Open Agenda

Southwark Council

Southwark NHS Primary Care Trust

Health and Social Care Board

July 2 2009 at 6.30 pm
Town Hall, Peckham Road, London SE5 8UB

Executive Membership

Councillor Nick Stanton (Chair)	Leader of the Council
Councillor Kim Humphreys	Deputy Leader and Housing
Councillor Paul Kyriacou	Environment
Councillor Linda Manchester	Community Safety
Councillor Tim McNally	Resources
Councillor Adele Morris	Citizenship, Equalities and Communities
Councillor David Noakes	Health and Adult Care
Councillor Paul Noblet	Regeneration
Councillor Lisa Rajan	Children's Services
Councillor Lewis Robinson	Culture, Leisure and Sport

Southwark NHS Primary Care Trust Board Membership

Mee Ling Ng	Chair & Non Executive Director
Susanna White	Chief Executive, Southwark PCT & Strategic Director of Health and Community Services, Southwark Council
Malcolm Hines	Deputy Chief Executive & Director of Resources
Ann Marie Connolly	Director of Public Health
Dr Olufemi Osonuga	Professional Executive Committee Chair
Peta Caine	Vice-Chair, Non Executive Director
Richard Gibbs	Non Executive Director
Anne Montgomery	Non Executive Director
Robert Park	Non Executive Director
Edward Robinson	Non Executive Director
Winston Tayler	Non Executive Director

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Contact: Everton Roberts on 020 7525 7221 or email: everton.roberts@southwark.gov.uk

Members of the Board are summoned to attend this meeting.

Councillor Nick Stanton, Leader of the Council and Mee Ling Ng, Chair Southwark PCT Board
Date: June 29 2009

PRINTED ON RECYCLED PAPER

Health and Social Care Broad

Thursday July 2 2009
6.30 pm
Town Hall, Peckham Road, London SE5 8UB

Order of Business

Item No.	Title	Page No.
1.	**APOLOGIES** To receive any apologies for absence.	
2.	**WELCOME AND INTRODUCTIONS**	
3.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE JOINT CHAIRS DEEM AS URGENT** The Access to Information Procedure Rules permits an item of business to be added to an agenda within five clear days of the meeting by reason of special circumstances, which shall be specified in the Minutes.	
4.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** All members present are required to declare, at this point in the meeting (or as soon as possible thereafter), any personal interest(s) and dispensation (if any) in respect of any item or issue to be considered at this meeting.	
5.	**MINUTES** To approve as a correct record, the minutes of the meeting held on March 12 2009.	1 - 3
6.	**MATTERS ARISING** To consider any matters arising from the minutes of the meeting held on March 12 2009.	

Date: June 29 2009

Agenda Item 5

SOUTHWARK HEALTH AND SOCIAL CARE BOARD

Minutes of the meeting of the Southwark Health & Social Care Board held on Thursday March 12 2009 at 6.30pm at the Town Hall, Peckham Road, London SE5 8UB

PRESENT:

EXECUTIVE

Councillor Nick Stanton	Leader of the Council (Joint Chair)
Councillor Kim Humphreys	Deputy Leader and Housing
Councillor David Noakes	Health and Adult Care
Councillor Lewis Robinson	Culture, Leisure and Sport

SOUTHWARK NHS PRIMARY CARE TRUST BOARD

Mee Ling Ng	Non-Executive Director, Southwark PCT (Joint Chair)
Malcolm Hines	Deputy Chief Executive and Director of Resources
Ann Marie Connolly	Director of Pubic Health
Dr Olufemi Osonuga	Professional Executive Committee Chair
Peta Caine	Non Executive Director, Southwark PCT
Richard Gibbs	Non Executive Director, Southwark PCT
Anne Montgomery	Non Executive Director, Southwark PCT
Robert Park	Non Executive Director, Southwark PCT
Edward Robinson	Non Executive Director, Southwark PCT
Winston Tayler	Non Executive Director, Southwark PCT

1 APOLOGIES FOR ABSENCE

Apologies for absence were received on behalf of Councillor Jeff Hook, Councillor Paul Kyriacou, Councillor Tim McNally, Councillor Adele Morris, Councillor Paul Noblet, Councillor Lisa Rajan and Susanna White.

