option B being seriously considered? It seems to be more difficult to manage and implement, it's probably more expensive, and it's possibly less effective.
A3. Option B is being seriously considered. Option B is closer to what is happening at the moment, although not as efficiently. (Dr Roger Durston)

Q4. Is there a GPs collective view on which option could be better? If so, what is it?
A4. No there is not a collective view. (Dr Femi Osonuga)

Q5. Not all GP surgeries are the same size and do not all offer the same range of services. Are things going to get fragmented?
A5. If a GP is providing a service, it is going to be as comprehensive as it can be. With the health centre option, The CCG might be able to have more specialist services coming from the hospital to the health centre. (Dr Femi Osonuga)

Q6. Can we have clarification over what will happen to the land on the Dulwich site?
A6. The CCG talked about maybe needing 30%, perhaps more, of the Dulwich site for a health centre. In relation to the rest of the site, the CCG will be guided by needs of other public sector services first. Government regulations say that use of the site must be offered to public sector bidders first. The council has a consultation on its own planning guidance, which finishes today (the 30th April 2013). This makes mention of the Dulwich site and talks about the potential for health, residential and other mixed use development in the future. There may be scope for the site to be developed into a primary school. This could be part of an overall business case in a few years' time. (Malcolm Hines)

Q7. Are there any other barriers to overcome before the new healthcare services could be realised?
A7. The CCG will have to get planning permissions. The council would have to look at the proposition. (Malcolm Hines)

Q8. Do you agree that the need for absolute clarity between what is done at the GP level, and what is done at the central level and secondly, do you agree that it is adding to the complexity of an already complex system if GPs refer to other GPs for other services?
A8. The CCG is very much listening over the next few weeks to get to a final set of recommendations. This is a time of financial constraints; going forward, the CCG does not expect that to get any easier. The best combination the CCG can get in terms of primary care and a centralised healthcare centre will provide the best long term solution for the Dulwich area. (Malcolm Hines)
The area has had a GP to GP referral system for the best part of 20 years. That seems to have worked well, however as time passed it has become more inefficient. The CCG agrees that clarity and simplification are the goals of the proposals. (Dr Roger Durston)

Improving Health Services in Dulwich and the Surrounding Areas
22 May 2013, at St. Barnabas Church

The meeting at St Barnabas Church had around 20 attendees from Dulwich and the surrounding area. Attendees from NHS Southwark CCG included Rebecca Scott, Rosemary Watts, Colin Beesting and Malcolm Hines, Chief Financial Officer of Southwark CCG. Dr. Femi Osonuga and Dr. Roger Durston were also present.

The following is an account based on observations made by Opinion Leader, who attended and recorded the proceedings in their entirety. For the event, a recorder captured the beginning of the meeting, the presentation, the questions asked at the beginning of the event and the Q&A section at the end. An individual from Opinion Leader was present at each of the two tables for the discussions.

The meeting began with an introduction on how the public meeting at St. Barnabas Church fitted into the consultation process and what the overall objective of the consultation was; that being to glean insight

from the people in the area on the subject 'Improving Healthcare Services in Dulwich and the Surrounding Area'.

Presentation

During the presentation, a number of questions arose. They are listed below along with the answers provided:

1. **Q.** Is this the only public meeting for the consultation? The age demographic is not representative of the Southwark community.
   A. This is the second public meeting. Over the course of the consultation, drop in sessions, patient participation groups, discussions with specific patient groups and other forums for people to give their views have been held.
2. **Q.** What was the age profile at the previous public meeting?
   A. At the other public meeting there was a great spread of ages including young mothers.
3. **Q.** Have the press been invited to public meetings?
   A. The press have not been formally invited, but they are welcome to attend.
4. **Q.** Where will the services be located? Will the Dulwich hospital site be used?
   A. This will be covered in the presentation.
5. **Q.** If services were to be moved from GP centres to a central hub, would that cost more?
   A. No.
6. **Q.** What is the difference in costs between current services and proposed services?
   A. There is a very clear difference in cost between hospital prices for a consultation and the price of a consultation in a local healthcare centre or GP practice. This is why the proposals aim to move primary healthcare to a more community-based location.
7. A number of other questions were asked over the course of the presentation, and participants were asked if they might 'hold their thoughts' and raise them in the group discussions as GPs would be present and better able to answer the question.

These questions included:

Q. What is the rationale for not sending someone to a specialist in a hospital?
Q. If specialists were to operate out of GP practices, would there be space for that? How would the specialist services be organised? GPs would be trained as specialists?
Q. Would it be cheaper to move more GP services to a healthcare centre?

It was pointed out that as the group was composed of older people, it was difficult for them to remember the questions and so it was easier to ask them as the presentation proceeded.

The facilitator explained that there were post-it notepads in the centre of the table for people to write down questions to make sure they remember them. Participants were also informed that there would be an overall Q&A session at the end of the discussion to address any outstanding questions.
For the discussions, the group was split into two tables and discussions took place along four themes; primary healthcare, preventative healthcare, maternity and family healthcare and healthcare for the elderly and those with long term conditions.

Key themes from the discussions

1. A number of people present felt they did not have adequate information to make a judgement on how best to decide between option A and option B for healthcare needs. They felt they needed more information on costs, on how GP surgeries could be expanded to house extra healthcare needs, on how specialists would operate in Option A and Option B to deliver healthcare needs, and so on.

2. A key concern for the group was the inclusion of out-of-hours services as a consideration for primary care services, regardless of whether or not Option A or Option B were chosen.

Primary Care

The rationale behind the proposals

- Some of those in the group questioned why the new proposals to house primary care in the community were being put forward. They were informed by Dr. Osonuga, the GP present at the table that many low risk treatments can be managed in primary care in the local community which would free up time for high risk treatments to be treated at a hospital.

Retaining the Dulwich Hospital Site in its entirety

- Some strongly argued for the entire Dulwich hospital site to be retained for the new healthcare centre, as the bigger the health centre, the better able it would be to meet the needs of the community. It was also strongly felt that if the site or part of the site was lost, it would be extremely difficult to get it back for healthcare services in the community.

Out-of-Hours' Services

- Some felt that in order to ensure sufficient access to primary care via out of hours' services GP's commitment to working out of hours and full hours was necessary. A suggestion made was that more minor primary care procedures could be carried out by nurses or pharmacists, to free up GP time.

Specialist Services

- Some participants mentioned the importance of including diagnostic services and also, ensuring that GPs were sufficiently specialised to deal with more complicated on-going health needs like diabetes.

GP services

- A number of those present felt that they would prefer for primary care to be provided in a GP surgery as they would be more confident that a regular GP would understand their specific health needs and history.

Working towards the ideal healthcare option, rather than option A or B

- Finally, the group asked the CCG to focus on an ideal version of healthcare and to work towards that, rather than trying to orientate a fresh healthcare service around the existing reality/set-up of GP surgeries and the Dulwich Hospital site.

Prevention

Additional services/issues

- On the list of preventive healthcare issues, those present asked for falls clinics, chiropody, sexual health and reproductive health to be included.

Centralised health services

- A strong argument was made by some of the group for housing all healthcare services in a central location, as it was felt that currently, treatment for some services was laborious, as patients had to travel between GPs, Dulwich Hospital and other healthcare locations.

Improving access to and knowledge of preventative healthcare

- The subject of screening for breast cancer was brought up and those present felt that mobile units were not an effective preventive measure. They felt that mobile units spread resources too thinly and that patient choice was being prioritised over the efficiencies of care.

GP working hours

- Again, the subject of consistent, full-time GP working hours was felt to be a key area for ensuring efficient preventive care.

Young Family Healthcare

Accessibility of healthcare

- Some of those present felt that there was a severe lack of resources for expectant mothers. A key issue raised was accessibility of these services, to ensure that mothers did not have to travel too far for their healthcare needs.

Integration of health services

- A criticism that emerged was the feeling that at present, there is a lack of joined up care between GPs and midwives, with little opportunity for the two groups to interact and with the result that there is a lack of clarity over who is responsible for healthcare needs.
    - Some felt that a centralised healthcare centre would be better for this as it would facilitate joined up healthcare, communication between groups and would ensure consistency of care for mother and baby.
    - Others in the group, however, felt that locating young family healthcare in GP surgeries was preferable as this would allow for a relationship to be established between mother and GP, with greater scope for understanding the patient's healthcare history and needs.
    - Continuity of care for mother and baby was mentioned, to prevent healthcare problems emerging. Visits to mother and baby and clear lines of communication between healthcare specialists were felt to be important elements to consider for this group.

Out-of-Hours care

- Out-of-hours access for family planning, contraceptive and sexual health needs was mentioned here and it was felt that STI screening etc. needed to be more accessible.

Long Term Conditions

Integration of health services

- People were positive about communication between social services, pharmacists, and GPs. They felt, however, that care and health needed to be integrated further to ensure joined up care for those with on-going conditions.
- The concept of integrated care was stressed here. People wanted to see a healthcare service that joined up re-enablement, social care, acute hospital care, primary care, preventive care and so on.
    - They questioned how out-of-hours care would be factored in to these conditions and how it could be organised within option A or B to ensure continuity of care.
    - A suggestion made by the group was to include charities' expertise in the delivery of health and social care services to older people or people with long-term conditions. It was felt that the NHS alone would not be able to provide adequate social care and comfort to vulnerable people in the community. Therapy for older people like art and other social/mobility activities were considered key services for ensuring rounded, excellent healthcare for this group.

Option A

- The Betty Alexander Clinic was mentioned a number of times as an example of a facility delivering excellent healthcare services for older people with multiple illnesses, providing a range of treatments in one location.

Option B

- Others, however, felt that having a familiar GP as a first point of contact was an important aspect of healthcare and they did not want to lose that contact.

Additional services/issues

- Of the list of long-term conditions, people mentioned that dementia and respite care should be included. Lung function tests, warfarin services, and having district nurses to come and visit people were also services people wanted to include for elderly residents.
- On the subject of mental health, people felt that it was vital that expert care be provided for young people and other age groups with mental health needs.

Questions and Answers Section

[Not word-for-word responses]

Attendees then reconvened for a questions and answers session. A panel consisting of NHS Southwark CCG representatives and the two clinical leads on this project, Dr. Femi Osonuga and Dr. Roger Durston answered the questions put forward from each table.

Q1. Where will the funding come from to train specialists to work in community care or will it be people from Kings Hospital coming out to clinics? How does this relate to Kings and to the departments that are there already? For example, the physio department, who's going to be using that? Why would you have a duplicate on the Dulwich site?

A1. (Malcolm Hines, CFO of Southwark CCG) In terms of training, NHS Southwark has training for clinical staff. NHS Southwark as clinical commissioning group does not directly employ clinicians; we arrange contracts and services and monitor the quality of services. Our biggest contacts are with Kings, Guys and Slam Mental Health Trust. NHS Southwark is part funding, as are the department of health, various education activities for the hospital-based employees. Also through funding routes comes the training funding for GPs and registrars who move up and become GPs and other specialists. That funding is provided through our contracts and through money from central government for training and research. That provides an on-going stream of people. In terms of the sort of things we are talking about here, there are specialists within the hospital setting, the community setting and the GP family. There are many GPs already who have additional training and specialist interests. NHS Southwark goes out to procure or purchase services from both hospital and GP specialists.

Q1. You imply extra specialism, are you saying you already have that from the GPs? Who's going to do it in future? Who is going to make up these hours?

A1. (Malcolm Hines, CFO of Southwark CCG) I'm saying we have a mixture of skills both within the GP family and within the hospital. It's about us looking and negotiating what we need to provide the pattern of services that you're helping us shape through this consultation. There will not be a one fits all. There will be different patterns.

A1. (Dr. Osonuga) The questions I have - how do we prevent duplication? How do we prevent distortion of services and disjointed services? If anybody needs to have step up care from the clinic, we can easily transfer that to the hospital and from there, if needed, we can transfer to a specialist. In terms of the capacity within primary care, the question should be- where are you going to do that? Most GPs will be part time now, because of the nature of the workforce. We want to provide a joined up care service, a step up service, so if a person visits their GP and needs great specialism, we can easily transfer that person to hospital, to a specialist.

A1. (Dr. Durston) A lot of people coming into General Practice have particular interests. It's different in every place, but what we want to do is make Southwark a place where good clinicians want to work. It's how can we structure ourselves so that good clinicians want to come and work in Southwark rather than Bromley? GPs with an interest in dermatology for example, club together for basic dermatological needs so that consultants, who are expensive, can deal with more complex needs.

Q2. Are there going to be changes to the out-of-hours' services?
A2. (Dr. Osonuga) At the moment, there are a variety of out of hours' services. In Lambeth and Southwark there is a collective of GPs who provide out of hours care with SELDOC. Also the rapid response team for elderly care work over the weekends so that is a 24/7 service and that is new.

Q3. Will there be access to patients' history in out of hours' services?
A3. (Dr. Osonuga) We are trying to develop an IT and computer system to help us share information. One of the drivers for this will be a strong IT system.

Q4. When drafting the proposal and looking at options A and B, how is the Betty Alexander Clinic tied into that?
A4. (Dr. Durston) The Betty Alexander Clinic is a specialist service for the elderly. What they try to do is approach it in a holistic manner. It is a very good example of a clinic that is a very valued service by my patients and by me. I know if I send a patient to The Betty Alexander Clinic I will get the whole person looked at in a sensible joined up manner. As the population gets older in Southwark, quite clearly, we are going to need more of that. We will look closely at Betty Alexander to see how we can deliver that sort of service to the patients of Southwark.

Q5. Is this process actually going to happen?
A5. (Malcolm Hines, CFO of Southwark CCG) Yes absolutely. We are going through a very thorough process of consultation. We are required to by the department of health and we value it. We want to hear people's views. In terms of Dulwich Hospital, we will come back with a write up a full report. We will take that to our Governing Body and from there, we continue with work on our business case. Late 2013, then we will at the earliest opportunity be seeking to get that approval. We're talking to councillors to keep them briefed. From our point of view, everybody's views are vital. In terms of decisions, we hope to get to decision points over the next few months and then work on the business plan during the following months.

Q6. Are you going to be able to go through the business case in a reasonable timeframe?
A6. I think the answer is yes. The council has run a consultation on their Supplementary Planning Document in which the Dulwich hospital is mentioned. The council talks about their future vision for this part of the borough. It talks about the Dulwich hospital site being used for healthcare, and some residential and potentially primary school development. We have had discussions with these people. When we put in a planning application, clearly our interest is to deliver improved healthcare services. As part of that, the council is going to say, 'what are the plans for the rest of the site?' The answer is that we have to offer the rest of the site before it goes to any other purpose, to the rest of the public sector. I'm choosing my words carefully because I have to present a business case that shows we are getting the best value.

Q7. Have GPs been instructed about the message they should have on their telephone?
A7. (Dr. Durston) As it happens, one of the residents in Dulwich checked about half the answering machines in Southwark. General Practice isn't just about GPs; it's about the other staff. An accurate answer phone message does not cost any money. It will save money.
A7. (Malcolm Hines, CFO of Southwark CCG) We have gone back to all practices in the last week and reminded them to check and asked them to have appropriate messages for daytime and for the weekends.

Q8. GP surgeries should have proper services. Some practices are larger than others, how can they all have the same services?
A8. (Dr. Osonuga) I don't think we can settle for this in this day and age. The building should improve access to primary care. How do we improve that access? That is what we are discussing here. How do we address the inequality? Do we have small practices and big practices sending their patients to a health centre or do we find a way to do it within their surgery? Your opinion on that is meant to shape how we make this decision.

Q9. Is anyone taking any notice of that standard of GP premises? Are they monitored? What happens when you see a surgery with consistently poor ratings?
A9. (Malcolm Hines, CFO of Southwark CCG) There are surveys done every couple of years of all premises. Once those are done, there are discussions with the practices. We carry out checks and we are due another check shortly. We do take note of them and take note of issues with premises. NHS quality services rake action of premises being improved over the next couple of years. We now have Care Quality Commission that can visit practices unannounced.

Version 3.0

Improving health services in Dulwich and surrounding areas: Initial Equalities Impact Assessment

Verve Communications

Gemma Novis, Associate Director, July 2013

verve communications

Development Timetable	Date	Responsible Manager
Date of completion – Version 1.0:	28 Feb 2013	Rebecca Scott Programme Director NHS Southwark
Date of Review (Mid-Consultation) – Version 2.0:	13 May 2013	As above
Date of Review (Post-Consultation) - final Version 3.0:	5 July 2013	As above
Proposed Date for Annual Review:	5 July 2014	As above

1. Purpose of our assessment

In February 2013, NHS Southwark[1] commissioned Verve Communications to undertake an independent initial Equalities Impact Assessment (EqIA) of a series of suggested improvements and changes to health services in the Dulwich area of the London Borough of Southwark.

This report represents the opinions of Verve Communications and is our independent advice to the NHS Southwark Clinical Commissioning Group (NHS Southwark CCG) and the Dulwich Programme Board (DPB).

Verve Communications is a specialist company which supports organisational and service change with a particular emphasis on engaging citizens in development of public services, particularly in health and local government. We also work in partnership with the Afiya Trust: a national charity that works to reduce inequalities in health and social care provision.

The author of this report, Gemma Novis, is the former Equality and Diversity Manager for NHS Lewisham where she co-ordinated Equality Impact Assessments in areas such as Urgent Care services and Improved Access to Psychological Therapies. In addition to this work Gemma was a finalist for Community Leader of the Year in the NHS Leadership Awards 2010.

Gemma has recently completed an Equality Analysis of the NHS South East London Commissioning Strategy Plan 2012–2014 and an equalities impact assessment of the proposed NHS SE London 111 Service. Other relevant equalities work undertaken by Verve includes an Equalities Impact Assessment on Shaping the Future of Healthcare in NHS Berkshire and analysis of the effectiveness of the Equalities Delivery System (EDS) for Bromley Healthcare.

The objective of this initial EqIA is to identify potential positive and negative impacts that may result as a consequence of the proposals outlined in the Southwark Clinical Commissing Group (Southwark CCG) consultation document titled: *Improving health services in Dulwich and the surrounding areas - A consultation about local services*, with a particular emphasis on enhancing the local fulfilment of the Public Sector Equality Duties (PSED) within which NHS Southwark CCG has a duty to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Equality Act 2010;
2. Advance equality of opportunity between people who share a protected characteristic and those who do not;
3. Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The focus of this report will be on assessing the potential impact of the proposals to improve health services in Dulwich and the surrounding areas on individual patients and relatives/carers who share one or more of the following nine protected characteristics (in no particular order):

- **Age**
- **Race**
- **Disability**
- **Sex**
- **Sexual Orientation**
- **Religion / Belief**

[1] On 1st April2013 NHS Southwark will cease to exist and its role in commissioning most health services in Southwark will become the responsibility of the NHS Southwark Clinical Commissioning Group (NHS Southwark CCG)

- **Marriage & Civil Partnership**
- **Gender Reassignment**
- **Pregnancy and Maternity**

This Equality Impact Assessment process seeks to align outcomes with the vision of the NHS Southwark CCG as identified in local commissioning plans. The local commissioning plans (the Integrated Plan) seek to deliver the CCG's vision to secure the best possible health outcomes for people in Southwark by ensuring that:

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

The CCG's first Integrated Plan, 2012/13 -2014/15, builds upon the strategic objectives of the most recent commissioning strategy plan for south east London: '*Better for you'* and prioritises action in the seven areas listed below:

- Better outcomes for people with Long Term Conditions
- Supporting more people to stay healthy and prevent ill-health
- Improving patient experience of outpatients and delivering value for money
- Improving rates of early diagnosis and to provide better quality of life for people with cancer and at the end of life
- Improving outcomes for people with mental health needs
- Developing a well-integrated and high quality system of urgent care
- Embedding clinically and cost-effective prescribing across care settings.

2. Description and aims of policy / service (including relevance to equalities)

This assessment considers the proposals set out in the pre-consultation business case for Health services in Dulwich and the surrounding area dated 24 January 2013 which has been formally consulted on since 28 February 2013. The ward areas in the London Borough of Southwark affected by these proposals are:

- College
- East Dulwich
- Nunhead
- Peckham Rye
- South Camberwell
- The Lane
- Village

The overall vision for the future of community based health care in these wards has been encapsulated in the four points below:

1. Ensuring that individuals have access to healthcare advice and diagnostic services at a number of local sites including GP surgeries, pharmacies or at a local health centre. Reducing the length of time people have to wait for treatment and the need to visit the hospital

2. Detecting health problems early by improving the availability of screening, immunisation and prevention services in pharmacies, GP surgeries or a health centre in the locality, making it more convenient for people to use these services.

3. Providing health services that are close to home for expectant mothers and young children and joined up in local community facilities so that care is personalised and tailored to peoples needs

4. Helping people with on-going health conditions to manage them and remain independant by ensuring care is provided in the community and centralised in one place. Providing more joined up care and reducing the need to visit the hospital.