2 WELCOME & INTRODUCTIONS

Councillor Nick Stanton chaired the meeting.

Mee Ling Ng, introduced Ms Anne Montgomery, a new non executive director of, Southwark PCT.

3 **NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT**

There were no late items.

4 **DISCLOSURES OF INTERESTS AND DISPENSATION**

There were no disclosures of interests or dispensations.

5 **MINUTES** (see pages 1-3)

RESOLVED: That the minutes of the meeting held on October 16 2008 be agreed as a correct record and signed by the chair.

6 **MATTERS ARISING**

There were no matters arising.

7 **SOUTHWARK SAFEGUARDING ADULTS PARTNERSHIP BOARD – ANNUAL REPORT** (see pages 4-47)

The board received a presentation from Rod Craig, director of client group commissioning.

RESOLVED:

1. That the Safeguarding Adults Partnership Board annual report for 2007-08 and the work of the partnership be noted.

2. That the 2008-09 annual report be brought to members earlier in the year (June/July).

8 **THE FUTURE OF COMMUNITY HEALTH SERVICES – THE PROVIDER ARM OF THE NHS SOUTHWARK** (see pages 48-49)

RESOLVED:

1. That the approach adopted to separate the PCT's provider services by creation of an 'arms-length' provider organisation be noted and further discussions take place on the future options prior to April 2010.

2. That officers report back on progress at the October 2009 board meeting.

9 **STRENGTHENING COMMISSIONING** (see pages 50-51)

RESOLVED: That the NHS arrangements for acute commissioning locally and in London be noted.

10 **PERFORMANCE UPDATE – LOCAL AREA AGREEMENT TARGETS RELATING TO HEALTH AND SOCIAL CARE** (see pages 52-56)

RESOLVED:

1. That the report be noted.

2. That officers come back on points around incentives for smoking cessation, early childhood obesity strategy (as it develops) and early access to maternity services.

11 **FINANCE UPDATE** (see pages 57-60)

RESOLVED: That the current financial position of social care and the three operational pooled budgets set up under s31 of the Health Act 1999 be noted.

12 **FORWARD PLAN – FUTURE ITEMS** (For discussion)

No additional items were added.

13 **DATE OF NEXT MEETING**

It was noted that the next meeting was scheduled to take place in May 2009.

The meeting ended at 8.30pm

CHAIR

DATED

Agenda Item 7

Southwark NHS
Primary Care Trust

Health & Social Care Board

Date of meeting	**July 2 2009**
Name of Report	**Transforming Southwark's NHS**
Author	**Rebecca Dallmeyer, Deputy Director of Primary Care – Commissioning and Development**
Approved by	**Jane Fryer, Medical Director and acting Director of Primary Care**
Audit trail:	**Transforming Southwark Programme Board** **NHS Southwark Board Meeting - 21st May 2009**

1. Recommendation to the Board

1.1 To note and support the recommendations for implementation of the next steps identified for Transforming Southwark's NHS.

2. Background / Context

2.1 In response to recent national and London NHS policy, a Primary and Community Health Care Strategy was developed by NHS Southwark. The strategy for the next ten years identifies the challenges in Southwark, outlines how strengths and achievements of the current local service can be built on and describes how bringing together a range of services will reach out to the whole population of Southwark, delivering care that local people need and deserve. NHS Southwark plans to provide 4 networks of care with health and social care centres based in Peckham, Canada Water/Surrey Quays, Dulwich and Elephant and Castle being at their heart. The centres will be linked to and supported by GP practices, pharmacists, dentists and opticians.

2.2 At the end of 2008 Vision Twentyone was commissioned to help develop and to administer a 3 month consultation with people who used healthcare in Southwark. The consultation used a mixed methodology (including telephone, web, focus groups) to ensure all members of the community who were interested in getting involved and whose voice is not usually heard were able to do so.

3. Key issues for consideration

3.1 There is widespread support for on the direction of travel. The delivery plan will be challenged by the economic climate.

4. Policy and performance implications

4.1 The Primary and Community Care Strategy is consistent with the Next Stage Review, Healthcare for London and NHS London's approach to out of hospital care.