The main aspect of the proposal is to reconfigure the range of current and proposed health services across Dulwich and the surrounding area to meet the diversity of local health needs in a way that can be sustained into the future.

Specifically there are two proposed models for the delivery of community based healthcare services for those living in Dulwich and the surrounding areas:

A. **A centralised model** - which includes the development of a central health centre or 'hub' to provide a wide range of health services, with GP surgeries providing only core GP services (some, perhaps, less than currently).

B. **A networked model** - which includes the development of a health centre or 'hub' (offering a limited range of extra services) and GP surgeries, some of which would offer a wider range of service then they do at present. This approach would mean patients could receive a lot of non-hospital based health services from their GP surgery, or another GP surgery nearby or in a health centre.

In both cases a health centre will be designed and developed to meet local need, keeping in mind the broader vision for community health services as listed above, the only location that has been identified as a possible site for this health centre is the current Dulwich Community Hospital in East Dulwich Ward. Should other options emerge, these will be considered.

The proposals also aim to cause a significant shift in where individuals access services, reducing the need to go into acute settings and instead access services at home, via their GP, via pharmacies and in other community based settings.

3. Brief summary of research and data (relevant to Equalities)

It is important that all providers of community / home based health services give due regard to the differential needs, perceptions and experiences of individuals who share one or more protected characteristics. Most importantly it is necessary for all staff to have an understanding of how they promote and implement dignity and human rights i.e. 'live the spirit of the NHS constitution' in everything they do.

Across disability as a protected characteristic the 'centralised model' presents less immediate barriers in terms of access and continuity of care as individuals care packages will operate across less locations. The individuals will be registered at their choice of GP - one they can access, where there is parking and/or public transport routes that they are familiar with, for example - and then attend the central hub for other healthcare needs. This is particularly relavant for those with learning disability, sensory and/or physical disabilities. The 'centralised model' offers a wider range of services in one location then the networked model. Some older people might also prefer visiting fewer sites for their care and overall the 'centralised model' might be less confusing for them. However, the 'networked model' does present opportunities for services to be closer to where people live more generally and will include elements of patient choice regarding location of services.

Opportunities will emerge with a redevelopment of a new or refurbished building and it is recommended service development takes into account best practice. There is a need for ongoing organisational commitment to 'plan-in' access and communication for those who share protected characteristics. For example, maximising physical access for those who use mobility aids (i.e. disabled people, older people, people with long term conditions), having clear signage for people with learning and / or sensory disabilities and also ensuring staff within the improved service / buildings are trained and aware of their responsibilities to fulfil the requirements of the public sector equality duty.

Other planning might include ensuring spaces for family / carers to wait in comfort and with appropriate support, acknowledging religion / belief and a commitment to ensure dignity for service users at all times. The current proposals present opportunities to plan-in mental health, for example linking up with national programmes like '*Dementia Friendly Communities'* which can attract additional investment and foster good relations between those who have dementia and those who do not.

Regardless of which model is implemented it is recommended that older and disabled people are invited to inform the planning and design process for the new health hub and other sites that might be developed from the outset. Overall the proposed development of a new health hub holds opportunities to build social networks for local people; design services in a way that contributes positively to people's mental and physical health and enable individuals in the community to make connections with others that they would not normally come into contact with[2]. This contributes to the local fulfillment of the Public Sector Equality Duty to foster good relations.

Of the nine protected characteristics the following four hold particular vulnerabilites and thus have a greater need for specific assurances to be in place during the proposed service reconfiguration process:

Age - specifically ensuring positive health and wellbeing outcomes for older people in terms of patients and their carers. There is a growing population of older people across the borough generally and the diversity of older adults needs to be considered in a range of areas, e.g. relationships with staff; accessibility of buildings; accessibility and cost of transport and overall experience of local healthcare. It is also important to 'design out' isolation of older people as this is known to be a major factor leading to common mental illness in this age group.

Race - especially those who have specific cultural needs as well as past experiences of discrimination/receiving less than best care. In general Black, Asian and Minority Ethnic (BAME) patients with long term conditions may be younger than their white counterparts; this is due to prevalence of some health conditions like stroke and dementia occurring at younger age, especially in Black Caribbean / African communities. Needs assessments of the BAME community in the locality should continue to be incorporated into commissioning decisions.

Disability (inc. Long-term Conditions & Mental Health) – it is important to consider how the needs of individuals with Physical, Learning and/or Sensory disabilities are met across services. It is also crucial to consider the roles and needs of carers and this can be scoped into either proposal e.g. support and advice for those in a caring role. There is a high need to improve the quality of healthcare in the locality to better support people with Long-term conditions. It is known that there are many people with long term conditions (for example, hypertension, diabetes, coronary heart disease and chronic obstructive pulmonary disease) who are undiagnosed and/or not placed on disease registers. There are also great variations between GP practices in the extent to which they identify and treat their patients with long term conditions.[3]

[2] Morris, D and Gilchrist, A (2011). Communities connected: Inclusion, participation and common purpose. RSA, London.

[3] The Annual Report of the Southwark Director of Public Health, 2010

Pregnancy and maternity - it is important to take into account the diversity of women who become pregnant and require local maternity services e.g consider needs by ethnicity, age, sexual orientation and religion / belief. It is also important to support those who care for them - whether partners, guardians or next of kin. It is therefore a recommendation to consider more of the detail of service delivery and quality within the proposed reconfiguration (which should have a positive impact overall if specific and cross cutting assurances are in place). It is a recommendation that some 'mystery shopping' take place in elements of the ante-natal and post-natal services, particularly by women who identify as lesbian / bisexual, teenage mothers and those who are Black or Asian and speak English as a second language.

More generally this report has also recommended some reasonable adjustments to support improvements to service delivery for those who share one or more of the remaining five protected characteristics:

Sexual Orientation - specifically ensuring that sites are delivering to equally high standards in terms of service quality for individuals and their relatives who identify as Lesbian, Gay or Bisexual (LGB), including the provision of adequate training for all staff. Little is known about the local LGB population so providers will need to be monitored on their delivery of quality services to this group.

Gender Reassignment - As above

Sex - it is recommended that efforts be made to engage more men of working age in the formal public consultation process to inform how these proposals can encourage more men to understand and use community health services.

Religion and belief - steps have already been taken to encourage faith groups to engage in the formal public consultation process. Responses will need to be analysed by religion & belief to better inform local developments and service delivery, particularly in terms of minority religious and belief groups

Marriage and Civil Partnership - specifically in terms of staff being aware of the equal legal rights of those who are married and those same sex couples who have a civil partnership (e.g. information sharing, visiting, involvement in care planning etc).

4. Methods and outcome of research, involvement and consultation

This initial Equality Impact Assessment has drawn insight from a range of sources including but not limited to:

National and regional research led by relevant organisations and public bodies such as:

- Age UK
- Better Health UK
- Department of Health
- Equality & Human Rights Commission.
- Joseph Rowntree Foundation
- Men's Health Forum
- MENCAP
- NHS Southwark / Southwark Clinical Commissioning Group
- Princess Royal Trust for Carers
- Southwark Lesbian, Gay, Bisexual & Trans Network
- Stonewall
- Women's Resource Centre

Local demographic data relevant to the proposals to improve health services in Dulwich and the surrounding areas has been utilised, as well as local key documentation as detailed in the table below:

Key Documentation	Publication Date
Improving Health Services in Dulwich and the Surrounding Areas Consultation Report (prepared by Opinion Leader)	5 July 2013
Draft Consultation Document - Improving Health Services for Dulwich and the surrounding areas	1 Feb 2013
Health services in the Dulwich area - Pre-Consultation Business Case	24 Jan 2013
NHS South East London 111 Service - Equality Impact Assessment	1 Nov 2012
Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG	Sept 2012
Dulwich Locality Health Profile: NHS Southwark Public Health Intelligence Team	July 2012
Report of an Equality analysis of the NHS South East London Commissioning Strategy Plan 2012/13 - 2013/14	1 Mar 2012

Between 8th February and 11 May 2012 NHS Southwark undertook a three month engagment exercise - Developing Health Services in the Dulwich Area. This engagement exercise enabled commmunity and health partners, clinicians and staff to share their perspectove on the development of proposals for the commissioning of health services in the Dulwich area into the future.

Engagement activities included:

- ✓ Surveys distributed in paper and online formats
- ✓ Community road shows
- ✓ Drop-in sessions in the locality for informal one-to-one discussions
- ✓ Discussions with existing patient and public participation groups
- ✓ Presentations to the Community Councils of Dulwich, Camberwell, Peckham and Nunhead
- ✓ Semi-structured discussions with community groups
- ✓ Semi-structured discussions with service users individually and in groups
- ✓ Briefings to partner organisations, local Members of Parliament and Councillors
- ✓ Direct work with local media and specifically those publications that are delivered to every household locally.

All of the above activities have enabled the set of proposals for health services in the Dulwich Area to be developed and NHS Southwark CCG have taken these proposals to formal public consultation. Stakeholder engagement activities have continued and the following promoted the formal public consultation process among those they represent:

- Members of NHS staff within local providers
- Local GP's and other clinicians
- Local politicians (Council, Assembly and MPs) and local authority partners
- Community and voluntary sector organisations
- Home and neighbouring Health Overview & Scrutiny Committees
- Relevant Boards and Committees.

Between 20th February – 1st June 2013 residents and individuals that received healthcare in Dulwich, Nunhead, Herne Hill, south Camberwell and south Peckham areas were invited to participate in a 13-week formal consultation process. The number of individuals who participated in the process are detailed below:

- An estimated 667 people attended public meetings
- 568 people engaged in discussion meetings and events organised by NHS Southwark CCG
- 209 people responded to the formal consultation questionnaire
- 6 letters or emails were received from members of the public commenting on the proposals
- 14 stakeholder organisations sent in a written response
- 60 people attended round-table public events

All of the results of the engagement activities are described in the *"Improving Health Services in Dulwich & the Surrounding Areas Consultation Report*" prepared by Opinion Leader, dated 4th July 2013. Some of the feedback can also be found in Appendix One, the evidence section, from Page 20 of this Initial Equality Impact Assessment document.

5. Results of Initial Equality Impact Assessment – Summary Impact Tables

KEY FOR TABLES

Green Positive impact subject to specific assurances and reasonable adjustments being in place, including governance to report on their fulfilment. No additional research or engagement required.

Yellow Positive impact subject to specific assurances and reasonable adjustments being in place, including governance to report on their fulfilment and additional engagement efforts required if proposal goes ahead as planned or with changes

Orange Full Impact unknown. Further engagement with individuals who share the identified characteristic and / or population of focus recommended.

Red Negative. Proposal does not fulfill the legal requirement of the public sector equality duty.

Table 1A: Summary impact table of proposals as considered prior to and within the Formal Public Consultation Process dated 28th February – 1st June 2013

Service Element	Age	Race	Sex	Sexual Orientation	Marriage & Civil Partnership	Disability (inc. Mental Health & Learning Disabilities)	Religion & Belief	Gender Reassignment	Pregnancy & Maternity
Centralised Model	**Older people	**BAME	**Men	**LGB	*	*	*	*	*
Networked Model	**Older people	**BAME	**Men	**LGB	*	*	*	*	*
Improvements to ante and post-natal services	*	**BAME Women	*	**Lesbian or Bisexual Women	*	*	*	*	*
Development of Health Hub	*	*	*	*	*	*	*		*

**Positive Impact subject to specific and cross-cutting assurances being in place – see reasonable adjustments*

***Where a population of focus is identified this means the whole population who shares that characteristic in all their diversity e.g. Some older people might also have a disability, identify as Lesbian, Gay or Bisexual and be Black, Asian or from a minority ethnic group. It is important to seek to understand the different needs for the diversity of the population of focus.*

Table 1B: Summary impact table of proposals as assessed after the Formal Public Consultation Process and prior to the Implementation Phase

Service Element	Age	Race	Sex	Sexual Orientation	Marriage & Civil Partnership	Disability (inc. Mental Health, Sensory, Physical & Learning Disabilities)	Religion & Belief	Gender Reassignment	Pregnancy & Maternity
Centralised Model	**Older people	*	*	*	*	*	*	*	*
Networked Model	**Older people	*	*	*	*	*	*	*	*
Improvements to ante and post-natal services	** Teenage Mothers	*BAME Women	*	** Lesbian & Bisexual Women	*	*	*	*	*
Development of Health Hub	**Older People	*	*	*	*	*	*	*	*

**Positive Impact subject to specific and cross-cutting assurances being in place – see reasonable adjustments*

*** Where a population of focus is identified this means the whole population who shares that characteristic in all their diversity e.g. Some older people might also have a disability, identify as LGB and be Black, Asian or from a minority ethnic group so it is important to seek to understand the different needs for the diversity of Older People*

6. Decisions and Recommendations

Do the proposals breach equalities legislation?
No, however assurances must remain in place and all agreed actions be implemented with care and due diligence
Do the proposals prevent discrimination or inequality?
Yes - with assurances in place and as reasonable adjustments take place
Do the proposals promote equality and foster good relations?
Yes - with assurances in place and as reasonable adjustments take place

On the basis of this impact assessment the following recommendations are proposed:

If the proposal goes ahead *without any changes* this EqIA proposes the following recommendations:

To make the reasonable adjustments outlined in this document and to add further adjustments as the programme progresses. Some opportunities exist to maximise positive impacts for individuals and groups and this outcome should be strongly sought after for all service users and theose that care for them.

If the proposal goes ahead *with some changes* this EqIA proposes the following recommendations:

To review this EqIA in view of the proposed changes in terms of reasonable adjustments to ensure all foreseeable and potential negative impacts to the local population are mitigated. Any review of this EqIA needs to be completed with involvement from staff and service users / service user representatives, particularly staff and service users who share protected characteristics (identified in this EqIA screening).

7. Reasonable Adjustments to Promote Equality, Value Diversity and Protect Human Rights

The tables below list the recommended reasonable adjustments that can be considered for the formal consultation phase (Table 2) and those for Implementation for which the Dulwich Programme Board are responsible (Table 3). Some further reasonable adjustments / assurances have been listed that fall within the responsibility of Southwark Clinical Commissioning Group (Table 4).

Table 2: Reasonable Adjustments for the Formal Public Consultation

Ref:	Protected Characteristic	Function	Recommendations for Formal Public Consultation Phase	Status: Complete / Scheduled / Under Discussion
1	Disability / Age	Accessibility	Check issues that emerge regarding access, transport and building redesign to ensure all those relevant to access for disabled people are mitigated in terms of the new development	Complete
2	All	Equality Impact Assessment / Public Sector Equality Duty	Revisit this Equality Impact Assessment Report after the formal public consultation has been completed as findings will enable a second phase of assessment to take place which will include more detailed perspective from the local population across protected groups	Complete
3	Sexual Orientation	Formal Consultation	Invite national / regional organisations that represent those who identify as Lesbian, Gay or Bisexual to share their view within the formal consultation process.	Complete
4	All	Formal Public Consultation	To encourage responses from those who have a long-term health condition, in particular to seek their perspective of what needs to be in place to achieve best quality community based health care services	Complete
5	Sexual Orientation	Formal Public Consultation	To encourage lesbian, gay and bisexual people to attend local public consultation events, and collect monitoring data to enable robust analysis to take place to better meet their needs	Complete
6	Age / Disability / Race / Sexual Orientation / Religion & Belief	Formal Public Consultation	Encourage older people, disabled people, pregnant women and carers to engage with the formal consultation process – particularly those from BAME communities, who identify as Lesbian, Gay or Bisexual and who experience low income (who all face additional barriers when accessing services) in a way that is representative of local demographics	Complete
7	Gender Re-assignment	Formal Public Consultation	Invite regional or national organisations who might represent individuals who are / have undergone gender reassignment to share their perspective within the formal consultation process	Complete
8	Carers	Formal Public Consultation	To seek experiences from those who currently care for individuals who have / are using local health services and explore further what should be in place to support their changing needs, including a check on local support services and their ability to cater for an increase in demand	Complete

Ref:	Protected Characteristic	Function	Recommendations for Formal Public Consultation Phase	Status: Complete / Scheduled / Under Discussion
9	Pregnancy & Maternity / Race	Formal Public Consultation	To seek experiences from women who care for very young children via support of local services to seek their views and experience regarding choice, service quality, and other aspects of their care. Ensure representation of women from BAME communities, those with disabilities, and include those who live furthest away from hospital-based services.	Complete
10	Disability / Age/ Socio-Economic	Formal Public Consultation	To seek experiences from individuals in terms of public transport requirement with a particular focus on encouraging participation from disabled people, older people with mobility needs, those from areas of high economic deprivation and those families with young children without access to a vehicle.	Complete
11	Sex	Formal Public Consultation	Actively encourage men of working age to participate in the formal public consultation process through a range of methods	Complete
12	Sexual Orientation	Monitoring & Evaluation	To collect data regarding sexual orientation of respondents to the formal consultation process, or take steps to invite national / regional organisations that represent those who identify as Lesbian, Gay or Bisexual to share their view within the formal consultation process.	Complete

Table 3: Reasonable Adjustments for the Implementation Phase (Responsibility of the Dulwich Programme Board)

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / To be Scheduled / Under Discussion
13	Disability / Age	Access Audit	Involve older and disabled people themselves in the design / planning for new and modern facilities to ensure full accessibility from the outset	To be scheduled
14	All	Communication	To seek to improve the way information is made available to the public, taking into account diversity and difference. To continue to make use of varied communication methods to ensure messages are communicated clearly, in good time and in a way that is appropriate to audience	On-Going
15	All	Communication	Clear communication with service users about building changes throughout the redevelopment process at the Dulwich Community Hospital site	To be scheduled
16	All / Sexual Orientation / Religion & Belief	Communication & Community Engagement	Seek opportunities to fulfil requirements of the public sector equality duty throughout the redevelopment process. In particular to foster good relations e.g. create a service that maximises social capital and promote the service to various religion/belief groups, and to individuals who identify as lesbian, gay and bisexual.	To be scheduled
17	Disability / Race / Religion & Belief	Communication / Community Engagement	To involve local people in developing effective and appropriate communication tools, for example the 'Speaking Up' group to better reach and support those with learning disability, and faith groups to build local understanding and partnerships	To be scheduled
18	All	Service Audit	To conduct a local service audit of organisations which already exist that can support integrated approaches to community based healthcare	Under Discussion
19	Age / Disability	Service Development	Consider how to link local development with national programme of creating Dementia Friendly Communities	Under Discussion
20	Disability	Transport Audit	To involve disabled people themselves to test transport routes from potential hot spots	To be scheduled
21	Age - Older People / Disability	Transport Audit	To hold a focus group on transport experiences and requirements, with a particular focus on encouraging participation from disabled people, older people with mobility needs, those from areas of high economic deprivation and those families with young children without access to a vehicle.	To be scheduled

Table 4: Reasonable Adjustments for the Implementation Phase (Wider Responsibilities of NHS Southwark Clinical Commissioning Group)

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / Scheduled / Under Discussion	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
22	Sex	Access / Service Development	Address men's historic under-use of GPs, pharmacies, smoking cessation, weight management services and health trainers throughout the local service improvement plans	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
23	Carers	Commissioning	Continued support for carers and the organisations that provide support services for them (working with Local Authority)	Scheduled- in Operating Plan	See Appendix Two for further information about wider NHS Southwark CCG activities
24	All	Commissioning	Rigorous monitoring and evaluation of local health system to test outcomes for those who do and do not share protected characteristics e.g. patient experience, service quality, reducing health inequalities etc	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
25	All / Older people	Commissioning	Use opportunities to promote and protect human rights in the way that services are commissioned, procured and monitored. In particular those services that are to be delivered in peoples own homes	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
26	Sex	Commissioning	Embed improving men's health and tackling gender equalities into the commissioning process.	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
27	Race / Sexual Orientation / Religion & Belief / Disability	Community Engagement	Community engagement to continue with a focus on individuals / groups / representatives of those who share protected characteristics, with a particular focus on finding and responding to the needs of new and transient BAME communities, the LGB population and to continue the community engagement/partnership work with local faith groups	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
28	All	Community Engagement	Explore avenues to enable continuous feedback from those who share or represent those who share protected characteristics throughout the implementation of the programme (e.g. establish an Equality Reference Group or something similar)	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / Scheduled / Under Discussion	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
29	All	Equality Impact Assessment	Whilst this assessment focuses on service users and the general population, it is recommended that an assessment of impacts of NHS staff should take place once the final changes are agreed following the formal public consultation in 2013.	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
30	All	Monitoring & Evaluation	Providers to continue to be required to provide monitoring data across the protected characteristics to enable robust monitoring of access and appropriate/responsive services to take place (in partial fulfilment of the local Equality Delivery System)	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
31	Sexual Orientation	Monitoring & Evaluation	Continue to monitor the sexual orientation of service users to increase local intelligence of how accessible, appropriate and responsive local services are for those who identify as lesbian, gay or bisexual.	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
32	All	Public Health	Seek to influence a refresh of the Joint Strategic Needs Assessment and ensure it assesses local health needs by protected characteristics (as relevant) as this will assist future Equality Impact Assessment Processes. Continue local Health Needs Assessments to look into differing needs of service users taking into account protected characteristics and commissioners to take proactive steps to address the diversity of needs.	Under discussion – Public Health now in LA	See Appendix Two for further information about wider NHS Southwark CCG activities
33	All	Public Sector Equality Duty	All providers to fulfill requirements of the Public Sector Equality Duty, CQC criteria and local NHS Equality Delivery Systems	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
34	All	Public Sector Equality Duty	Providers to ensure all staff comply with Equality and diversity practice and policies, as well as adhere to the spirit of the NHS Constitution	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
35	Dignity & Human Rights	Public Sector Equality Duty	All staff are trained on the principles of human rights - fairness, respect, equality, dignity and autonomy	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities

Ref.	Protected Characteristic	Function	Recommendations for Implementation Phase	Status: Complete / Scheduled / Under Discussion	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
36	Sexual Orientation / Marriage & Civil Partnership	Public Sector Equality Duty	To ensure all staff are aware that those who are married and those who have civil partnerships share the same legal rights and that all relevant policies regarding staff and service users reflect this recent legislative change. This might affect change to local guidelines regarding 'next of kin', visiting guidelines, attendance to appointments etc.	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
37	All	Public Sector Equality Duty	Human Rights/implementation of the NHS Constitution to be integral to providing high quality care within patients own homes for groups including: older people; people with mental health conditions; BAME groups (including recognition of cultural diversity); offering adequate support for carers (e.g. family or friends); protecting the rights of those who are lesbian, gay or bisexual in civil partnerships (equal rights of those who are married)	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
38	All	Public Sector Equality Duty	Equality, Diversity and Human Rights training will continue for all NHS staff (commissioners and providers have a policy in place)	Complete	See Appendix Two for further information about wider NHS Southwark CCG activities
39	All	Public Sector Equality Duty	Formal Public Consultation results to inform PSED objectives 2013-15	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
40	Gender Reassignment	Research / Commissioning	Commission local research on the health needs/ service requirements for those who have gone through / are considering gender reassignment	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
41	Pregnancy & Maternity / Race	Service Development	To revisit service provision as local demand increases in line with increasing birth projections.	Under discussion	See Appendix Two for further information about wider NHS Southwark CCG activities
42	Pregnancy & Maternity / Sexual orientation / Race	Service Development	Service to invite 'mystery shoppers' to visit providers of local maternity (Ante and post natal) services. In particular young single mothers, those who identify as being lesbian or bisexual and also BAME	Under Discussion	See Appendix Two for further information about wider NHS Southwark CCG activities

8. Monitoring and Review Arrangements (including date of next full review)

This Equality Impact Assessment process will run until mid-June 2013 in 3 stages:

1. Initial draft of an EqIA report to consolidate current understanding / intention and be made publically available via the website on 28th February 2013 and provide a list of Reasonable Adjustments to inform the Formal Public Consultation Process.
2. To seek further understanding of communities via the Formal Public Consultation process which has been designed to maximise local fulfilment of the Public Sector Equality Duties (some of the reasonable adjustments to enhance the consultation process for equalities are listed in this assessment report)
3. To refresh this full Equality Impact Assessment report in view of the deeper understanding gained through the formal public consultation process and recommend a long-list of reasonable adjustments to inform the implementation of improvements to healthcare in Dulwich and the surrounding areas.

This Equality Impact Assessment Report will be reassessed once a decision has been made regarding the final and agreed plans for improving healthcare in Dulwich and the surrounding areas and reviewed annually there after.

Agreed reasonable adjustments will be integrated into the local implementation plan which will be monitored by the Dulwich Programme Board and NHS Southwark Clinical Commissioning Group.

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Appendix One: Full Impact Assessment Evidence and Key Issues

This section presents a range of evidence, including but not limited to local demographic and population data; anecdotal evidence; findings in national and regional research and comments recieved from individuals and groups during local community engagement activity in a way that highlights some key factors relating to each protected characteristic as well as infomration regarding 'Dignity & Human Rights' and 'Supporting Carers'. It should be noted here that this section is not 'fixed' and will be added to / amended as new findings emerge. The current evidence is presented in the following order:

1. **Age**
2. **Sex**
3. **Race**
4. **Disability**
5. **Sexual Orientation**
6. **Gender Reassignment**
7. **Religion & Belief**
8. **Marriage & Civil Partnership**
9. **Maternity & Pregnancy**
10. **Dignity & Human Rights**
11. **Carers**

In July 2012 the Dulwich Locality Health Profile provided the following key headlines regarding local health and wellbeing data which have underpinned the proposals to improve healthcare for the population in Dulwich and the surrounding areas:

1. Early (under 75 years) death rates are particularly high in Nunhead ward. For males, early death rates are also high in The Lane. Early deaths rates in all other wards (College, East Dulwich, Peckham Rye, South Camberwell, Village) are not significantly different to the England average.
2. The early death rate from cardiovascular disease is higher than the England average in the North East of the area – towards Nunhead, Peckham Rye and The Lane.
3. Early death rate from cancer is high in two wards – Nunhead and College.
4. As elsewhere in the borough, there are people with long term conditions (for example, hypertension, diabetes, coronary heart disease and chronic obstructive pulmonary disease) who are undiagnosed and/or not placed on GP disease registers.
5. As elsewhere in the borough, there is great variation between GP practices in the extent to which they identify and treat their patients with long term conditions.
6. Between 2002 and 2009, there has been an increase in the birth rate in the East Dulwich ward.
7. In Southwark, there is projected to be an increase in the number and proportion of older people (65 years and older) living in the borough.

In 2012 Southwark Clinical Commissioning Group completed a pre-consultation engagement exercise to inform the current proposals. Of the 157 survey respondents (which make up approximately one third of those engaged in the exercise), 21% of respondents chose not to answer the questions about themselves such as their age, sex, ethnicity etc. The sharing of personal information in this way enables a more robust local analysis to take place which in turn offers opportunities for the local health system to futher remove barriers in access to high quality health care whilst the respondants remain anonymous. The Formal Public Consultation Process

from 28th February – 1st June 2013 encouraged further Personal Information Sharing and the evidence in this section will incorporate statistical data arising from this process where relevant.

1. Age

Emerging data from the 2011 census states that the London Borough of Southwark has a population of 288,283. In 2009 there were 29,700 older people in Southwark, which is 10.4% of the population, lower than London (13.7%) or England (19.3%). By 2020 numbers of older people are predicted to increase by just over 8%, a slower rate of increase than Southwark's population overall. According to 2007 ethnicity estimates, 68.5% of Southwark's older people are 'White British', a greater proportion than Adults (51.7%) and Children (46.5%), but a smaller proportion than older people in London (72%) or England (91.8%). All 'White' ethnicities make up 80.4% of the older population. 'Black' ethnicities make up 14%, and of these 9.2% are 'Black Caribbean,' which contrasts with Adults and Children where 'Black African' is the largest Black ethnic group.

The Dulwich Locality Health profile dated 2006 highlighted that:

- The projected resident population for Dulwich in 2006 is 70,187, making it a similar size to Borough & Walworth locality.
- 18.8% of the population are under 15 years of age and 9.6% of its' residents are 65 years or over.
- Like most of London, Dulwich locality has a large young adult population (25-44 years), which is very different from the national age structure.
- Compared to Southwark, Dulwich locality has fewer people in their twenties, fewer babies and toddlers (0-4 years) but slightly more females in their thirties and early forties. However this varies greatly by ward.

Since 2001 the population of the Dulwich Community Council area and the Nunhead & Peckham Rye Community Council area has increased, most of the increase has been due to more babies being born in Nunhead & Peckham Rye Community Council area than people moving into the area. The Southwark JSNA lists the following evidence regarding need amongst older people in the locality:

- About 9% of people in Southwark are over 65 years, and 81% of these are from white ethnic groups.
- Death rates have been reducing for the past twenty years and life expectancy at 65 in Southwark exceeds that for London and England. However this masks wide inequalities within the borough.
- Long term conditions and dementia are more prevalent in older people, and many are not recognised by general practitioners, for example under half of people with dementia are known to GPs.
- Just under a third of older people used their Accident & Emergency department at least once in 2010, and also make up a high number of emergency admissions, the likelihood of emergency admission rising with age.
- Most people wish to remain independent in their own homes for as long as possible. This is made more difficult because 11% of older people in Southwark live in homes hazardous to health (cold, damp and fire risk) and 12% live in non decent homes. There are long waiting lists for making minor adaptations to older people's home in order to prolong independent living.
- Older people will remain the highest users of health and social care.

In general terms older people can be marginalised in society, and older people from BAME communities can face additional barriers to appropriate and effective services. Some of these barriers are specific to older people with mental health problems, others to the particular circumstances of minority groups. For instance, some older people from BAME groups have specific communication difficulties that limit the usefulness of written material in their own language. In addition, the higher risks of physical and mental health problems among specific ethnic and cultural groups requires more and seamless packages of care that address service users' needs holistically.

It has been estimated that 4.6 per cent of people over 75 are deafblind, a group that faces particular barriers in terms of access to information and involvement in social activities (Sense, 2008). This figure may be a significant under-representation as it excludes adults with profound learning disabilities or multiple disabilities and older people in nursing homes. This reminds us that many older people will have more than one disability or long-term condition and that there will be interplay between these 'multiple conditions'. People with learning disabilities experience higher rates of dementia (King, 2004); some of those with dementia will also be deaf (according to research by Professor Alys Young;); and so on. (Joseph Rowntree Foundation, 2010).

In their report, Close to Home (2011) the Equality and Human Rights Commission drew the following key conclusions from the inquiry evidence which can inform the delivery and design of local healthcare which is delivered in peoples homes:

> *"Many older people are very happy with the home care service they receive and value the autonomy it gives them to carry on living the lives they want. However there were many instances of home care where human rights were breached or put at risk because of the way care was delivered. Many of these problems could be resolved by local authorities using opportunities to promote and protect older people's human rights in the way they commission home care and the way they procure and monitor home care contracts. Older people are very reluctant to make complaints, even when they are aware of how to do so. Therefore more sophisticated ways are needed to create an easy dialogue and flow of information between older people and the services that support them so that any threats to human rights can be picked up and resolved as early as possible."*

In the 2012 pre-consultation engagement exercise all ages from 24 to 85 were well represented. There were some responses from people who were aged below 24, although that age group are less likely to be regular users of health services. As well as managing long term conditions including mental health (especially depression and dementia) respondants through this engagement activity felt that as part of managing services for older people, having audiology testing, hearing aid support and batteries available was important. Within the 2013 formal public consultation process 31% of participants were aged over 55 with more than half of this being aged 65 and older. Some participants aged over 60 highlighted a desire to have sexual health services in community settings and noted the reported increase in STIs among older people (Opinion Leader, 2013).

References for the protected characteristic of Age:

1. EHRC (2011) Close to Home: An inquiry into older people and human rights in home care. Equality & human Rights Commission
2. Joseph Rowntree Foundation (October 2010) Equality and diversity and older people with high support needs (contains an annotated list of national and regional organisations from which NHS can seek advice as part of informing decision making processes)
3. National Council on Ageing and Older People (2006) health and Social services for older people. Consulting older people with mental health problems on health and social services: A survey of service use, experience and needs
4. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG.

5. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG
6. The Princess Royal Trust for Carers (2011) Always on call, always concerned: A survey of the experiences of older carers

2. Sex (Male or Female)

Just over half 51.8% of residents in the Dulwich locality are female. (Southwark PCT 2006) however during the 2012 pre-consultation engagement exercise 79% of the survey respondents were women, a characteristic possibly explained by the very high interest in antenatal care, maternity services, and services covering the first year of life. The disproportionate level of engagement in the pre-consultation could also be symptomatic of men not utilising community based health services more generally. In their policy briefing paper for National Men's Health Week in 2009 the Men's Health Forum reported:

"In Great Britain, men visit their GP 20% less frequently than women. The difference in usage is most marked for the 16-44 age group – women of this age are more than twice as likely to use services as men. Women have higher consultation rates for a wide range of illnesses, so the gender differences cannot be explained simply by their need for contraceptive and pregnancy care.

Men, especially young men, are much less likely than women to have regular dental check-ups or to use community pharmacies as a source of advice and information about health. Just 10% of NHS community contraception service users are male.

NHS smoking cessation programmes are less well used by men than women and the same is true of NHS and commercial weight management services, health trainers and of disease-specific helplines run by third sector organisations. Male uptake was markedly lower than female uptake in the pilot programmes for the NHS Bowel Cancer Screening Programme.

Men's reluctance to seek help is an underlying cause of their poor use of primary health services. This is a result of the way men are brought up to behave. Men are not supposed to admit to personal problems, weakness or vulnerability. Embarassment leads many men to delay seeking help with prostate disease (intimate examinations are perceived as a particular threat to the male image) and many want to appear strong, independent and in control in front of a male GP. As a consequence, men often wait until they are in considerable pain or are convinced they have a serious problem.

Men's unwillingness to seek help is reinforced by a number of practical barriers, including the demands of long working hours and problems with accessing primary care services near the workplace. Anecdotal evidence suggests that some men are deterred by a perception that GP and pharmacy services are aimed mainly at women and children and feel like 'feminised' spaces.

Lack of familiarity with the health system may also be a factor. Women are much more likely to use health services routinely – for contraception, cervical cancer screening (after the age of 25), pregnancy, childbirth and for their children's health. When they are ill, they are more likely to know how to access services, and which services to use, and to feel more comfortable with a healthcare professional.

Older men often do not feel that services run specifically for their age group are appropriate for their needs except perhaps as a last resort. They tend to avoid services where

participants (and staff) are mostly women and consider that attendance at a day centre suggests that they have 'given up'."

There is growing awareness that one of the factors governing access to primary care is that the opening hours at local surgeries make it more difficult for certain population groups to gain access to services. Evidence suggests that this may be a particular problem for people who work longer hours – a problem that is a clear issue of gender equity, since men are twice as likely as women to have a full-time job and are more than three times as likely to work over 45 hours per week (ONS, 2008a). It seems probable that people with significant caring responsibilities (a majority of whom are women) may also experience problems of access (The Gender and Access to Health Services Study - 2008, DoH, Men's Health Forum & University of Bristol).

All of the above evidence indicates that efforts to engage men (in all their diversity) within the process of developing community health services are required for those who live and work in Dulwich and the surrounding areas. Of particular importance is to encourage the participation of men in the formal public consultation process to inform local decision making regarding the range of services locally and where they are based.

References for the protected characteristic of Sex:

1. Davidson K., Arber S. (2003), 'Older men's health: a life course issue', Men's Health Journal 2(3):72-75.
2. George A., Fleming P (2004), 'Factors affecting men's help-seeking in the early detection of prostate cancer: implications for health promotion, Journal of Men's Health and Gender 1(4):345-352.
3. Juel K., Christensen K. (2008), 'Are men seeking medical advice too late? Contacts to general practitioners and hospital admissions in Denmark 2005', Journal of Public Health 30(1):111-3.
4. Keating F. (2007), African and Caribbean men and mental health. A Race Equality Foundation Briefing Paper.
5. Men's Health Forum (2005), Hazardous Waist? Tackling the epidemic of excess weight in men.
6. Men's Health Forum (2005), Men tell us why they don't go to the doctor's.
7. Men's Health Forum (2007), Men and long term health conditions: a policy briefing paper.
8. Men's Health Forum (2008), Improving male health by taking action in the workplace: A policy briefing paper.
9. Men's Health forum (2009) Challenges & Choices - Improving Health Services to Save Men's lives
10. National Statistics (2000), Adult Dental Health Survey: Oral Health in the United Kingdom 1998.
11. PAGB and Reader's Digest (2005), A Picture of Health: a survey of the nation's approach to everyday health and well-being.
12. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. SCCG
13. Sharpe S. (2002), 'Attitudes and beliefs of men and their health', Men's Health Journal 1(4):118-120.
14. Weller D, et al. (2006), English Pilot of Bowel Cancer Screening: an evaluation of the second round.
15. Wilkins, D (2008) The Gender and Access to health Services Study. Department of Health & University of Bristol

3. Race

The population figures for 2001 show that the people in Dulwich and surrounding areas are predominantly White British (comprising 69% of the total population), while the proportion of Black, Asian and Minority Ethnic (BAME) population is 31% (ONS, 2001). Dulwich Community Council Area has a more ethnically diverse population than the national average, however the population is less diverse then Southwark as a whole. Nationally, the White and BAME population breakdown, based on the 2001 Census, is 90% and 10% respectively. The Black Caribbean and Black African population comprise an estimated 12.3% of the total population in Dulwich Community Council Area and 25.5% in Nunhead and Peckham Rye. Of the Black African population across the London Borough of Southwark over two-thirds are from Central and Western Africa with approximately half of these being Nigerian. Asian, Chinese, and other groups are estimated to

represent 4% and 1.5% of the total population respectively. There are also other sizeable minority ethnic populations within the borough, such as Polish and Turkish communities. Emerging figures from the 2011 census suggest an increase in the ethnic diversity of the population in Southwark which underlines the importance of making reasonable adjustments to ensure equity in healthcare for all ethnic groups in Dulwich and the surrounding areas from now into the future.

Over 53% of children under the age of 16 are Black, Asian or from a minority ethnic group. The current trend of growth in local BAME populations across Southwark, including Dulwich and surrounding areas, is set to continue and so the ethnic diversity of older people and people managing long term conditions, for example, needs to be taken into account in local commissioning. Diabetes, stroke, TB and HIV have been experienced disproportionately by those who are Black or Asian and such conditions have been diagnosed among individuals of a younger age on average then their white counterparts. This is also the case with the prevalence of conditions such as dementia. Steps need to be taken to promote services effectively to tindividuals who identify as BAME and to challenge inequalities in access to local healthcare services.

An important implication of the ageing of the black and minority ethnic population in the United Kingdom (UK) is the increase in the number of people with dementia from minority ethnic backgrounds (Moriarty *et al.*, 2010). There is some evidence that people from BME groups are more likely to suffer from dementia at a younger age. While 2.2% of the general population with dementia are of early onset, the proportion is 6.1% in BAME groups (Alzheimer's Society, 2011). The Dementia Strategy (Department of Health, 2009), issued by the last Labour government but taken forward by the Coalition government (Department of Health, 2010), calls on dementia care services to ensure that these groups achieve equal access to services and also highlights the need for specially tailored approaches to reach out to some ethnic groups. (Better Health Care Briefing Update 2011). With an ageing BAME population in the Dulwich locality, in particular Black Caribbean is important to ensure local services are equipped to meet this increasing need. There is an opportunity in the current proposals to consider creating a dementia friendly community in Dulwich and the surrounding areas.

Refugees and asylum seekers face particular barriers to accessing and using mental health services. As well as experiencing the issues associated with the BAME groups to which they belong, refugees have often been exposed to severe physical and psychological trauma as a result of war, imprisonment, torture or oppression. In their new host country they can then experience social isolation, homelessness, language difficulties, hostility and racism, all of which are strong predictors of poor mental health.

It is also acknowledged that Gypsies and Travellers experience significantly poorer health than the general population, along with greatly restricted access to health and social care services. IN the formal public consultation process some members of the traveller stakeholder groups reported difficulty in accessing GP services at convenient times when juggling the conflicting demands of family life. This led some to use out-of-hours GP as their default primary care service, rather than waiting for an appointment with their GP practice (Opinion Leader, 2013). There is an opportunity through future developments to seek improvements to community and home based services e.g. placing higher expectations on providers in regards to training; cultural competency and awareness; equality, diversity and human rights training and all of these are necessary with the development of a new local model of service delivery in Dulwich.

The emerging results of the 2011 Census show that approximately 10,000 individuals in the London Borough of Southwark do not speak English well or very well. The following languages are spoken by people who speak English as a second or third language (listed in descending order - where the borough hosts over 900 speakers of each): French, Portuguese, Spanish, Polish, Italian, Turkish, Arabic, Bengali, Greek, Russian, Vietnamese, Somali, Akan, Yoroba.

In the Dulwich Project 2012 pre-consultation engagement exercise 85% of the survey respondents identified themselves as white. This is against a resident population of 69% white. This was noted

during the reviews that were undertaken, and as a result further work was undertaken to reach black and minority ethnic populations via churches, voluntary sector organisations and discussion groups. In the 2013 Formal Public Consultation Process 74% of respondents identified themselves as White British (which included 1% being White Irish and 8% being White Other). Of the 26% of respondents that identified themselves as being Black, Asian or from a Minority Ethnic Group near 10% identified themselves as being Black British of Caribbean or African descent. There were no significant differences in the responses given by BAME groups and individuals who engaged with the consultation, however some BAME participants were particularly interested in seeing an increase in prevention / health promotion services available in community settings (Opinion Leader, 2013).