5. Risk implications and Actions Taken

5.1 A risk management strategy will be developed by the Programme Board

6. Impact statements

6.1 An impact assessment will be undertaken for each care network

7. Results of the consultation

7.1 Almost 1,400 people responded to the consultation, including patients, public, councillors, hard to reach participants, staff and local professional groups.

a) Access to current services

The majority of the public and patients interviewed had used core primary care services such as GPs, pharmacy, dentistry and urgent care, and accessed outpatient services and simple diagnostic tests. The key issues that people raised were language barriers, difficulties with appointment systems and continuity of service.

b) What do service users want?

The majority of respondents across the different groups broadly agreed with the proposals. In particular fast and convenient access to diagnostics and urgent access to a doctor or nurse, especially for children, were considered very important by the public, patients and staff. Hard to reach participants highlighted more convenient and longer opening times at the doctors and access to a GP of choice.

c) Principles for services and their design

NHS Southwark has eight overarching principles to address existing and expected demands on local health services. The majority of respondents agreed that the principles would improve local healthcare services, although some were sceptical. The majority of respondents were supportive of all the principles, with a focus on detection and prevention, improved quality and safety and management of long term conditions being most positively supported.

d) Feedback on networks of care

Most people were very positive and agreed with the proposals. In general the focus group attendees were supportive of the proposed plans, particular stating that they liked the later opening hours of the centres, the idea of a walk in centre and having a range of primary and community care services all under one roof.

e) Locations and services

Most people were supportive of the four locations for the health and social care centres and the four key services proposed for the health and social care centres. Respondents were positive about the opening times, the mix of walk in and bookable appointments and specific service provision for the health and social care centres.

f) Concerns

The main concerns raised were about possible duplication of services, impact on existing services on hospital and in the community, resources (staff and money), the imposition of standard centres and possible confusion amongst patients and the public.

g) Suggestions

The main suggestions were based on easy and convenient accessibility, effective working with GP surgeries in the network and good publicity to reduce confusion.

h) Dulwich health and social care centre

The consultation also focussed on the development of services at the Dulwich site. In general people supported the proposed site and services including services for people with urgent problems and community and social care services including mental health. The CICG focus group were positive towards the idea of having a centre at the Dulwich site but were keen for it to include the continuation of intermediate care beds. The Staff focus group (made up of the intermediate care team) also thought this was an important factor for the Dulwich site and talked about the current service only including step down care. Some people had concerns about the transport links to the site and its close proximity to King's College Hospital.

8. Update on progress

8.1 The Transforming NHS Southwark Programme Board has recently been established to oversee the implementation of Primary and Community Care Strategies. The Programme Board has agreed to resource a project manager to develop the commissioning template for each network of care.

9. Recommendations and next steps

9.1 Vision Twentyone and the Transforming NHS Southwark Programme Board have identified the following recommendations from the consultation findings:

- work with local people to develop proposals for each care network, being explicit about the role of the health and social care centres and the supporting GPs, community pharmacists, dentists and optometrists and local hospitals

- identify locations for services within each care network, taking account of accessibility and transport links

- identify the services, funding and staffing to implement each care network

- develop and implement care pathway redesign, especially for long term conditions, including referral to other services

- develop an intermediate care strategy

- develop clear, visual plans for how the care network will look and feel, including case histories

- develop clear involvement and communication strategies for people who use or provide health and social care in Southwark

- to task the Programme Board to oversee the implementation of the Primary and Community Care strategies taking account of the views expressed in the consultation and including those recommendations listed above.

Agenda Item 8

Meeting name:	**Southwark Health and Social Care Board**
Date:	**July 2 2009**
Report Title:	**The Future of NHS Community Services: Implications for Southwark**
Classification:	**Open**
From:	**Susanna White** Strategic Director of Health & Community Services and Chief Executive of Southwark PCT

Recommendations

1. To note the developments set out in the report.

2. To agree to develop specific options for Southwark Health & Care systems.

Purpose of report

3. To set out the issues for Southwark which arise from changes in NHS Community Services

Developments

4. The strategic position of the PCT to commission integrated services and maintain a Southwark only provider arm has been reconsidered in recent months. A range of factors have contributed to this.

5. There are clear expectations that economies of scale will be achieved by provider arm mergers. The economic downturn and predictions of flat line funding for the NHS from 2011/12 have highlighted this as a key driver.

6. Other local organisations have approached Southwark PCT to 'sound out' and initiate merger opportunities.

7. PCTs are required to have a clear and sustainable way forward by October 2009, for implementation in April 2010. A single borough directly provided unit is not seen as a long-term option.

8. The more general architecture of the NHS in London has been taking shape. There are three key components

   - Acute commissioning in larger units – six sectors in London. Locally, acute commissioning is via the Lambeth, Southwark & Lewisham Alliance, now established. This relates to the wider South East London sector.

- Provider separation

- Borough commissioning – there is clear encouragement for closer collaboration on local community based services, including: GPs, Mental Health, Children and Vulnerable Adults.

Key Considerations

9. Initial discussions have taken place with Board members and key Councillors.

10. There is a joint desire to preserve a unique Southwark approach of close integration at strategic and front-line levels.

11. The development of 'Guiding Principles' across the Southwark system has been suggested. These would be designed to inform and influence the processes and decision-making, in any new arrangements.

12. Guiding Principles could include:

- Presentation of 'whole system' approach and integrated working
- Southwark specific focus and management in any multi-borough/ agency arrangement
- Clear financial transparency
- Strong NHS/Council commissioning arrangements
- Focus on Southwark population, patients and clients
- Value for money

Southwark Way Forward

13. Ways to achieve this, within the new architecture have been considered, taking into account the specific issues of children, adults, public health, commissioning and providing.

14. An integrated commissioning approach across the whole system, with specific outcomes to be specified from providers should be able to meet the considerations set out above. Particular consideration will need to be given to adult social care and its permanent operational arrangements.

15. Both NHS Southwark and the Council will need to give consideration to this, both separately and together.

London Position

16. The Borough Commissioning – Council/NHS relationship is being considered by London Councils and NHS London in July. Appendices A, B and C give further details:

27 April 2009	London Councils report
19 May 2009	Letter from CE Barking & Dagenham Council
2 June 2009	Letter from NHS London

Executive

NHS London Strengthening Commissioning Programme - future implications

Item no: 5

Report by:	Dick Sorabji	**Job title:**	Corporate Director, Policy and Public Affairs
Date:	27 April 2009		
Contact Officer:	Dick Sorabji		
Telephone:	020 7934 9761	**Email:**	Dick.Sorabji@londoncouncils.gov.uk

Summary

This report updates the Executive on the development of NHS London commissioning plans during 2008/9. Describes the impact this had had on existing London Councils policy and makes recommendations for more proactive engagement to ensure that borough level commissioning of health care is enhanced within the Strengthening Commissioning Programme of NHS London.

Recommendations

The Executive is asked to:

- Note and agree the direction of travel described in the report.
- Encourage all boroughs to develop proposals for borough level commissioning.
- Agree that London Councils investigate the potential for pan-London support to boroughs developing borough level health commissioning proposals.
- Note that creation of common information analysis system will be an early priority for investigation.

NHS London Strengthening Commissioning Programme – future implications

Overview

1. London Councils has previously defined core principles guiding the response to NHS London plans for commissioning and related changes in health care delivery. Recent developments suggest that more proactive engagement by London boroughs may now be required to maintain these core principles.

2. This report describes the increasing pace of developments in NHS London's Strengthening Commissioning Programme and the actions of London Councils and London local government in response. This recent experience suggests that London Councils policy of supporting borough level commissioning and coterminous PCTs will require London local government to influence future policy by making proposals for local commissioning rather than waiting to respond to NHS plans.

3. To this end a range of approaches to borough commissioning is described that are consistent with policies on health care in London agreed by the Executive and Leaders Committees of London Councils. The report makes related recommendations on how London Councils might support all London boroughs to more effectively influence the emerging design of health care commissioning, ensuring strong links between PCTs and local government at borough level.

4. The Executive is asked to consider the direction of travel described by the report and to agree the proposals for future action.