References for the protected characteristic of Race:

1. Better Health Briefing 18 (2010) Effective methods of engaging with black and minority ethnic communities within healthcare settings. Race for Health
2. Better Health Briefing 2 (2007) Effective communication with Service Users. Race for Health
3. Better Health Briefing 9 (2012) The Health and Social Care experiences of Black and minority ethnic older people. Race for Health
4. Better Health Briefing Paper 20 (2010) Improving Health and Social Care support for carers from black and minority ethnic communities. Race for Health
5. HFT (2012) A guide to meeting the needs of people with learning disabilities and family carers, from newly arrived, Black, Asian and other Minority Ethnic (BME) Communities. Dept of Health
6. Lawrence, V., Samsi, K., Banerjee, S., Morgan, C. and Murray, J. (2010) 'Threat to valued elements of life: the experience of dementia across three ethnic groups'
7. Moriarty. J, Sharif.N & Robinson.J (March 2011) Black and minority ethnic people with dementia and their access to support and services. SCIE
8. NHS Executive (1998) Tackling Racial Harassment in the NHS. London: NHSE
9. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG
10. Rawaf, S. & Bahl, V (1998) Assessing health needs of people from minority ethnic groups. Royal College of Physicians & Faculty of Public Health Medicine: London
11. Southwark Analytical Hub (2008) Dulwich Community Council Population: Now and the future.
12. Southwark Analytical Hub (2008) Nunhead & Peckham Rye Community Council Population: Now and the future.

4. Disability

The Annual Population Survey 09/10 estimates there are 36,600 people in Southwark with a disability, 17.5% of the adult population, more than Lambeth (14.6%), Lewisham (15.2%) and London (16.2%) but less than England (19.2%). 19,700 (54%) of adults with a disability in Southwark are considered economically active, a higher proportion than near neighbour boroughs and London (52%) but slightly less than England (55%). Of those people 2,700 (13.7%) are unemployed, this rate is higher than near neighbours and England (10.8%) but similar to London (13.9%). In Southwark there are more adult women with disability (19,300 (19.4%)) than men (17,300 (15.9%), this is broadly consistent with other areas[4]. In the 2012 pre-consultation engagement exercise 20% of survey respondents regarded themselves as being disabled- whether or not registered. More recently within the formal consultation process completed in 2013, 29% of participants reported having a disability or long term condition, of these 23% experience Sensory Impairment (Sight & Hearing); 29% experience a physical disability affecting their mobility which included 5% using a wheelchair; 13% experience mental ill health and 3% experience a moderate to severe learning disability (Opinion Leader, 2013).

[4] Southwark Joint Strategic Needs Assessment 2013

4.1 Physical disabilities

There is no single recognised data source for prevalence of disability. It is estimated that just under 6% of the population in the London Borough of Southwark are disabled, of whom 1.4% of the population have a severe disability. It is clear that an area with high levels of deprivation is likely to experience higher rates of disability. In terms of the formal public consultation, Whilst some respondents who experience a physical disability which affected their mobility highlighted the need for buildings to be fully accessible, in terms of location, most groups did not express strong opinions regarding location as they would access patient transport or use private transport to travel to services (Opinion Leader, 2013).

4.2 Sensory Impairment

In 2008 there were 750 people registered as blind in Southwark, 310 aged 0 - 64 and 440 aged 65 and over. Therefore, 0.12% of the 0 - 64 population are registered blind, a slightly higher proportion than London (0.09%) and England (0.09%), and 1.8% of the 65+ population, in line with London (1.7%) and higher than England (1.3%). There were also 520 people registered as partially sighted, 200 aged 0 - 64 and 320 aged 65 and over. Therefore, 0.08% of the 0 - 64 population are registered as partially sighted, in line with London (0.08%) and England (0.09%), and 1.3% of the 65+ population, slightly less than London (1.4%) and England (1.4%). Emerging data from the 2011 census highlighted that 153 individuals in LB Southwark use sign language. The incidence of mental health problems in the deaf population is reported to be 40%, compared to 25% in the general population. Within the formal public consultation process in 2013 some members of stakeholder groups with severe hearing impairment raised concerns about their ability to quickly access their services at their GP practice or health centre. This meant that it was difficult to access unplanned care services independently (Opinion Leader, 2013).

4.3 Learning disabilities

- Approximately 20 people per 1000 in England have a learning disability.
- There are approximately 707 to 809 adults with moderate/severe learning disabilities and 5,287 adults with mild learning disabilities in Southwark
- The number of people with severe learning disabilities is likely to increase by one percent per annum as a result of improved health care and increased life expectancy
- The health conditions affecting people with learning disabilities (PWLD) are different to the general population: more PWLD die from respiratory disease and congenital heart disease (rather than ischaemic heart disease)
- Four times as many PWLD die of preventable causes than the general population. Obesity is more common than in the general population and PWLD are more likely to live sedentary lifestyles. (Southwark JSNA, 2013)

The Learning Disabilities Profile 2012 for the London Borough of Southwark identifies that some work needs to be done regarding improving the identification of people with learning disabilities in hospital and in-patient statistics. It was also highlighted that the emergency admissions rate as a percentage of total population known to have learning disability was very high. This suggests that more needs to be done in the Borough to plan in for people with Learning disability and opportunities for this could be sought in local proposals.

Some GP's have begun to use the notes section of Choose and Book system to flag up additional needs of their patients e.g if they need a longer appointment time, have additional communication needs so that providers can be better prepared with new referrals.

Table 1 Barriers to the access of people with learning disabilities to health care services (Lindsey, M (2002)

Barrier	Addressed by:
The learning and communication difficulties of people with learning disabilities	Providing opportunities for service users to learn about health issues and to self-advocate
Lack of carer and professional awareness of the health needs of people with learning disabilities	Provision of suitable training for carers and health professionals
Discriminatory attitudes of carers and professionals	Disability awareness training Explicit organisational policies and codes of conduct
Physical barriers and inflexible administrative and care procedures	Involvement of service users and carers in planning; implementation of adaptations and changes; Awareness of consent issues
Poor awareness of other factors that can create disadvantage	Sensitivity to social, ethnic, cultural and economical needs of individuals

Physical barriers to access may be present and these include not only unsuitable buildings but also unsuitable signs, support, information about appointments, timing of appointments and information about treatment. Sometimes people with learning disabilities need careful preparation for appointments or admissions and opportunities to familiarise themselves with places and procedures (Linsay, M 2002). Within the formal public consultation process some members of stakeholder groups with learning disabilities reported concern about the ability of primary care staff to communicate with them and understand their needs. One suggestion was that learning disability groups might be involved in delivering training events to help staff gain new skills and knowledge. Familiarity of environments, continuity of care – specifically with seeing the same clinicians on an ongoing basis – was also of particular concern (Opinion Leader, 2013).

4.4 Long term conditions

In the pre-consultation engagement exercise completed in mid-2012 48% of respondents identified themselves as having a 'long term condition', with a wide variety of additional conditions (over and above diabetes, heart disease and lung disease) being named, and a number of people with more than one condition. When asked about the support they had received, apart from GP input and Kings out-patients, most had not received any other support. The numbers of people who did receive support were small, which makes analysis difficult. However, where it was received, practice nurse and physiotherapy support was well regarded, and OT and equipment moderately well. Foot health was not, on the whole, so well regarded, although this is likely to be because of the access issues that remain. Interestingly, 19% said they had received enough support at home, and 40% said they had to some extent. However, 25% said they hadn't received enough support.

Overall community based support for people with long-term conditions was broadly welcomed 'as long as it works as planned' some further suggestions from local people regarding support needs for people with long term conditions are listed below:

- A local directory of services available would be very useful
- Care packages need to be put into place quickly as continuity of care is crucial. Local care can still be disorganised e.g. lack of follow -ups from consultations, delays in getting results from tests and poor organisation of follow-up appointments. Various

care providers need to work in more integrated ways to ensure no one falls through any gaps between services

- There needs to be more clarity over the care pathway patients are following, with the clinicians looking after them able to explain where everything fits in. There needs to be much better communication and co-ordination between professionals/services and between them and the patients.
- There was a strong call for foot health services to be more easily available.
- People wanted to see prompt access to equipment to enable people to stay at home, and their carers to be able to manage.
- The palliative care model is seen as being excellent – responsive and understanding, and people wanted a service more like that.
- There was strong support for the concept of a 'hub' supporting long term conditions care. As well as there being a hub for services, patients would like there to be a way of co-ordinating appointments to reduce journeys and journey time.

4.5 Mental Health

In 2006 Southwark ranked third in the Local Index of mental health need which ranks boroughs in London from highest health need to lowest. Similar findings are reported by the Eastern Region Public Health Observatory (2008) who consistently place Southwark in the top quintile for greatest mental health needs nationally:

- mild mental disorders affect approximately one in six adults in the population, accounting for one in four consultations with GPs
- more severe but less common conditions such as schizophrenia, affect approximately one in a thousand people
- Southwark has statistically significantly higher rates of hospital admissions under general psychiatry than the national average.

It is estimated that 3 million older people in the UK suffer from symptoms of mental health problems that affect the quality of their lives. It is believed that 25% of all people over the age of 65 (one in four) living in the community have symptoms of depression that are serious enough to warrant intervention, however only a third of older people with depression discuss it with their GPs, and only half of them are treated for depression. Of those who are offered treatment, only a very small proportion receives psychological therapy. Older people have some of the highest suicide rates compared to other age groups. National evidence also suggests that the incidence of depression and anxiety is higher in older people than in the population as a whole, so we would expect to high use of local mental health services by older people in Dulwich and surrounding areas:

During the 2012 pre-consultation engagement exercise the following issues were raised by local people regarding mental health:

- There was a strong sense that mental health should be considered to be a 'Long Term Condition' and that a local hub should have some mental health services provision.
- People felt there needed to be far more access to 'talking therapies' for people with mild-moderate depression/anxiety.
- The mental health pathway is not easily accessed- especially in crisis, especially since there is no longer an emergency clinic at the Maudsley.
- Not all GPs are able to manage or support patients with mental health issues.
- There is a need for better early detection of dementia, and more support for people and their carers.
- The impact of mental health problems on people's lives can be easily underestimated.

- The substance misuse care pathway is not easily understood by either patients or health professionals – especially in crisis, when sometimes they can't even get out of the house.
- There is lots of scope for a more organised approach to using the voluntary sector better, with the provision of support and activities for people with mild-moderate depression/anxiety.

Within the 2013 Formal Public Consultation some people using mental health services highlighted concerns regarding the knowledge and experience of GP's and other primary care staff to recognise, diagnose and manage mental health. They also highlighted the need to understand the relationship between physical and mental health. Respondents who identified as being Lesbian, Gay or Bisexual highlighted the need for those providing mental health services to have access to specific LGB groups where appropriate. The need to develop dementia friendly communities was highlighted by some older people's groups (Opinion Leader, 2013).

References for the protected characteristic of Disability:

1. HFT (2012) A guide to meeting the needs of people with learning disabilities and family carers, from newly arrived, Black, Asian and other Minority Ethnic (BME) Communities. Dept of Health
2. Learning Disabilities Profile (2012) Improving Health and Lives: Learning Disabilities Observatory
3. Linsay, Mary (2002) Comprehensive Healthcare services for people with learning disabilities. Advances in Pscyhiatric Treatment Journal.
4. MENCAP (2012) Death by indifference: 74 deaths and counting - A progress report 5 years on
5. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG
6. Scott, R (2012) Developing Health Services in the Dulwich Area: Report on Patient and Public Engagement. NHS Southwark CCG

5. Sexual Orientation

In England and Wales, under the Equality Act 2010, it is unlawful to treat people unfairly because of their sexual orientation. This means that service providers have a duty to ensure that their services and their staff do not discriminate against people on the grounds of their sexual orientation. Although it is known that Lesbian, Gay and Bisexual (LGB) people make up over 10% of the population in greater London. Approximately 6% of the adult population in LB Southwark identify as being LGB (estimated as 16, 464).

Research from the national charity Stonewall, focusing specifically on the health of lesbians and bisexual women found discrimination and negative attitudes towards lesbians and bisexual women within health services. Examples included inappropriate comments from healthcare professionals and unwelcoming attitudes to same-sex partners. Black and Asian LGB people may face double discrimination, being at risk of negative perceptions and treatment on the basis of both their sexuality and their visible ethnicity. LGB people whose minority ethnicity is less visible (for example, Eastern European people) are less likely to experience some forms of racial discrimination.

It is likely that older lesbian, gay and bisexual people are over-represented amongst those needing formal support as they are less likely to have children, more likely to be out of touch with their birth families and their own children, and 2.5 times more likely than heterosexual older people to be living alone (Age Concern, 2006). Evidence suggests that the older lesbian, gay or bisexual population has a higher incidence of certain health conditions and health-related behaviours than the general older population, including higher levels of smoking, drinking, mental health problems, cervical and breast cancer amongst women, and HIV infection amongst men (Musingarimi,

2008a). It is also likely that many older people in this group who do have support needs are 'hidden' from service providers and policy-makers since their fears and experiences of discrimination can act as a barrier to seeking help. In addition, often individuals in this group, when they do access services, decide not to disclose their sexuality (Musingarimi, 2008b). The current generation of older lesbian, gay or bisexual people may have experienced incarceration and 'corrective' treatments in the past, and some will have moved to the UK from countries which continue with punitive or medical approaches to their sexuality.

Further research completed by Stonewall indicated that only a quarter of gay and bisexual men said that healthcare workers had given them information relevant to their sexual orientation. The research recommended that patients should be asked about sexual orientation as part of patient records (to give individuals the opportunity to share their sexual orientation and thus receive more appropriate services). The introduction of a new service provides an opportunity to enhance equality between those who identify as lesbian, gay or bisexual and those who do not in terms of perceptions to quality services and opportunities to receive appropriate care.

In a 2006 survey targeted at the LGBT community in Lambeth the following statistics came to light: Overall, 15% of respondents indicated they had a long-term illness, health problem or disability which limited their daily activities or the work they could do. This did not vary by living in Lambeth or not, being a Trans person or not or ethnicity. It did vary by gender, with more men (17%) having a disability or health problem than women (10%). 14% of respondents had diagnosed HIV infection. Having HIV did not vary by Trans status, residence or ethnicity, but did vary by gender. All but one of those with HIV were men, which meant 20% (64/324) of males had HIV compared to 1% (1/132) of females. 70% of respondents described their ethnicity as white british. Southwark has the second highest prevalence of HIV in London 1039/100,000. Every borough in South East London had higher rates than the England average. There were 702 new diagnoses in SE London in 2008, with the majority being amongst white males and African women. (Director of Public Health, NHS SE London). Difficulties with mental and emotional health were the most common problems reported in the last year (41% of all respondents). Moreover, a high proportion of respondents felt their LGBT identity was relevant to the problem (54%). This meant mental and emotional health stood out from all other areas as being the greatest source of LGBT related suffering.

Some recent findings from research around the perceptions and experiences of healthcare by older Lesbian, gay and bisexual people indicate a need for extra efforts to eliminate discrimination, enhance equality and foster good relations between those who identify as LGB and those who do not. It is recognised that the local NHS has a role to play in these efforts. Local assurances need to be in place to ensure community services, including home based services value and offer quality outcomes for such individuals. In 2011 Stonewall commissioned YouGov to survey a sample of 1,050 heterosexual and 1,036 lesbian, gay and bisexual people over the age of 55 across Britain. This survey asked about their experiences and expectations of getting older and examined their personal support structures, family connections and living arrangements. It also asked about how they feel about getting older, the help they expect to need, and what they would like to be available from health and social care services. Some key findings included:

Lesbian, gay and bisexual people over the age of 55 are:

- More likely to be single. Gay and bisexual men are almost three times more likely to be single than heterosexual men, 40 per cent compared to 15 per cent.
- More likely to live alone. 41 per cent of lesbian, gay and bisexual people live alone compared to 28 per cent of heterosexual people.

- Less likely to have children. Just over a quarter of gay and bisexual men and half of lesbian and bisexual women have children compared to almost nine in ten heterosexual men and women.
- Less likely to see biological family members on a regular basis. Less than a quarter of lesbian, gay and bisexual people see their biological family members at least once a week compared to more than half of heterosexual people.
- Three in five are not confident that social care and support services, like paid carers, or housing services would be able to understand and meet their needs.
- One in six are not confident that their GP and other health services would be able to understand and meet their needs.

During the formal public consultation process in 2013 many individuals who identified as LGB and LGB stakeholder groups advocated for more comprehensive recording of data about service users sexual orientation to help better identify the specific needs of LGB service users in the future (Opinion Leader, 2013). It is therefore recommended that local organisations begin to monitor sexual orientation of service users to increase local intelligence of how accessible, appropriate and responsive local services are for those who identify as lesbian, gay or bisexual. At present very little data exists and even some anecdotal data would go a long way to enable commissioners to be absolutely sure services are meeting local need.

References for protected characteristic of Sexual Orientation:

1. Age UK's (previously Age Concern and Help the Aged) Opening Doors programme addresses the needs of older LGBT people, service users and carers. www.ageuk.org.uk/health-wellbeing/relationships-and-family/older-lesbian-gay-andbisexual.
2. Briefing 12: Lesbian, Gay and Bisexual (LGB) People from Black and Minority Ethnic Communities,www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347
3. Hunt, R. and Fish, J. 2008*, Prescription for Change: Lesbian and bisexual women's health check 2008*, Stonewall.
4. Keogh.P, Reid.D & Weatherburn.P (2006) Lambeth LGBT Matters: The needs and experiences of lesbian women, gay men, bisexual and Trans men and women in Lambeth. Lambeth Council
5. King, M. and McKeown, E. 2003, *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales*, Mind.
6. King, M. et al 2007, *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people*, British Association for Counselling and Psychotherapy.
7. Opinion Leader (2013) Improving Health Services in Dulwich and the Surrounding Areas Consultation Report. NHS Southwark CCG
8. Stonewall (2008) Prescription for change: Lesbian and Bisexual Women's Health Check – South Central SHA Data report
9. Stonewall (2011) Report on health and social care perceptions & experiences of Lesbian, Gay and Bisexual People in Later life.
10. Stonewall (2012) Gay & Bisexual Men's Health Survey 2012: South Central data report by Local authority area of residence
11. Warner, J. et al 2004, 'Rates and predictors of mental illness in gay men, lesbians and bisexual men and women', *British Journal of Psychiatry*, vol.185, pp.479-485.

6. Gender Reassignment

Individuals who identify as Transgender have rights under the NHS Constitution, which describes the objectives of the NHS, the rights and responsibilities of the various parties involved in healthcare (patients, staff, trust boards) and the guiding principles which govern the service. These rights cover access, quality of care and environment, access to treatments, medicines and

screening programmes, respect, consent and confidentiality, informed choice, patient involvement in healthcare and public involvement in the NHS, and complaints and redress. NHS bodies, primary care services, and independent and third sector organisations providing NHS care in England are required by the Health Act 2009 to have regard to the NHS Constitution. In practice, this means that NHS services should be provided in a non-discriminatory way and there should be no absolute absence or refusal of service.

Older transgender people constitute another emerging ageing community as, although previous generations have experienced gender 'dysphoria', treatments and surgery have been made available only relatively recently. Research conducted by Whittle et al. (2007) estimate that 7 per cent of the transgender population are over 61, and 4 per cent of those who underwent gender reassignment surgery in England in 2005/6 were aged 60–74 (Age Concern, 2008). This group face considerable prejudice and, in social care, may have various needs around their personal care, for example, the need to shave, catheterise or find appropriate gender clothing in the right size (Age Concern, 2007b). The barriers which trans people have described in accessing services with dignity, may raise human rights issues and cause distress to them at a vulnerable and sensitive point in their lives.

The Human Rights Act (HRA) 1998 is also relevant to the provision of gender reassignment services. The Act requires public bodies carrying out public functions to take account of the human rights dimensions of services for which they are responsible. Article 8 of the Convention, the right to a private and family life, is particularly applicable to NHS gender reassignment services. The concept of the right to a private and family life covers the importance of personal dignity and autonomy and the interaction a person has with others, both in private or in public. Respect for one's private life includes respect for individual sexuality, the right to personal autonomy and physical and psychological integrity. Providers of NHS gender reassignment services should therefore be taking account of the human rights dimensions of those services. The barriers which trans people have described in accessing these services with dignity, may raise human rights issues and cause distress to them at a vulnerable and sensitive point in their lives.

In the 2006 survey based in Lambeth Trans people were more likely to have a problem with mental and emotional health (67%) than others (40%) and if they did have a problem were more likely to think their LGBT identity was relevant (81% v 52%).

In terms of engagement with the formal public consultation process, no individual or organisation raised concerns about the proposals in terms of gender reassignment. Some discussion however has taken place regarding local data including a suggestion of revisiting the 2006 survey of Trans people in Lambeth by working together across SE London Boroughs.