Previous Policy Decisions

5. Over time London Councils has developed wide ranging policy on health care in London. Policy reflects both general principles on local democratic control and also responses to NHS plans including Healthcare for London that followed the Darzi review and the Strengthening Commissioning programme. The decisions of the Executive Committee on 6th October 2008 and Leaders' Committee on the 8th July 2008 are especially relevant to recent developments in NHS Commissioning policy. London Councils principles include:
   - The retention of coterminous PCT and borough boundaries is essential for high quality health care in London. It underpins partnership working with the NHS,

democratic accountability and statutory accountability for LAAs, JSNA and the coming CAA.

- In the medium term local government in London should exercise stronger local democratic influence over commissioning health care and this should include devolution of PCT commissioning budgets within guidelines protecting national policy.
- London local government recognises the sub-regional and pan-London implications of the current weaknesses in the commissioning of acute care in London and that, within the context of coterminous PCTs; this will lead to discussion of strategies to improve outcomes for patients through collaboration between PCTs.
- Partnership working and joint commissioning between PCTs and local government is a vital contribution to ensuring that Londoners get the best quality health services.
- Delivery partnerships between boroughs and PCTs are an important contribution to high quality care. They should be fostered and not undermined simply to meet administrative requirements.

6. London Councils has also made clear its view that the process of change and development in NHS provision must be open, transparent and inclusive. Early warning of future plans is a necessary condition for ensuring constructive joint working.

NHS London - Implementing Strengthened Commissioning

7. Since the summer of 2008 the pace of change in NHS London commissioning and delivery has accelerated. This is the result both of the Strengthening Commissioning Programme gathering momentum and also of wider pressures on NHS London to drive up health care standards more swiftly. Developments include:
   - The first World Class Commissioning Assessments were conducted between June 2008 and March 2009. The process has accentuated the urgency of NHS London's drive to raise commissioning standards.
   - On 8th December 2008 the Health Secretary announced PCT budgets for the next two years. The majority of London PCTs received the lowest level of increase of all PCTs in England at 10.6% over two years compared to an average rise of 11.3%. Changes to the funding formula mean that finance will become tighter after the end of 2010/11.
   - In December 2008 NHS London approved the business plan for the London Clinical & Business Support Agency (LCBSA) a pan-London service designed with PCTs to support individual PCTs health improvement plans.

- Consultation on major trauma and stroke services began in January 2009 and will close on 8th May.
- On 24th March the appointment of six Sector Chief Executives was announced to work at sub-regional level across PCTs. They will lead the creation of larger commissioning entities for acute care and be responsible for performance management issues in acute care. These officers will continue in their roles as chief executives of individual PCTs.
- Five Polyclinics are planned to open in London by April 2009.
- National government has required the NHS to separate out internal provider services from PCTs by April 2009.

Local Government Response

8. London Councils has responded to these initiatives as they arise making clear local government's concern that stronger commissioning should be borough led. Following both the Leaders Committee of July 2008 and the Executive Committee in October 2008 London Councils arranged discussions with NHS London at political level. These discussions have been underpinned by ongoing work at officer level which has engaged chief executives from London boroughs. There is now a network of ongoing officer level discussion between local government and NHS London.

9. However, three types of pressure are increasing the importance of more proactive engagement by London local government in order to maintain and then advance existing policy on health care. These are:
   - The pace of NHS decisions on commissioning is increasing and it is more important to shape these decisions before they are made, rather than to respond to them.
   - Individual boroughs are already engaged in detailed discussions.
   - Long term concerns about the cost and quality of health care unless devolution can be delivered.

10. NHS initiatives during the last nine months have often had implications for London Councils policy supporting coterminous PCTs. Some of the developments described above have caused concerns about centralisation, the relative priority given to borough level and sub-regional or pan-London commissioning capacity and about the time available to discuss the implications of change. In retrospect it appears that local government could have had more influence if it had been in a position to offer its own

proposals for the design of borough level commissioning, rather than responding to NHS plans.

11. During recent months many individual boroughs working individually and in groups have entered detailed discussions on the Strengthening Commissioning programme. This work has highlighted the importance of joint working between PCTs and London local government to strengthen borough level commissioning and improve patient outcomes. The process has led to the emergence of differing policy initiatives in different parts of London. During 2009/10 borough level commissioning is programmed as a priority within NHS London and so the opportunity to shape and enhance NHS policy by proposing specific health commissioning plans at borough level will increase.