References for for the protected characteristic of Gender Reassignment:

1. Dept. of Health (2010) An Introduction to Working with Transgender People;
2. Dept. of Health (2010) Bereavement: A guide for transsexual, transgender people and their loved ones;
3. Dept. of Health (2010) Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People: Briefings for health and social care staff.
4. Dept. of Health (2010) Transgender Experiences – Information and Support;
5. Dept. of Health (2011) Trans: A practical guide for the NHS;

7. Religion and Belief

The London Borough of Southwark has over 360 faith groups. The following table highlights the number of people in the London Borough of Southwark who identified that they practiced the following religion and beliefs in the 2011 census:

Religion / Belief	Number of people
Christian	151462
No Religion	77098
Muslim	24551
Buddhist	3884
Hindu	3668
Other	1350
Jewish	1006
Sikh	653

Generally, individuals from black and minority ethnic communities in the UK are more likely than the white majority to be practising their religious faith. In one study a higher proportion of African Caribbean people affirmed a religious (predominantly Christian) belief than that of the white population or other minority ethnic communities.

Efforts to engage local faith groups in the formal public consultation process....

References for the protected characteristic of Religion & Belief:

1. Ellison C and Levin J (1998) The religion-health connection: evidence theory and future directions Health Education and Behaviour 5(6) 700-720
2. Friedli L (2000) A matter of faith: religion and mental health International Journal of Mental Health Promotion 2(2) 7-13

8. Marriage & Civil Partnership

Same-sex couples can currenlty have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters.

If two people of the same-sex are civil partners, they have the same rights as a heterosexual married couple. A civil partnership also gives the right to be your partner's nearest relative. This means that they can make certain decisions about healthcare, such as making an application for their partner to be admitted for assessment. If a couple are not in a civil partnership or marriage, the ethical approach of many healthcare teams is to ask patients who they would like as their point of contact (rather than using the term 'next of kin'). This is so that their wishes are recognised by the healthcare team.

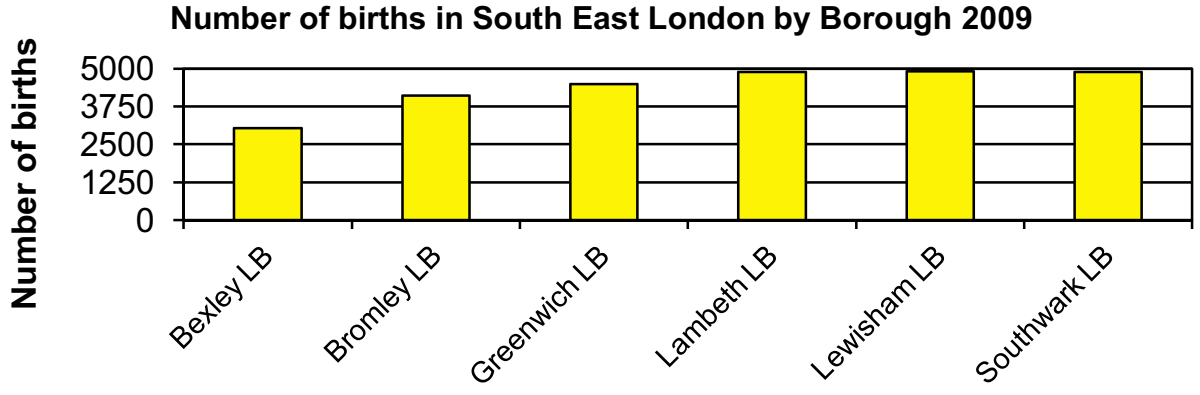
References for the protected characteristic of Marriage and Civil Partnership:

1. NHS Choices: Next of kin (www.nhs.uk)

9. Maternity & Pregnancy

Between 2002 and 2009, there has been a significant increase in the birth rate in the East Dulwich area (2002 to 2009). In 2009, Lambeth, Lewisham and Southwark had the highest number of births in SE London with approx 4700 births in each borough. South East London has a comparatively high birth rate compared to other areas in England. The Teenage Conception rate across Southwark in 2007 was 76.7 per 1000 this is high when compared to the London rate of 45.7 per 1000 (ONS, 2007). Although the Teenage Conception rate in Dulwich Community Council

area is lower than the Southwark wide ratio it is important to ensure the service developments include due consideration for how teenage mothers/parents will be supported by the system locally. This support might include sign-posting and advice for relating to other services in the Borough.



Overall, findings from a large scale national survey (Journal of the Royal Society of Medicine, 2010) show that there are some significant differences between subgroups of women in their experiences of maternity services, including in aspects of care where NICE guidance applies – such as seeing a healthcare professional within 12 completed weeks of pregnancy and having a scan at 20 weeks. Women at risk of poorer maternal and infant outcomes are among those accessing services late, and often reporting poorer experiences of services when they do – such as those from black and minority ethnic groups, women from poorer educational backgrounds, and single mothers.

"Research has highlighted some important differences in the way that women from BAME backgrounds may access and utilise maternity services compared to their white counterparts. Such differential receipt of services is identified as a factor contributing to adverse maternal and neonatal outcomes (Lewis, 2004, 2007). Notwithstanding important diversity within and between minority ethnic groups, national surveys indicate that, as a whole, women from BAME groups are more likely to ' book late' (i.e. receive their first antenatal checkup beyond the recommended twelve weeks' gestation), are less likely to receive antenatal care regularly and therefore also tend to receive fewer antenatal check-ups (Redshaw et al ., 2007; CHAI, 2008). Overall, women from BME backgrounds are also less likely to have discussed breastfeeding with the midwife, although they are significantly more likely to initiate breastfeeding and are more likely to be exclusively breastfeeding following birth (Redshaw et al ., 2007).

Evidence also suggests that some women from some minority groups are less likely than the majority White British to have dating or anomaly scans and to be offered or to undertake screening (Ahmed et al ., 2002; CHAI, 2008). Findings from investigations identify a range of barriers to receipt of high quality care and satisfaction with services among minority women. Minority women continue to voice concerns about a lack of adequate and appropriate information and a consequent inability to exercise their right to choice in relation to their care (Bharj, 2007; Redshaw et al ., 2007).

Although commissioners of maternity services should actively engage in undertaking health needs assessment, accessing adequate and appropriate data to inform decisions is a challenge (Dixon-Woods et al., 2005; CHAI, 2008). Nonetheless, health needs assessment data are critical in forecasting demand as well as in identifying ethnicity-related gaps in

services. Commissioners and providers of maternity services need to work together to ensure that data on ethnicity and other pertinent information (particularly language and interpretation needs) are collected robustly and routinely. They must maximise the use of proposed frameworks as well as information technology programmes (DH, 2008) to commission and deliver world-class maternity services. Effective use should also be made of consultation with local providers (statutory and voluntary), health care professionals and, most importantly, women who use services, and their families.: - Better Health Briefing 2008

In 2001 it was estimated that between 12% and 35% of lesbian women have children and there is a significant and growing number of LBT women wanting to have children or having, adopting or fostering children. However, LBT women who are parents may face a variety of negative attitudes and have little support. One study in 2001 found that lesbian women receiving maternity care reported high levels of anxiety about the implications of disclosing their sexual orientation, together with acute awareness of midwives' personal attitudes and prejudices which led to discomfort, and included inappropriate service delivery and even hostility. This demonstrates the extent to which these issues may negatively impact on quality of care, and 'booking in' and antenatal education were identified as the two areas where service delivery is least effective in meeting the needs of these women. Assumptions of heterosexuality are a barrier to accessing services and have particularly been reported with fertility, maternity and post-natal services which are services commonly used by lesbian and bisexual women. (Womens Resource Centre, 2010)

During the Dulwich project 2012 pre-consulation engagement exercise respondants shared their perspective on local services for people who have (or are about to have) very young families, interestingly much of the content of responses echoes that detailed above: 55 people said that they, or someone close to them had or who were about to have very young families. 50 of those people went on to give more detail about their views on the services, including some extensive comments. Ante-natal care was, largely considered good, although parentcraft classes were less highly rated. Post-natal care was not rated nearly so highly.

- There were a number of comments saying that the advice from Health Visitors is not always consistent, evidence-based or up to date.
- People felt it should be possible that Health Visitors could organise their time better so that they can give a time when they say they will arrive and then come at that time. Voicemail messages didn't always get returned, and between the patients and the health visitor things got forgotten.
- Post-natally, there were a number of comments about the space available in both general practices and at Townley Road for running baby clinics, with the view that they were too cramped and too busy.
- Better communication between professionals would improve the diagnosis and management of post-natal depression.
- Many people didn't know what Children's Centres offered, and who could use them.
- People felt that there was not enough health visiting. They wanted the professional support and advice for breast feeding, weaning, sleep issues, etc. This could be either as 1:1 support or as a support group.
- People liked having the opportunity to 'drop in' to baby clinics, either for weighing or reassurance or where they had questions to ask.
- There was a lot of support for greater integration between the ante-natal and post-natal services – closer working between midwives, GPs and Health Visitors.
- Women who had experienced a service where there was close working between midwife, GP/practice nurseand Health Visitor valued this highly.
- People felt that continuity was important – someone who knows you and your history. Caseload midwifery is very highly valued, with a large number of very positive

experiences reported. Those women who had continuity of care throughout their pregnancy and birth valued that very highly. Some women received some inconsistent advice – where they were not receiving caseload midwifery services.

- Sometimes there could be room for improvement in the systems for making referrals, booking parent-craft classes.
- Some women said they would definitely support the idea of a midwife-led birthing centre.
- For births, a large number of people reported that the services at both King's and at St Thomas' are overcrowded and overstretched, with women reporting being turned away in labour despite being booked.

The Southwark Clinical Commissioning Group has already embarked on discussions with King's about increasing capacity for maternity services. They are looking at a number of options, including a Midwife-led Birthing Centre on the Denmark Hill site. All the comments about post-natal care services have been given to the commissioners and the provider of those services. There are national changes in train about how Health Visiting works, and there are additional investments being made in Health Visiting over the next three years. There is also a local commitment to make sure that people know what is available at Children's Centres and how that can be accessed.

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11. Raleigh VS, Hussey D, Seccombe I & Halt, K (2010) Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. Journal of the royal society of medicine
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14. Womens resource Centre (2010) Briefing 16: Lesbian, Bisexual and Trans womens services in the UK

10. Dignity & Human Rights

The Human Rights Act (HRA) 1998 requires public bodies carrying out public functions to take account of the human rights dimensions of services for which they are responsible. Article 8 of the Convention, the right to a private and family life, is particularly applicable to gender reassignment. The concept of the right to a private and family life covers the importance of personal dignity and autonomy and the interaction a person has with others, both in private or in public. Respect for

one's private life includes respect for individual sexuality, the right to personal autonomy and physical and psychological integrity. Providers of NHS services should therefore be taking account of the human rights dimensions of services.

All those who share protected characteristics also have rights under the NHS Constitution, which describes the objectives of the NHS, the rights and responsibilities of the various parties involved in healthcare (patients, staff, trust boards) and the guiding principles which govern the service. These rights cover access, quality of care and environment, access to treatments, medicines and screening programmes, respect, consent and confidentiality, informed choice, patient involvement in healthcare and public involvement in the NHS, and complaints and redress. NHS bodies, primary care services, and independent and third sector organisations providing NHS care in England are required by the Health Act 2009 to have regard to the NHS Constitution. In practice, this means that NHS services should be provided in a non-discriminatory way and there should be no absolute absence or refusal of service.

Relevant articles include:

- Right not to be discriminated against
- Right to confidentiality of personal data etc
- Rights to live free from inhuman and degrading treatment
- Rights to respect for privacy and family life
- The right to liberty and security.

The proposal holds the potential to increase local knowledge and awareness about human rights including rights for confidentiality and around access to services – the action plan should include steps to maximise this potential

'There are many codes of conduct and clinical guidelines that detail the way the NHS and its staff should work. The essence of such standards is captured in the opening words of the NHS Constitution: '*The NHS touches our lives at times of basic human need, when care and compassion are what matter most*'. Adopted in England in 2009, the Constitution goes on to set out the expectations we are all entitled to have of the NHS. Its principles include a commitment to respect the human rights of those it serves; to provide high-quality care that is safe, effective and focused on patient experience, to reflect the needs and preferences of patients and their families and to involve and consult them about care and treatment. Users of NHS services should be treated with respect, dignity and compassion'[5] Training of staff needs to take in account the principles of human rights – fairness, respect, equality, dignity and autonomy – as reflected in the NHS Constitution.

References for Human Rights:

1. NHS (2009) The NHS Constitution: The NHS Belongs to Us All.

11. Carers

Census data indicates that there are 20,000 to 25,000 carers in the London Borough of Southwark making a substantial and unpaid contribution to the local health and social care workforce. In 2001, 37 percent of carers in Southwark provided care for more than 20 hours a week. Being a carer may impact adversely upon health, especially those putting in long hours; caring for people with challenging behaviour, or who are themselves sick or disabled.

[5] Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people Health Service Ombudsman for England February 2011

Census data for Southwark showed that 45 percent of carers of working age combine paid work with caring. Working carers are an important group but as research from Carers UK shows, many feel poorly supported, suffer impacts on their health and financial position, and would like more help from formal services.

Other carers are unable to undertake as much paid work as they would wish because of the demands of their role. Caring for a relative or partner can leave people isolated and on a low income. (Southwark JSNA)

Research carried out by the Princess Royal Trust for Carers in 2011 discovered that:

- almost 70% of carers aged 60 and over said that looking after someone else had damaged their health.
- Nearly half (49.2%) admitted that their health has deteriorated in the last year because of their caring duties.
- Nearly two-thirds (65%) of those polled said they had health problems or a disability of their own, while only half of these felt confident lifting the person they care for.
- The respondents also revealed that caring for another person also took its toll mentally, with 68.8% saying being a carer had damaged their psychological well-being, and 42.9% reporting that their mental health had worsened in the past year.
- Subsequently, the Princess Royal Trust for Carers wants GPs to provide health checks and screening for depression to carers once a year, and home visits where needed.

We know that some equality groups are over-represented amongst those who provide care to older people with high support needs, both in a paid and in an informal capacity. Younger family members caring for older relatives are more likely to be women, and Bangladeshi and Pakistani people are three times more likely than white British people to provide care (Carers UK, 2009). Although 70 per cent of those receiving family care are aged under 65,11.5 per cent of those providing care are over 65, and those providing high levels of care are twice as likely to be 'permanently sick or disabled' as those not caring (Carers UK, 2009). Older spousal carers are more likely to be men, are more likely to be from white or Indian backgrounds (Buckner and Yeandle, 2005) and are more likely to be from lower socio-economic groups, reflecting the higher levels of disability and the reduced opportunity to buy in formal care (Lloyd, 2008).

Carers from refugee and new migrant communities are likely to have difficulty understanding health and social care systems and to lack social networks. Access to support and services may be further complicated by language barriers and lesser rights for non-citizen members of black and minority ethnic communities. This highlights the need for further research and for outreach work to ensure equal access to services from now into the future.

Research suggests that an increasing number of people with learning disabilities are taking on a caring role (Mencap, 2010). A large proportion are living with older parents and providing mutual care, while the move towards independent living implies that others may be supporting a partner. Black and minority ethnic people in this position may be unaware of their caring role, while professionals often fail to identify those with a learning disability as carers (Mencap, 2010). These carers may not have English as a first language and are likely to require information and assessments in appropriate formats, together with assistance to identify and access culturally sensitive support.

Black and minority ethnic LGBT carers are likely to be affected by the prevalence of both racism and heterosexism in health and social care and the assumption that LGBT identity is predominantly a White British issue (Fish, 2006). Carers may lack community support because of the taboo around LGBT orientation and there are few, if any, mainstream projects that address the

specific needs and circumstances of LGBT carers from black and minority ethnic backgrounds. Research suggests that black and minority ethnic LGBT people are disproportionately affected by homophobic violence, abuse and harassment and the costs of disclosure are likely to be higher than for their White British counterparts. These carers may not identify with the terms 'gay' or 'lesbian' (Fish, 2007).

In the 2012 pre-consultation exercise respondants stated that support for carers, including respite care is crucial and stakeholder groups representing carers during the formal public consultation process in 2013 highlighted concerns that carers still find it difficult to access carers services available from diverse voluntary sector groups in Southwark and a need to develop improved sign-posting mechanisms to support them (Opinion Leader, 2013).

References for Information about Carers:

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2. National Council on Ageing and Older People (2006) health and Social services for older people. Consulting older people with mental health problems on health and social services: A survey of service use, experience and needs
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6. Office for Disability Issues (2010). The life opportunities of disabled people: Qualitative research with learning, memory and neuro-diversity impairments. HM Government, London.
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Appendix Two: Reasonable Adjustments for the Implementation Phase – Wider responsibilities and Updates from the NHS Southwark Clinical Commissioning Group (NHS Southwark CCG)

Ref.	Recommendations for Implementation Phase	Embedding Equality & Human Rights within the CCG's Operating Plan, Business Plan, Organisational and Workforce Development
22	Address men's historic under-use of GPs, pharmacies, smoking cessation, weight management services and health trainers throughout the local service improvement plans	• The Men's Health Forum, currently funded by the Guy's and St Thomas' charity for one year to scope men's health needs has identified a number of key themes pertinent to Southwark as part of the Men's Health Improvement Programme for Lambeth and Southwark. The top 5 health issues for men in Lambeth and Southwark were: 1. Stress 29% 2. Cancer 24% 3. Heart Conditions 18% 4. Diabetes 14% 5. Depression 14% Other Key themes identified by Men's Health Forum include the fact that: • Male Hospital admissions rates in Southwark are both significantly higher than the England rate • Southwark hospital admission rate for prostate cancer is the highest in London • HIV- Lambeth and Southwark account for almost 25% of cases in England • STI's – Southwark has the highest Acute amongst all London Boroughs • The Men's Health Forum is putting together a business case for additional funding for implementation of initiatives to address the above issues with the support of local partners including the CCG • Men's health is an on-going issue nationally compounded by differential access to services by race, religion and cultural factors. The CCG will continue to work with its partners, the local Council and the Public Health teams to address these issues through better and targeted health promotion and other initiatives.

23	Continued support for carers and the organisations that provide support services for them (working with Local Authority)	• Work to develop strategies to support carers in Southwark is led jointly by the CCG, local authority and voluntary groups. • The CCG has agreed a Carers Strategy (Vision and Direction of Travel) with Southwark Social Services, this is published on the website. The CCG and Southwark Council are committed to working together to develop services to meet the diverse needs of carers, including child carers of adults. • The Head of Continuing Care and Safeguarding is the lead for carers within the CCG and has worked jointly with the SCCG Chief Finance Officer during the budget setting process in March 2013 to identify the total budget to support carers and the indicative number of breaks available within this budget. • Personal Health Budgets are in place for clients in receipt of Continuing Healthcare to support both clients and carers to have more control and choice in planning care and meeting health outcomes • Ongoing improvement in identification and recognition of carers and ensure all carers in receipt of NHS Fully Funded Care have a carers assessment. • Budgets have been agreed with the Health & Wellbeing Board (HWB) and voluntary groups to support carers • Ongoing joint working with Southwark local authority to review and implement recommendations from the Carers UK review of carers needs in Southwark • Ongoing work to support Carers to be embedded into new care pathways for all long term conditions with primary care staff to receive carer awareness training and on-going engagement with carer support services. Carers to be supported to fully engage in the process of hospital discharge. • Ongoing work to reduce the waiting time for Improving Access to Psychological Therapies (IAPT), and to ensure the service reaches Carers
24	Rigorous monitoring and evaluation of local health system to test outcomes for those who do and do not share protected characteristics e.g. patient experience, service quality, reducing health inequalities etc	• The CCG continues to make good progress on meeting the General Duty under the PSED and compliance with the Human Rights Act. • The learning from the Dulwich Health Services Consultation will inform the CCG's revised equality objectives to be published by 31 Oct 2013 • The CCG is a partner in the Southwark Winterbourne Working Group, which reports to the Southwark Older People's Partnership Board and Southwark CCG Safeguarding Executive and has a reporting line to the Southwark Learning Disabilities Partnership Board. • The CCG is also cultivating a culture of quality and compassionate care across the organisation, workforce, member practices and partners. It has produced a challenging equality, human rights, quality and compassionate care workplan to Dec 2013 • The CCG has established a quality working group (which incorporates the Francis Report recommendations) and endorsed the Commissioning for Quality approach and begun to develop enhanced quality reports to provide a wider and deeper source of intelligence in relation to the quality of

		commissioned services underpinned by equality and human rights outcomes. Typically, the CCG Quality Report includes: • CQC information relating to local providers • Commentary on the key quality issues identified with each provider and a summary of commissioner actions in respect of these. • Detail on patient experience, including summaries of provider data on patient experience, patient surveys, local intelligence from Healthwatch and the CCG's patient engagement structure, and issues raised by patients and the public. • A summary of Quality Alerts raised by Southwark practices, including key themes and actions. • Summaries of any site visits or clinical audits undertaken. • A log of quality issues identified in the report and a reference to their inclusion in the CCG Risk Register.
25	Use opportunities to promote and protect human rights in the way that services are commissioned, procured and monitored. In particular those services that are to be delivered in peoples own homes	• The CCG has recognised that dementia and care of older people is a key challenge and is working with Southwark Council to continue to provide access to a highly responsive and timely memory services • The CCG is working towards reducing the waiting time for Improving Access to Psychological Therapies (IAPT), and to ensure the service reaches isolated older people including those from the BAME communities • The CCG is working towards ensuring increased availability of specialist home care to enable people with dementia to stay in their own homes for longer. • The CCG is working towards ensuring reduction in the use of antipsychotic drugs through greater access to non- pharmacological management of behavioural disturbances, e.g. enhanced home treatment for older adults and management services. • The CCG is working towards improving the accommodation pathway for adults with mental health problems, so that it provides more effective support and recovery to service users in a community setting • The CCG has agreed a joint vision with the council and providers for raising the quality and compassionate care standards for care homes in Southwark • During 2012/13 the CCG developed and implemented registers of older people at risk, holistic health assessments (including mental health) and a system of case management for older people through GP practices, urgent access telephone lines and geriatric outpatient clinics for rapid diagnosis • A one year pilot of a Home Treatment Team (HTT) for Older Adults is underway which aims to reduce the number of admissions into acute services • The CCG is a partner in the Southwark Winterbourne Working Group, which reports to the Southwark Older People's Partnership Board • People's Partnership Board and Southwark CCG Safeguarding Executive • See also comments above in row (24)

26	Embed improving men's health and tackling gender equalities into the commissioning process.	• See comments above in row (22) • See comments below in row (40) • See comments below in row (41) • Gender Reassignment remains a hard to reach group because local data on Gender Reassignment is limited, but over the coming year the CCG working with stakeholders, member practices, provider services, public health and the LGBT network aims to improve local intelligence and feedback into the commissioning cycle
27	Community engagement to continue with a focus on individuals / groups / representatives of those who share protected characteristics, with a particular focus on finding and responding to the needs of new and transient BAME communities, the LGB population and to continue the community engagement/partnership work with local faith groups	• See comments below in row (28)
28	Explore avenues to enable continuous feedback from those who share or represent those who share protected characteristics throughout the implementation of the programme (e.g. establish an Equality Reference Group or something similar)	• The Membership, Engagement and Communications Team has a full programme of community engagement activities with stakeholders, member practices and the voluntary and community sector • As part of the Authorisation process the CCG developed and implemented a robust communications and engagement strategy for consulting, engaging and involving patients, carers and stakeholder organisations to develop and improve service access/delivery across the nine protected characteristics (Objective 5 of the communications and engagement strategy). • As part of the Everyone Counts 2013/14 guidance, the CCGs and local communities have identified three locally- defined outcome indicators to be used to assess the commissioning impact on the outcomes of the targeted patient groups • The CCG's enhanced quality reports provide a wider and deeper source of intelligence in relation to the quality of commissioned services underpinned by equality and human rights outcomes • The CCG is currently in the process of developing a Primary and Community Care Strategy (PCCS). There is a plan in place to focus engagement with stakeholders in the production of this strategy. • A steering group has been set up to oversee the development of the PCCS – members include Healthwatch, GP Commissioning leads, CCG officers, Public Health and NHS England. • The CCG has committed to a co-production approach to developing the strategy, working with patients and the public. In particular, the input of patients has been sought to co-produce the PCCS priorities and options for developing primary and community care. • Engagement plans with a range of stakeholders include:

		• Patients, carers and members of the public Southwark GP practices and their staff • Provider organisations, including community, acute, mental health, both NHS, independent and third sector • Pharmacists (via the LPC) • Public Health • Social Care • NHS England • The Local Medical Committee • South London Integrated Care • Exceptions/issues are reported to the Engagement and Patient Experience Committee (EPEC), IG&PC or the CCG Board
29	Whilst this assessment focuses on service users and the general population, it is recommended that an assessment of impacts of NHS staff should take place once the final changes are agreed following the formal public consultation in 2013.	• The impact assessment on NHS staff will follow the usual equality and employment law practices and Human Resources policy and procedures.
30	Providers to continue to be required to provide monitoring data across the protected characteristics to enable robust monitoring of access and appropriate/responsive services to take place (in partial fulfilment of the local Equality Delivery System)	• Generally all providers have their own service access/delivery strategies and policy and procedures in place to ensure they comply with equality and human rights legislation outcomes • Over the coming year the CCG aims to review commissioned contracts to ensure that the specifications contain reasonable clauses that comply with Equality Act 2010, public sector duty, the Human Rights Act 1998. • The CCG has established a quality working group (which incorporates the Francis Report recommendations) and endorsed the Commissioning for Quality approach and begun to develop enhanced quality reports to provide a wider and deeper source of intelligence in relation to the quality of commissioned services underpinned by equality and human rights outcomes.
31	Continue to monitor the sexual orientation of service users to increase local intelligence of how accessible, appropriate and responsive local services are for those who identify as lesbian, gay or bisexual.	• This will continue to be a challenge for certain sexual orientation (i.e. LGBT) because of the reluctance to declare sexual orientation, however, the CCG is working with the LGBT network to develop better local intelligence • Case law, however, is very clear that someone's "human condition" (age, disability, gender reassignment, race, sex or sexual orientation) cannot be compromised by someone's "lifestyle choice" (i.e. religion or belief) • There is also a hierarchy of rights in an employee/service user relationship – an employee's "lifestyle choice" cannot compromise a service user's "human condition". In other words, a service user cannot be denied a service (or given poorer quality service) because of an employee's lifestyle choice

32	Seek to influence a refresh of the Joint Strategic Needs Assessment and ensure it assesses local health needs by protected characteristics (as relevant) as this will assist future Equality Impact Assessment Processes. Continue local Health Needs Assessments to look into differing needs of service users taking into account protected characteristics and commissioners to take proactive steps to address the diversity of needs.	• Southwark and Lambeth public health work with the CCG. Since April 2013, local authorities took over responsibility for public health services. Lambeth and Southwark councils run a shared public health service with a single Director of Public Health. The overall goal of public health is to:
		  • Protect and promote health and wellbeing
		  • Minimise risks to health and wellbeing
		  • Prevent disease and their complications
		  • Reduce health and healthcare inequalities
		• The CCG and Southwark Council, through their collaborative work with statutory agencies, voluntary sector and communities, will continue to influence the wider determinants of health, reduce health inequalities and promote healthy lifestyles to Southwark people as well as shaping the provision of local health services.

33	All providers to fulfill requirements of the Public Sector Equality Duty, CQC criteria and local NHS Equality Delivery Systems	• Generally all providers have they own service access/delivery strategies and policy and procedures in place to ensure they comply with equality and human rights legislation and CQC outcomes
		• Over the coming year the CCG aims to review commissioned contracts to explore enhanced equality, human rights, quality and compassionate care specifications
		• The CCG as part of the work planned by the response to the publication of the Francis Report and the Report on Winterbourne View, has begun to develop the CCG's reports to provide a wider and deeper source of intelligence in relation to the quality of commissioned services. In essence, the enhanced quality report includes:
		  • Care Quality Commission information relating to local providers
		  • Narrative commentary on the key quality issues identified with each provider
		  • Issues associated with quality and patient experience as identified by Healthwatch
		  • More detail on patient experience, including summaries of provider data on patient experience, national patient surveys and intelligence on issues raised by patients and the public
		  • A summary of Quality Alerts raised by Southwark practices, including key themes and outcomes from alerts
		  • Summaries of any relevant site visits or clinical audits

34	Providers to ensure all staff comply with Equality and diversity practice and policies, as well as adhere to the spirit of the NHS Constitution	• Generally all providers have they own workforce and organisational development strategies and policy and procedures in place to ensure they comply with equality and human rights legislation and CQC outcomes • As part of the CCG's quality reports it will seek assurances that providers' equality and human rights policies are in place and compliance with the NHS Constitution

35	All staff are trained on the principles of human rights - fairness, respect, equality, dignity and autonomy	• The CCG's Mission, Values, Goals and Priorities are all grounded in the human rights principles known as the "**FREDA Principles**". This means that commissioning decisions about care pathways for Southwark people are subject to: **Fairness; Respect; Equality; Dignity; Autonomy** • The CCG is refreshing its equality and human rights training/learning tools/action learning sets which is underpinned by compassionate care • All CCG staff are required to attended refreshed instructor-led equality, human rights and quality compassionate care training by end of Dec 2013 • Specialist monthly themes via new bulletin and or articles on E&HRs in relation to OD, Workforce and Patients to be disseminated widely
36	To ensure all staff are aware that those who are married and those who have civil partnerships share the same legal rights and that all relevant policies regarding staff and service users reflect this recent legislative change. This might affect change to local guidelines regarding 'next of kin', visiting guidelines, attendance to appointments etc.	• See comments above in row (31) • See comments above in row (35)
37	Human Rights/implementation of the NHS Constitution to be integral to providing high quality care within patients own homes for groups including: older people; people with mental health conditions; BAME groups (including recognition of cultural diversity); offering adequate support for carers (e.g. family or friends); protecting the rights of those who are lesbian, gay or bisexual in civil partnerships (equal rights of those who are married)	The CCG has made equality and human rights 'everyone's business' because taking a "human rights based approach" to commissioning is the key to delivering high quality, compassionate and personalised care pathways. • The CCG's commitment to protect human rights and enhance quality and compassionate care is integral to its core business and reflected throughout the Business and Operating Plan 2013/14. • The CCG's Mission, Values, Goals and Priorities are all grounded in the human rights principles known as the "**FREDA Principles**". This means that commissioning decisions about care pathways for Southwark people are subject to: **Fairness; Respect; Equality; Dignity; Autonomy** • The current CCG equality objectives are in the process of being refreshed and the Dulwich Health Services consultation results will also inform the equality objectives which the CCG will need to set in place by 31 Oct 2013 See comments in rows 22-42 to support the implementation of the PSED
38	Equality, Diversity and Human Rights training will continue for all NHS staff (commissioners and providers have a policy in place)	• Southwark CCG (including in its previous shadow form) has a strong track record of integrating and delivering on equality and human rights. From the outset, Southwark PCT pioneered human rights in healthcare with its participation in the Department of Health's pilot project and publication of "Human Rights in Healthcare: A Framework for Local Action". That pioneering spirit continues to be embodied in the new CCG. • All CCG staff are required to attended refreshed instructor-led equality, human rights, and quality

		compassionate care training by end of Dec 2013 • The CCG will seek assurance from providers that they have equality and human rights policy in place as well as the provision of training for staff
39	Formal Public Consultation results to inform PSED objectives 2013-15	• The current CCG equality objectives are in the process of being refreshed and the Dulwich Health Services consultation results will also inform the equality objectives which the CCG will need to set in place by 31 Oct 2013
40	Commission local research on the health needs/ service requirements for those who have gone through / are considering gender reassignment	• Gender Reassignment remains a hard to reach group because local data on Gender Reassignment is limited, but over the coming year the CCG working with stakeholders, member practices, provider services, public health and the LGBT network aims to improve local intelligence and feedback into the commissioning cycle
41	To revisit service provision as local demand increases in line with increasing birth projections.	• The CCG works collaboratively with South London Commissioning Support Unit and other CCGs in respect of maternity, and this will be increasingly important as it begins to implement the changes proposed by the Trust Strategic Administrator • The CCG will continue to work with providers of maternity services, health visitors and primary care to ensure that maternity services deliver high quality care. In particular, in 2013/2014 the CCG will be focusing on ensuring that there is sufficient capacity in local services to deliver safe care which supports a positive maternal experience, and offers a choice of location of birth.

42	Service to invite 'mystery shoppers' to visit providers of local maternity (Ante and post natal) services. In particular young single mothers, those who identify as being lesbian or bisexual and also BAME	• The CCG's has made it a priority to ensure that Southwark women are supported in accessing ante- natal care at an early stage so that they can receive the necessary screening, assessment and support.
		• Over the coming months the CCG will:
		  • Review Maternity Specification in KCH and GSTT contracts and agree any changes to quality monitoring arrangements.
		  • Review Trust capacity plans for Maternity services, including provision of midwifery led birth choice.
		  • Review Trust action plans for delivery of ante-natal access by 12 weeks 6 days.
		• As part of Reviewing Maternity Specification KCH and GSTT contracts specification the CCG could consider 'mystery shoppers' in relation to LGB and the BAME communities
		See also comments above in row (41)

--- END ---

Agenda Item 11

Southwark Council

Scrutiny review proposal

1 What is the review?

Review theme : Public Health / Health inequalities

Focus: BME Psychosis: prevalence and access to services.

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

A reduction in the risk of BME community members developing Psychosis and improved access to treatment.

Agencies the review seeks to influence are :

The council

SLaM

Southwark Clinical Commissioning group

Partners on the Health and Wellbeing Board

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

Initial scoping will take place in the municipal year 2012/13. The new health scrutiny committee may chose to complete the review if they consider there is sufficient evidence to warrant a full investigation and they wish to prioritise this area of work .

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

The first priority will be to establish a robust evidence base by requesting papers and comment from council officers, SLaM, Public Health, CCG and LINk / Healthwatch

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

A clearer understanding of the prevalence of Psychosis amongst Southwark residents and its present treatment by SlaM.

International good practice in the prevention and treatment of Psychosis.

An initial exploration of the links to the wider social determinates of health and the development of Psychosis, in particular the very high level of Psychosis in Black BME communities.

An understanding of how agencies work together to tackle these and undertake preventative work.

The impact of welfare reform and economic difficulties on those at risk .

Existing reports done by the former LINk on the equality of access of the BME community to mental health services.

Clarity on why the Black BME community has a higher prevalence of Psychosis but is proportionally seen by mental health teams / IAPT and is under represented in Psychological Therapy Service (and if this is relevant).

Preventing physical ill health in people with Psychosis.

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

Initially : council officers, SLaM, Public Health, CCG and LINk / Healthwatch

A full review would seek the involvement of the wider community, including BME groups and groups involved with mental health advocacy and service delivery, both local, London wide and nationally.

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

SlaM will be asked to provide good practice from the Institute of Psychiatry

THE ABANDONED ILLNESS A report by the Schizophrenia Commission

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

Presentations and reports will be sought for the first stage.

Psychotic disorders in ethnic minority populations in Lambeth & Southwark
An introduction
Lambeth & Southwark Public Health Team
July 2013

1. Introduction

This is an introductory briefing on psychotic disorders and the impact on ethnic minority populations with particular reference to populations in Lambeth and Southwark.

Psychotic disorders (sometimes called severe mental illness - SMI) include schizophrenia and extreme disorders of mood (mainly bipolar disorder). The disorders are characterised by severe disturbances in thinking and perception such that perception of reality is distorted. This may result in different types of delusions about the self, others and the environment including hearing voices.

There is substantial research that shows that in the UK rates of mental illness including psychosis in some ethnic minority populations are higher than rates in white British populations although the levels are not consistent and are different for men and women.

The main source of information about the numbers of people in the population with mental ill health nationally is taken from a large household survey conducted in England in 2007, and its predecessors which covered England, Scotland and Wales in 1993 (16-64 year olds) and 2000 (16-74 year olds) by the Office for National Statistics (ONS).

The Adult Psychiatric Morbidity Survey (2007) for England (a household survey)
The proportion of the population assessed as having a psychotic disorder in the past year prior to interview was 0.4% (0.3%of men, 0.5% of women). There was no change in the overall prevalence of probable psychosis between the 2000 and 2007 surveys

In both surveys the highest prevalence was observed among those aged 35 to 44 years (1.0% in 2000, 0.8% in 2007). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7%and 1.1%respectively).

The age standardised prevalence of psychotic disorder (schizophrenia and bipolar disorder) was significantly higher among black men (3.1%) than men from other ethnic groups (0.2%of white men, with no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women.

The prevalence of psychotic disorder varied by equivalised household income, increasing from 0.1%of adults in the highest income quintile to 0.9%of adults in the lowest income quintile. This trend was more prominent among men than women.

In addition to these estimates 0.5% of the population were thought to have 'probable psychosis' where symptoms did not reach threshold levels or the interview suggested a history of a psychotic episode but not during the year previously.

There is also an increasing body of research in the UK and internationally. Much of the UK research is of the population in south east London. A rise in the number of people nationally with psychotic disorders would be expected at least until 2026 mainly in older age groups, due to demographic change in the population.

Newton[1] summarises the international picture from the literature

- Rates of new cases of psychotic illness vary from between 8 – 43 per 100,000
- Rates in men are usually significantly higher than in women
- It is common to find higher rates in migrants, people born in cities and people born in the winter-spring
- There are differences in recovery between developed and developing countries with substantially better recovery in developing countries than in developed nations (although this is contested in more detail where there are negative connotations to mental illness and restrictive practices (such as incarceration and restraint)
- Outcomes are worse where the onset is insidious rather than acute & outcomes at 2 years were the best predictor of outcome at 15 years

2. What does this mean for Lambeth & Southwark?

A very rough estimate of expected numbers in Lambeth and Southwark can be made using the ONS prevalence rate and applying it to the adult population. This is a 'point prevalence' so the estimate is more likely to be a range around this figure but the figure is also likely to *underestimate* actual numbers because the national survey did not include people in hospital, supported accommodation, prison or secure mental health institutions.

Table 1 Expected number of adults with psychosis or probable psychosis by borough

	Population Aged 16+ years	Estimated prevalence	Estimated expected number with psychotic disorder in the past year
Lambeth	255,000	0.4%	1,020
		0.5% (probable psychosis)	1,275
Southwark	242,000	0.4%	968
		0.5% (probable psychosis)	1,120

Source: Greater London Authority Interim Round Population Projections (2012) and Psychiatric Morbidity Survey (2007)

3. Detection of psychotic disorders in Lambeth and Southwark

Apart from applying national or research data to local populations an important method of estimating prevalence is to look at local rates of detection; how many people do we know about with psychotic disorders? This can be done by looking at the numbers of people with a documented severe mental illness (SMI) in GP records.

Although it is not possible to know about severity from this figure it is fairly reliable because it is a requirement that all people known to have SMI are offered a physical health check annually and GPs have to report on this. Against this is the fact that there can be a delay in maintaining up to date records when people move or die or get better so again this should be seen as an estimate. Furthermore, when calculating a rate, the GP registered population is used not the resident population. In both Lambeth and Southwark there are more people registered with GPs in the boroughs than there are in the census estimates. Despite this the detection of SMI in both boroughs is substantially higher than the estimates from the national survey and compared with London and England.

Table 2: Detection of Severe Mental Illness in Primary Care 2013

Area	Period	Number of registered patients aged 16 or over	Number with Severe Mental Illness	Prevalence (%)
Lambeth	2012/13	304,464	4,548	1.5%
Southwark	2011/12	270,004	3,504	1.3%
London	2011/12	7,178,822	89,289	1.2%
England	2011/12	45,284,513	452,608	1.0%

Source: DataNet 2012/13; QOF 2011/12
NB: Lambeth data omits 2 practices

Reasons for the higher rates may include

- The high levels of deprivation and inequality in Lambeth and Southwark
- The age distribution of the population which is relatively young compared to the national population (SMI is more common in people of early middle age)
- Higher than average prevalence in ethnic minority populations
- The proportion of people with SMI in hospital, supported accommodation, prison etc who remain on the GP list but would not have been identified in the national survey
- GPs in Lambeth and Southwark are good at detecting and recording SMI
- Delays in updating or maintaining records in primary care
- Migration of severely mentally ill to inner city conurbations

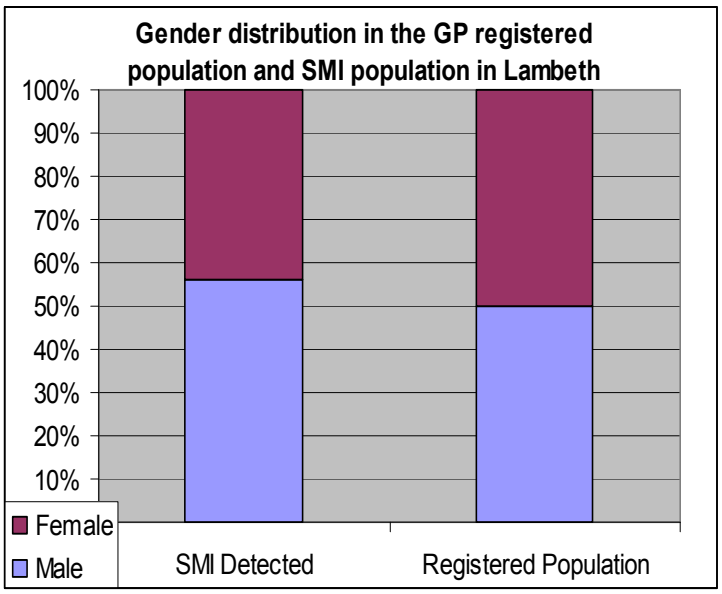
4. Who has SMI in Lambeth and Southwark?