12. In the long term the success of NHS London policy depends on being able to devolve health care to a more local level. The Darzi report revealed both the need to raise health care standards in London and also the high cost of low standards. The report forecast NHS costs would reach to £14.5 billion by 2016; £1.4 billion more than is funded on current plans.

13. In response *Healthcare for London* proposed closing the £1.4 billion shortfall and increasing patient activity by 57% through a shift of most health services to a more local level. By 2016 many aspects of health care in London's major hospitals would be devolved closer to communities:
    - In-patient work would be 59% devolved: 29% delivered in local hospitals, 20% at elective centres, and 8% with GPs and polyclinics and 2% no longer needed.
    - A&E work would be 80% devolved: 20% at local hospitals, 50% at polyclinics and 10% no longer needed.
    - Outpatient work would be 87% devolved: 13% at local hospitals, 13% at elective centres, 41% at polyclinics and 20% no longer needed.

14. It will be a challenge for the NHS to deliver this level of devolution by 2016. More proactive support by London boroughs could increase the chance of success and ensure that London local government's policy concerns are at the heart of future discussion.

Strengthening Local Influence on Health Commissioning

15. Officers from London Councils and London local government held a preliminary discussion with political Group Leaders and relevant Portfolio holders of London Councils to consider how to ensure that local government maintains influence on the future shape of health care commissioning. At the heart of the discussion was the need to raise the quality of health care for Londoners and to ensure local responsiveness through a strong link between coterminous PCTs and individual boroughs.

16. As a result it is proposed that London Councils should encourage as many London local authorities as possible to develop proposals for shaping health care commissioning in their borough. Different approaches will be required in different boroughs. Some common forms of support will be needed by all participating boroughs and should be provided on a pan-London basis. This should be facilitated by London Councils.

17. When considering what models for borough commissioning might be effective in a specific case there are a range of relevant issues:
    - What types of model are available and how fully have they been tested?
    - What factors affect the likely success of different models in different circumstances?
    - What types of pan-London support might be offered?

18. Possible approaches to borough commissioning cover a wide spectrum. However, it is possible to single out three distinct points on that spectrum:
    - Full integration of the management of both PCT and local authority and greater integration of governance structures between the local authority Cabinet and the PCT Board.
    - Integrated action through joint commissioning units, or allocation of lead commissioners between PCT and local authority, across a wide range of non-acute services for example older people, disabilities, learning disabilities, mental health, children, substance misuse and community care. This is often supported with joint appointments of specific staff such as Directors of Public Health. To have significant impact the system would need to deliver joint needs assessment, policy development, planning and public engagement.
    - Integrated information creating a common method for assessing and analysing need shared across PCT and local authority and defining need in terms of places and people, not professions and institutions. These systems will be easier to deliver and

yet offer a strong foundation for the development of joint analysis, the development of common strategies and vision for the area. This in turn will provide direct support for JSNA, CAA LAAs and WCC assessment of PCTs.

- Examples of these approaches are provided in appendices 1-3 of this report.

19. There is no one best approach. There are recent examples of attempts at joint working that look coherent in theory, but have not been sustainable in practise. Different places will need different approaches. When developing approaches for a particular place a range of competing pressures will need to be considered including:
    - The depth and quality of existing relationships and the extent of a common vision and common language for discussing policy solutions will be important in designing solutions.
    - A tension between ambition for quick results and the risk of policies that are too ambitious to succeed.
    - There will be trade offs between ideal solutions and those which can be developed within the time constraints on both boroughs and PCTs.
    - The financial stability of PCT and local authority

20. The more boroughs that put forward proposals, the greater the chance of influencing NHS London as a whole to protect and enhance borough level commissioning. NHS London works across six “sectors” or sub-regions. London local government will increase its ability to shape final outcomes if there are significant and positive interventions in each of these sectors.

21. In order to ensure that the largest possible number of boroughs adopt a proactive approach to NHS commissioning plans it is proposed that London Councils should investigate the resources that would be useful and could be marshalled to support individual boroughs when developing joint commissioning proposals.

22. A common approach to information analysis is especially important. It is recommended that this should be a priority area when considering possible forms of pan-London support.