For nearly 10 years Lambeth GPs in partnership with Public Health and London South Bank University (and now King's College London - KCL) have been developing use of their data for public health purposes particularly to understand some of the health inequalities between different populations and take appropriate action. To do this, in addition to clinical data GPs have also collected demographic information that can be extracted and analysed (anonymously) at borough level using a platform called DataNet. This means that it is relatively straightforward to assess inequalities at population level in the borough. The information provided in the next section is therefore taken from Lambeth data (note: all the data excludes information from two practices with a combined population of approximately 17,000 patients) but as a borough with many similarities to Southwark it can be used to illustrate some of the issues for Southwark patients.

There is a proposal to develop this facility in Southwark in partnership with KCL and the Lambeth & Southwark Public Health Team.

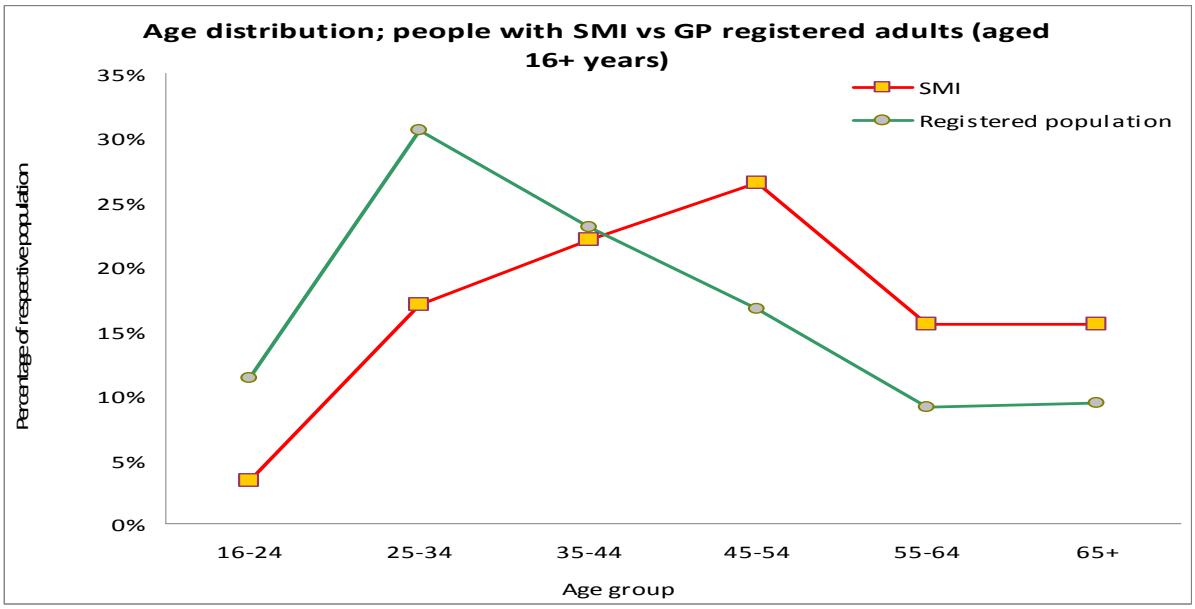
Figure 1 shows that slightly more men than women are diagnosed with SMI than would be expected from the population make up.

Figure 1: Registered and SMI Population by Gender in Lambeth



Source Lambeth DataNet 2013

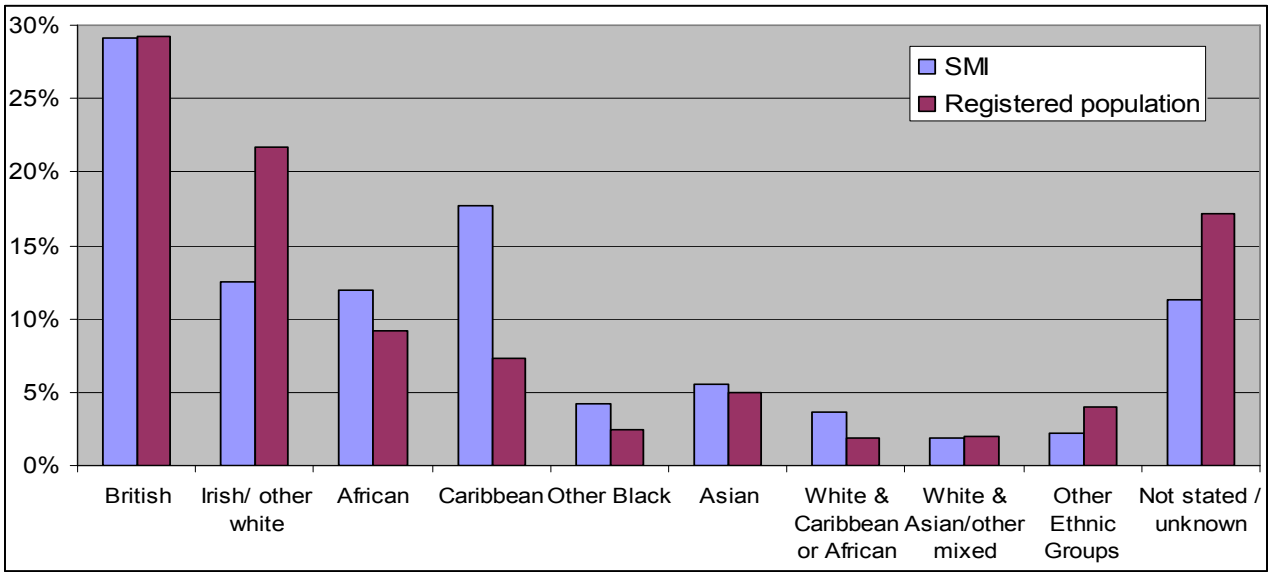
Figure 2: age distribution of the registered and SMI populations of Lambeth



Source: Lambeth DataNet 2013

Figure 2 shows that people with SMI tend to be older than would be expected from the population distribution. This is in keeping with the nature of psychotic disorders which tend to last for many years.

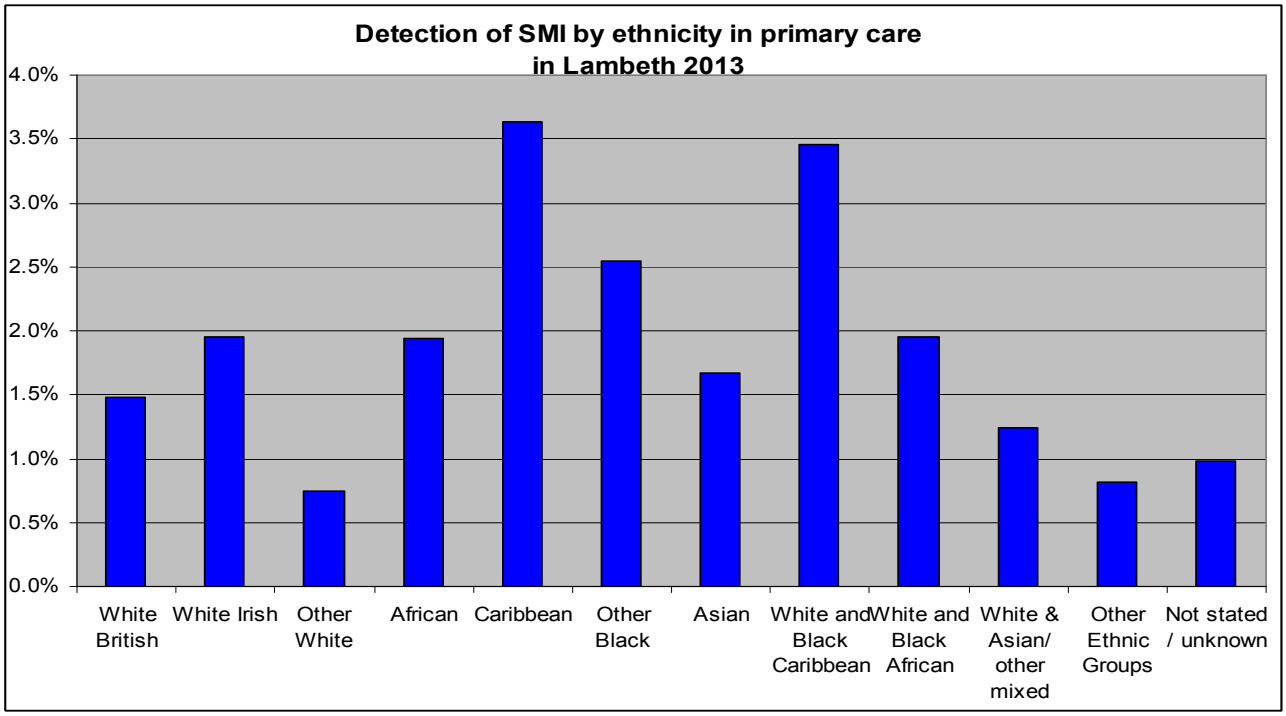
Figure 3: People detected with SMI & GP registered population by ethnicity



Source: Lambeth DataNet 2013.

Figure 3 compares the ethnic make up of the GP registered population and the group who are known to have SMI. It shows that whilst for some groups the proportion of people with SMI is roughly equivalent to the background GP registered population, for people of black and mixed white and black ethnic background there are higher than expected proportions known to have SMI especially for the black Caribbean group. The slightly higher rate in Asian groups is based on relatively small numbers.

Figure 4: Detection of people with SMI in primary care in Lambeth by ethnic group



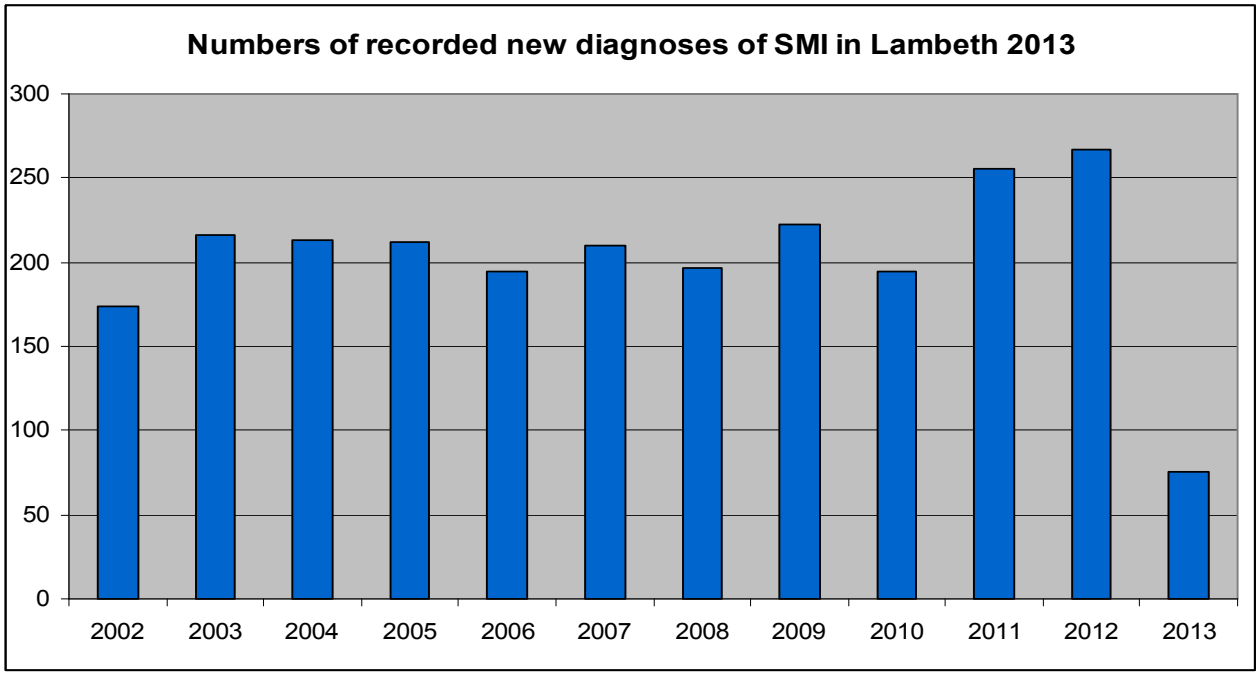
Source: Lambeth DataNet 2013

Figure 4 shows detection rate by ethnicity. The average detection rate in Lambeth is 1.5% so it can be seen that several groups including white Irish, black African, black Caribbean and other black have higher than average detection rates. The groups of white and black mixed ethnic background have similar rates to that of their counterparts who identify as black ie people of mixed white and black Caribbean origin have the same rate as people who identify as black Caribbean.

5. Incidence: new diagnoses

People are concerned that the numbers of new diagnoses of psychosis are increasing. Figure 5 shows the picture in Lambeth over the last ten years. The graph shows numbers not a rate but given that the GP registered population over this period has increased substantially the levels of new diagnoses per year is remarkably stable.

Figure 5: Numbers of newly recorded diagnoses of SMI in Lambeth 2013

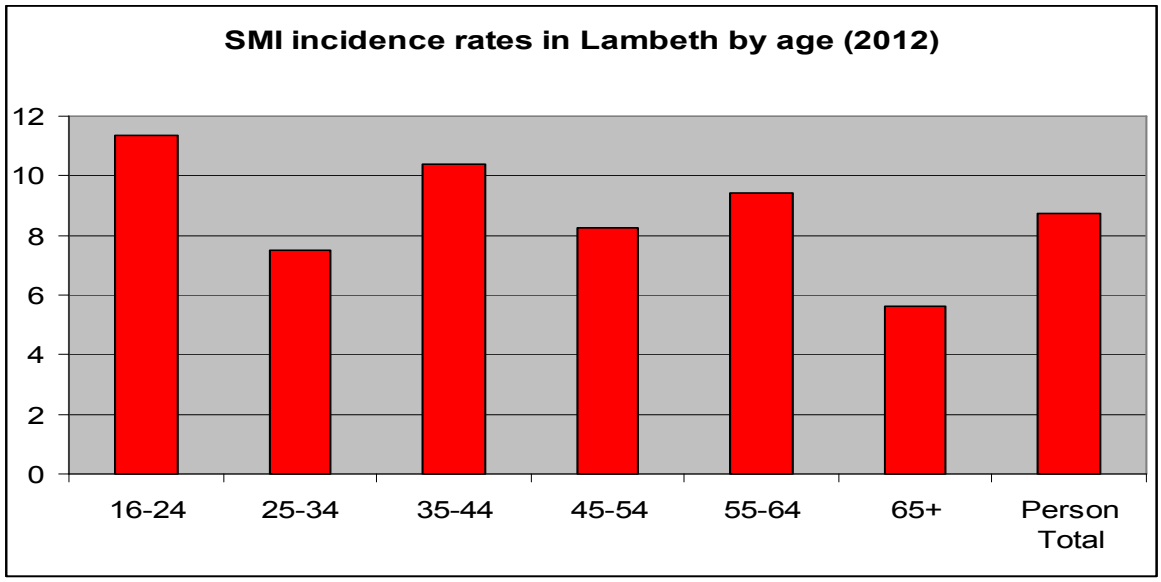


Sources: Lambeth DataNet, 2013

The years 2011 and 2012 may indicate a change but it is not easy to tell at this stage. Note that 2013 is an incomplete year.

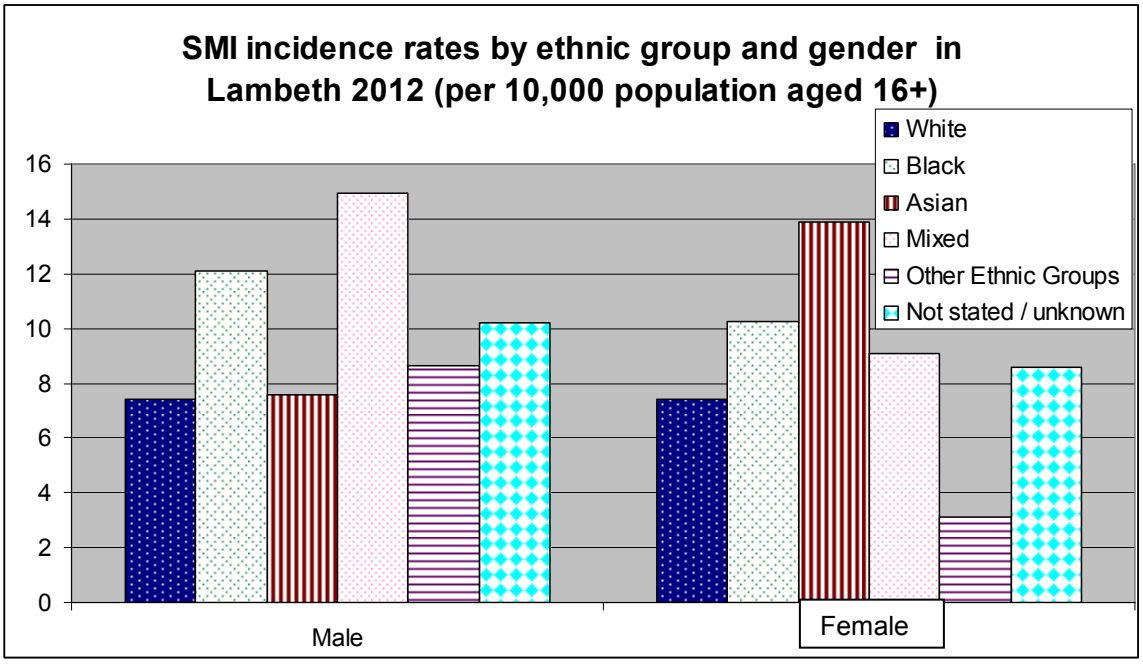
Small numbers make it difficult to assess trends in Figure 6 but suggest that, although as expected the highest rate of new cases is in the 16-24 year group and lowest in older people, new cases arise across the age range.

Figure 6: Rates of new diagnoses of SMI per 10,000 population per year in Lambeth by age group



Source: Lambeth DataNet 2013

Figure 7: rates of new detections by gender and ethnic group in Lambeth



Source Lambeth DataNet 2013

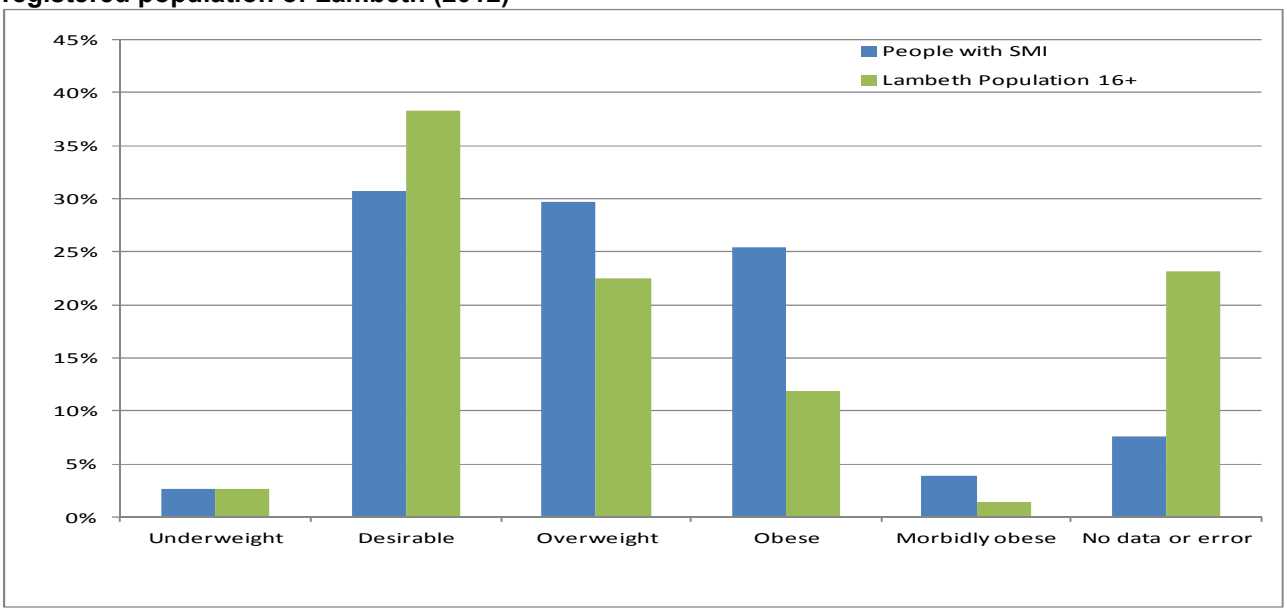
Figure 7 also uses small numbers so rates should be viewed with caution but the findings are in line with other information to suggest that the incidence is higher in Black populations and people of mixed heritage especially in men. In women the incidence appears higher in Asian groups.

6. Health of people with SMI

It is widely known that people with psychotic illness experience poorer health than average and are at increased risk of premature death (death before the age of 75 years).

The differences in health can be shown from GP records.

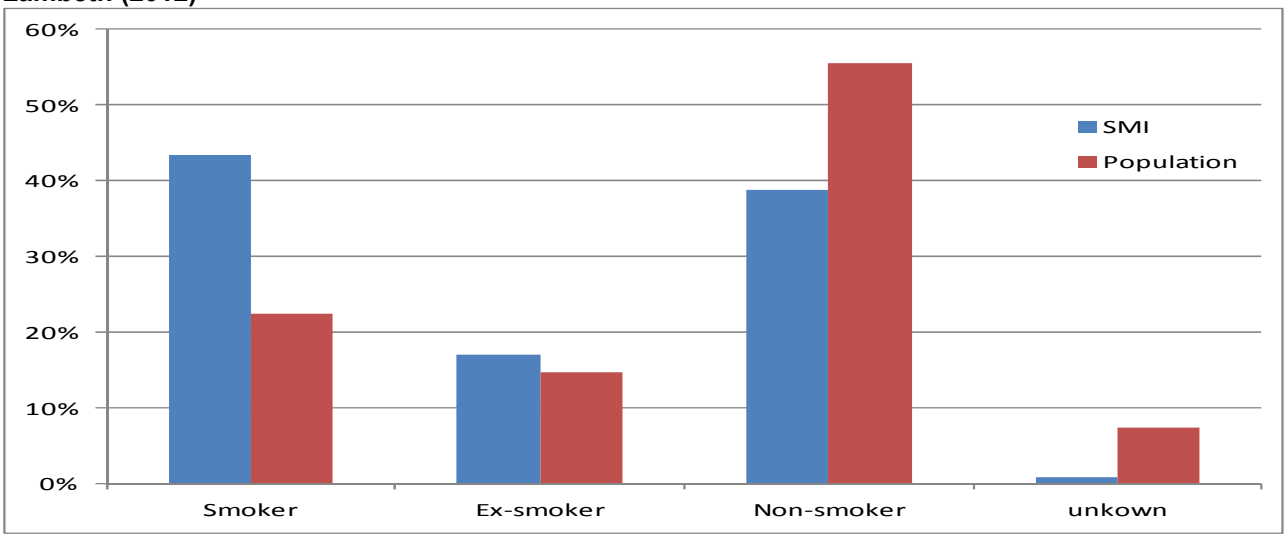
Figure 8: the distribution of overweight and obesity in people with SMI and the Adult GP registered population of Lambeth (2012)



Source: Lambeth DataNet 2012

Figure 8 shows that over 30% of GP registered adults are overweight or obese (although there is no record in over 20%) but for people with SMI this figure is nearly 60%.

Figure 9: the distribution of smoking in the adult GP registered and SMI populations in Lambeth (2012)



Source: Lambeth DataNet 2012

Figure 9 shows that whilst about 22% of the adult GP registered population smokes, over 40% of people with SMI smoke.

7. Access to services

People with psychotic illness are severely ill and need treatment. Nationally the APMS survey (ONS, 2007) found that about 65% of people with psychosis and 85% of people with probable psychosis living in private households were on treatment. The difference may be because some of the people with probable psychosis have a history of psychotic symptoms but had not experienced them in the previous year whereas some of the people with psychosis were new and had not yet accessed services.

One third of people with psychoses had contact with their GP in the past 2 weeks, and two thirds had had contact in the past year.

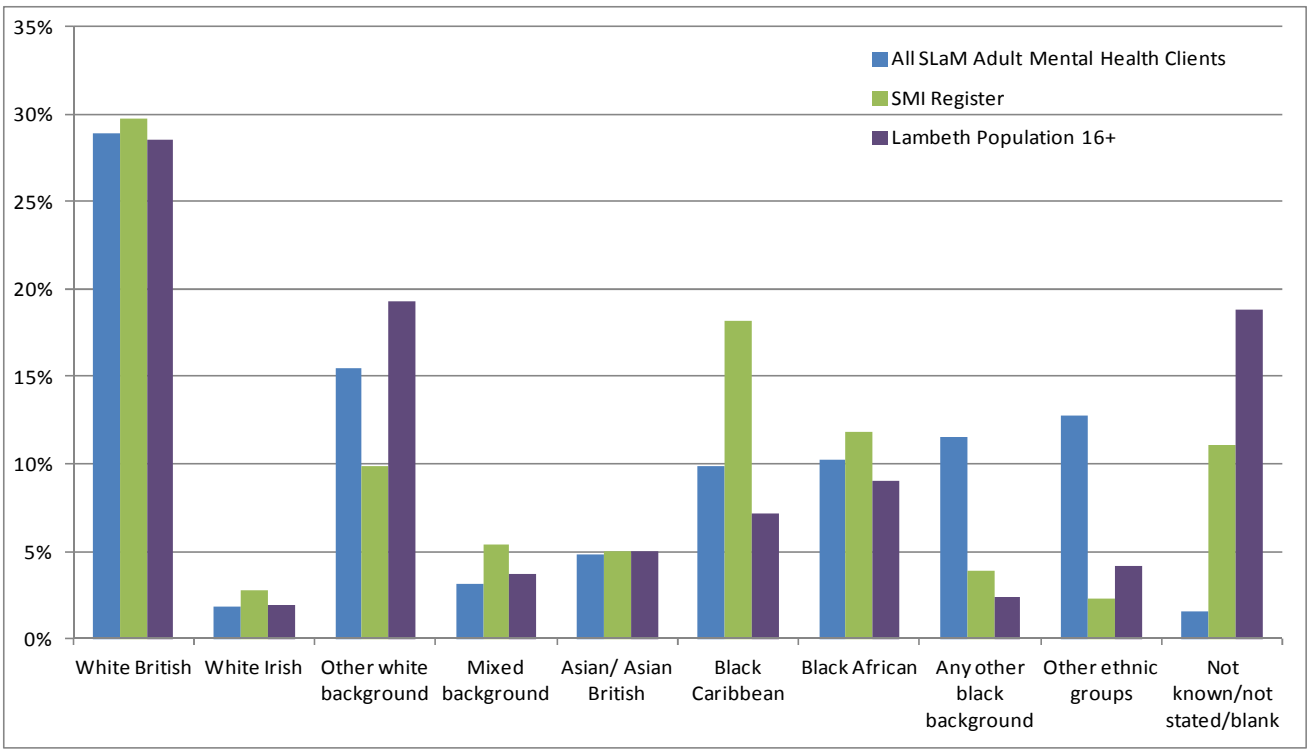
Table 3: Estimated numbers of *resident* population with SMI (Adults 16-74 years) who have used health services

	Expected number with psychotic disorder in the past year	Not receiving treatment (35%)	In patient sty in last 3 months (6%)	Out patient visit in last 3 months (30%)	Spoken with GP in last 2 weeks (25%)	Ever admitted to a hospital specialising in mental health (65%)
Lambeth	1,020	357	61	306	255	663
Southwark	968	339	58	290	242	629

Source: PMS 2007 and LGA (2012)

The national survey does not look at access to services by ethnicity but Figure 9 shows there are some differences in the ethnic make-up of the 3 populations; patients of mental health services, people with SMI known to the GP and the GP registered population. The differences in proportion between the GP registered population and the people known to have SMI have already been discussed in relation to Figure 3. This suggests that ethnic minorities have relatively good access to primary care for their SMI although this information does not tell us anything about quality or experience. There are some marked differences between the proportion of the population with SMI and the ethnicity of SLaM patients. This could represent a difference in access but without further investigation it is not possible to draw firm conclusions.

Figure 9: Ethnicity of SLaM (Lambeth) Adult Mental Health Clients, the GP SMI Register, & the Lambeth GP Registered Population (16+years)



Source: SLaM monitoring data, Lambeth DataNet (2012)

Nationally there is evidence of differential access to services for ethnic minority populations although some of this information is relatively historic eg;

- Admission rates to psychiatric hospitals for African-Caribbean populations are higher than for the general population (Coker 1994, Cochrane & Bal 1989) – *local data suggests this could be related to need*
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 to 6 times higher among African-Caribbean groups than among the white population (Coker 1994, Cochrane & Bal 1989) – *again this could be in line with what is expected in the population*
- Diagnoses of depression and anxiety are less likely among African-Caribbean groups than among the general population (Lloyd 1993) – *this could be related to differences in how diagnoses are made and the help seeking behaviour of different groups*
- African-Caribbean groups are more likely to be subjected to harsh and invasive types of treatment including intramuscular injections and electro-convulsive therapy, more likely to be placed in secure units, to be described as aggressive and to be hospitalized compulsorily under the Mental Health Act (Dunn and Fahy 1990, Davies 1996, Bhat 1996)
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 times higher among Asian males than among the white population (Coker 1994, Bhat 1996)
- Suicide rates among women from the Indian sub-continent and men and women from East Africa are higher than those for the general population (Soni Raleigh 1992, 1990) – *this is very difficult to look at locally as suicide numbers are low and suicides in women are very low*

- Suicide rates among Asian women 15-24 years are more than twice the national rate and 60% higher in Asian women aged 25-34 years (Soni Raleigh 1992, 1990)
- Psychiatric patients from B&EM groups make less use of psychiatric services (Donovan 1992, Kareem 1989)
- The ethnicity of a patient influences the clinical predictions and attitudes of practising psychiatrists (Lewis 1990)

Source: Lee, B., Syed, Q., Bellis, M. (2001). Improving the Health of Black and Ethnic Minority Communities: A North West England Perspective. North West Public Health Observatory.

8. The causes of mental ill health and why is incidence different in different ethnic groups?

Biological, psychological, and environmental (social, family, economic etc) factors all contribute to the development and progression of mental wellbeing and mental disorders. Opinions have swung to and fro between the relative contribution of biomedical (such as genes and brain chemistry) and environmental factors (such as parenting, school, work and life events) and between different interpretations and understanding of the brain and the mind. More recently there has been increasing recognition of the impact of nurturing on brain development in infancy and early childhood and specifically on the impact of negative infant and childhood experiences on future mental illness[2]. Studies now suggest that early childhood neglect and certainly more overt emotional or physical abuse can affect brain development adversely and increase risk of various issues including mental illness especially if other circumstances occur[3,4]. There is also recognition that some forms of mental illness seem to run in families especially bipolar disorder although in nearly two thirds of people with schizophrenia there is no other family member with the disorder[1].

Psychological factors that may contribute to mental illness include:

- Severe psychological trauma suffered as a child, such as emotional, physical, or sexual abuse
- An important early loss, such as the loss of a parent
- Neglect (emotional and, or physical)
- Poor ability to relate to others

Environmental factors or stressors that may trigger mental illness (although not specifically psychosis) in a person who is susceptible (especially having been exposed to some of the factors above) include:

- A dysfunctional family life including domestic violence
- Death or divorce
- Unemployment
- Bullying or harassment (in the workplace, school etc)
- Substance misuse by the person or the person's parents

These situations can be compounded where a person has pre-existing feelings of inadequacy, low self-esteem, anxiety, anger, or loneliness and, or where there are specific social or cultural expectations of someone (eg a society that associates beauty with thinness can be a factor in the development of eating disorders.)

A systematic review of the evidence[5] suggests that the following groups of people are at risk of poor mental health. This is mainly because of their exposure to traumatic life events, neglect and or the stress of social exclusion and social isolation.

Table 4.

Adults	Children
Unemployed Severe life events (eg; separation, bereavement) Long terms carers of highly dependent people Women with a history of depression in pregnancy	Living in poverty In a family experiencing parental separation or divorce, or bereavement With behavioural difficulties

A more comprehensive summary of potential risk factors is in the Appendix.

There is also a strong relationship between mental health problems and substance and, or alcohol misuse. This includes common mental illness, severe mental illness, problems with self harm and suicidal behaviour. Misuse of drugs and, or alcohol is also associated with increased risk of suicide. The Department of Health reports that about 30% of people seeking help for a mental health problem are likely to be misusing drugs[6]. What maybe less well explored is some of the motivations underlying substance and alcohol misuse for instance how people may use alcohol and drugs to offset or self medicate their mental and psychic pain. Both alcohol and drugs may also potentiate mental illness for instance alcohol is a depressant. The evidence around the influence of cannabis is controversial but may have a role in psychosis in genetically susceptible people (less than 20% of those developing a psychotic illness) when used in early teenage years. Cannabis can also exacerbate symptoms and sign in established psychotic illness eg paranoia and hallucinations[1].

Exposure to risk factors is variable across the population including within and between different ethnic groups and it is important not to make assumptions in this regard. However it is possible to summarise that not only do many people live in deprivation in Lambeth and Southwark, in itself a reason for high prevalence of mental health problems, but also for many ethnic minority groups, a higher proportion than (the national) average are poor and live in highly stressful circumstances (eg. more likely to be unemployed and unemployed for longer periods, living in poor housing in deprived areas, exposed to crime and violence both in the neighbourhood and personally, and subject to discrimination, bullying and victimisation at school, in the street and at work). This situation also impacts negatively on family life and can make it much more difficult for parents to provide for and nurture their children especially if they were also neglected as children.

This perspective should be seen as a general rather than a specific point. Clearly many people are extremely resilient in the most adverse circumstances and maintain strong and supportive family ties successfully bringing up similarly resilient children and young people. But the situation in Lambeth and Southwark is very unequal and for the most part ethnic minority populations are more likely to be disadvantaged and therefore at more risk.

In addition we know that in Lambeth substance and alcohol misuse is a substantial problem across most population groups.

All these factors contribute to the high prevalence of mental health problems in Lambeth and Southwark. The evidence also suggests that for some ethnic minority groups people's socio-economic circumstances and their experience of stigma and discrimination and social exclusion is highly relevant.

9. Possibilities for action

To be most effective and useful intervention should focus on the risk factors that can be altered. Whatever the contribution of genetics there is little that can be done to influence this. In contrast there is a great deal that the public sector and communities can do to prevent detrimental family settings and mitigate the impact of some of the traumatic trigger life events.

Newton (2013)[1] suggests that because of its contribution to mental illness including psychosis, childhood neglect/ abuse is the area that is maybe most amenable to intervention and would give the biggest impact. This could be achieved by eg

- Continued action to prevent teenage pregnancy that offers alternatives and promotes aspiration and educational success ie a holistic and integrated approach to adolescent development of boys and girls
- Continued and broadened parenting support especially to teenage parents, mothers with mental illness and others who are in particular difficulty including socio economic deprivation
- Offering therapeutic foster care in specific circumstances especially where foster care has broken down
- Offering expert support and supervision to parents with children under 8 years with special needs

Table 5 shows a generic list of 'best buys' in mental health. They are a mix of preventive and early intervention actions. In Lambeth and Southwark there are good examples of where these are being implemented but sometimes provision may be short term and not comprehensive so many people at most risk do not have access to what is on offer.

Table 5. Best buys to for mental health

Intervention	Saving (per £1 invested)
Social and emotional learning programmes in schools	£84
Suicide prevention through GP training	£44
Early intervention for psychosis	£18
Pre-school educational programmes for 3-4 year olds in low income families	£17
School based interventions to reduce bullying	£14
Screening and brief interventions in primary care for alcohol misuse	£12
Work based mental health promotion (after 1 year)	£10
Early interventions for parents of children with conduct disorder	£8

Early diagnosis and treatment of depression at work	£5
Debt advice services	£4
Cognitive behavioural therapy for people with medically unexplained symptoms	£1.75

In discussing the types of intervention that might be effective Newton notes that because much of the trauma experienced is that of deep humiliation and shame the type and method of intervention has to avoid compounding these feelings and doing more harm (eg by offering support that stigmatises and shows what a failure you have been in your parenting etc). This is a highly relevant point when planning how best to offer support to ethnic minority groups who may already feel stigmatised and excluded at societal level.

One way of achieving this is to ensure universal approaches ie where the provision is for all and within this setting there is access to additional support to avoid the benefits being 'captured' by those with more motivation and ability to make use of provision but who may have less need. As Lambeth and Southwark are highly diverse extra attention needs to be paid to the differing understandings and experiences of different groups. This requires excellent staff training and development beyond what is usually seen as adequate from a clinical or technical perspective.

The concept of a 'fresh start' has also been shown to be less stigmatising and relatively effective; offering input at community level that is not related specifically to failings or illness but that seeks to enable people to achieve their goals in life. The Cares of Life Project in Southwark was one such cost effective intervention.

Where psychotic illness has been diagnosed along with appropriate treatment, it is essential to have societal and staff attitudes that instil hope of recovery and the potential for a rewarding life. Anti stigma and mental health awareness programmes amongst communities and staff are helpful in achieving this.

Beyond the medical concepts of recovery (a reduction in signs and symptoms) a conceptual model for recovery that is not illness focused is suggested by Leamy et al (2011)[7]; that of

- Connections
- Hope
- Identity
- Meaning & purpose
- Empowerment

Or 'CHIME'. They found that in studies amongst ethnic minorities spirituality and stigma played a more important role and also identified two additional themes: culturally specific facilitating factors and collectivist notions of recovery; ie factors that were specific to the community in question and the extent to which the community sees a person as recovered.

10. Conclusion

This paper has outlined some preliminary information to show the disproportionate impact that psychosis has on some ethnic minority groups in Lambeth and Southwark. Although the data are mainly from Lambeth it is likely that they reflect the picture in Southwark and it will be helpful to undertake a similar exercise when technology allows

as well as in relation to people's access to services including in primary care to inform priorities and practice.

The data show that black groups, people of mixed white and black heritage, white Irish and Asian groups have a higher prevalence of severe mental illness than other groups. It suggests that despite the rising population new diagnoses of SMI are remaining relatively stable but the incidence rate in men of black or mixed heritage is higher than the average. The incidence rate in Asian women may also be higher than the average although this is based on small numbers

Analysis of quantitative data only takes knowledge so far. Qualitative information drawn from a good cross section of people with direct experience of psychosis and services is also essential to direct commissioning and service provision.

This paper has not covered the interesting findings in research relating to the distribution of schizophrenia and what is called 'ethnic density' (where ethnic minority groups are less likely to develop psychosis where they are living in close proximity with a community from their own ethnic background), much of which was undertaken locally. However given the known importance of social relationships in promoting and protecting mental health and wellbeing this is an area for further exploration.

Public health is working with both the Lambeth and Southwark Councils and CCGs to improve access to information and build the case for appropriate interventions to prevent mental illness and promote mental wellbeing. Interventions that are effective and appropriate for a highly diverse population is an integral aspect of this work.

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July 2013

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Lambeth & Southwark Public Health Team

Appendix 1

Risk factors potentially influencing the development of mental problems and mental disorders in individuals, particularly children[8]

Individual factors	**Family/social factors**	**School context**	**Life events and situations**	**Community and cultural factors**
Prenatal brain damage	Having a teenage mother	Bullying	Physical, sexual and emotional abuse	Socioeconomic disadvantage
Prematurity	Having a single parent	Peer rejection	School transitions	Social or cultural discrimination
Birth injury	Absence of father in childhood	Poor school attachment	Divorce and family breakup	Isolation
Low birthweight	Large family size	Inadequate behaviour management	Death of family member	Neighbourhood violence and crime
Birth complications	Antisocial role models (in childhood)	Deviant peer group	Physical illness/ impairment	Population density and housing conditions
Physical and intellectual disability	Family violence and disharmony	School failure	Unemployment, homelessness	Lack of support service including transport, recreational facilities etc.
Poor health in infancy	Marital discord in parents		Incarceration	
Insecure attachment in infant/child	Poor supervision and monitoring of child		Poverty/ economic insecurity	
Low intelligence	Low parental involvement in child's activities		Job insecurity	
Difficult temperament	Neglect in childhood		Unsatisfactory workplace relationships	
Chronic illness	Long-term parental unemployment		Workplace accident/injury	
Poor social skills	Criminality in parent		Caring for someone with an illness/ disability	
Low self esteem	Parental substance misuse		Living in nursing home or aged care hostel	
Alienation	Parental mental disorder		War or natural disasters	
Impulsivity	Harsh or inconsistent discipline style			
	Social isolation			
	Experiencing rejection			
	Lack of warmth and affection			

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Agenda Item 12

Southwark Council

Scrutiny review proposal

1 What is the review?

GP access (out of hours, A&E, 111 service, urgent care)

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

- We would like to ensure that Southwark residents are able to access the best level of care and GP access is allowing them to do so in a reasonable time frame without placing additional burdens on other services
- We would be looking to influence
  - CCG
  - Health & Wellbeing Board
  - Public Health England
  - Healthwatch
  - Council

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

Initial scoping to take place in June 2013 with a full review to be completed by end of municipal year 2013/14

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

We would propose a full review leading to a final report with recommendations

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

Out of hours GP services
Waiting times for appointments
111 service usage
Impact of A&E changes
Varying services throughout the borough

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

Public Health Director
Health & Wellbeing Board
CCG
Public Health England
Healthwatch

Hospitals
Patient Liaison Groups
Cabinet member (perhaps in December interview by committee)
Local experiences of patients

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

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

Verbal and written submissions
Online survey for Southwark Residents
Potential stakeholder roundtable with patients regarding their experiences

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2013-14**

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Dated: May 2013