Recommendations

23. To take forward existing London Councils policy in the light of the developments described in this report the Executive is asked to:
    - Note and agree the direction of travel described in the report.
    - Encourage all boroughs to develop proposals for borough level commissioning.
    - Agree that London Councils investigate the potential for pan-London support to boroughs developing borough level health commissioning proposals.
    - Note that creation of common information analysis system will be an early priority for investigation.

Financial Implications for London Councils

24. There are no financial implications for London Councils.

Legal Implications for London Councils

25. There are no legal implications for London Councils.

Equalities Implications for London Councils

26. There are no equalities implications for London Councils.

Appendices

Appendix one
A unified Executive team (Hammersmith and Fulham)

The proposal
In Hammersmith and Fulham, a proposal has been agreed to create a unified executive team for the London Borough of Hammersmith and Fulham (LBHF) and NHS Hammersmith and Fulham (NHS H&F).

The proposed approach is for:

- a unified management team to support the two continuing statutory bodies;
- a single Chief Executive for both LBHF and NHS H&F;
- a unified executive management team, consisting of the existing 5 directors of LBHF and a new post at NHS H&F of Managing Director Health;
- both the NHS H&F Board and the LBHF Cabinet continuing, with minor changes to membership; and
- the NHS H&F Board and LBHF Cabinet to meet twice a year to discuss shared agendas.

Context
Both organisations have a history of working together successfully. This proposal has come about as a result of agreement by the executive leadership of both organisations that the challenges they face can best be tackled through working together even more closely. A recent joint strategic needs assessment provided a clear picture of the health and well being needs of residents. It was evident that meeting these needs would require more than a traditional health service and would necessitate all partners working together. The new Local Area Agreement and Comprehensive Area Assessment with its focus on the area rather than the actions of individual statutory bodies also supported the need for the two bodies to reconsider how they work together for the benefit of residents. In the NHS, the emphasis on strengthening commissioning has required the NHS to look closely at how it commissions services locally. The context of constrained public sector growth in the future, combined with future cost pressures, is also a factor.

Expected benefits
It is considered that implementing a unified executive team can:

- improve resident and customer satisfaction with public services in H & F;
- deliver high quality, timely, effective services with best value for money;
- deliver real early benefits that will make a difference to residents;
- support both organisations to achieve and maintain excellence in delivering their functions: and
- over the long term, reduce inequalities and regenerate neighbourhoods

Organisational and governance arrangements
The Council Cabinet and the PCT board will be supported by a unified executive team. The Joint chief executive will be the head of paid service and principal adviser to the council and the accountable officer for NHS H&F for PCT functions. In addition to the existing directors from LBHF, a new post of Managing Director Health will be created which will report to the Joint Chief Executive. All directors who are part of the integrated management team will act on behalf of both organisations.

LBHF and NHS H&F will continue as separate legal entities. The Cabinet and NHS H&F Board will remain the key accountable bodies for local government and the NHS respectively. The proposal has recommended two changes to the membership of the NHS H&F Board:

- That the Managing Director Health is a member of the Board as well as the Chief Executive; and

- That the lead Councillor for Community and Children's services becomes an Associate Member of the Board to facilitate joint governance.

In the event of disagreement between the two bodies, the continued legal separation of the two entities will allow transparency with both bodies about their respective roles. The joint chief executive will be conscious of his respective legal responsibilities to both organisations. The chief executive also has authority, as now, to prevent certain actions being taken by the Cabinet if necessary.

Appendix Two

Borough based commissioning

In South West London[1], a partnership approach to borough based commissioning has been proposed. The approach was originally developed at a workshop attended by borough representatives, with input from chief executives, directors of children's services and directors of adult social services and based on work commissioned by the South West London boroughs to strengthen commissioning. It was refined further through a meeting between Chief Executives and senior officers of the councils and PCTs in January 2009.

It is considered that this proposal could achieve the following benefits:

- Commissioning led organisations that secure improved health and social care outcomes for their population;
- Horizontal integration of health and social care;
- Local borough focus;
- Harnessing capacity and capability;
- Accountability and democratic scrutiny of commissioning decisions;
- Optimising economies of scale; and
- Performance improvement.

There are a number of principles underpinning this approach:

- Changes in the manner that health care commissioning ordered and organised will inevitably have an impact on what is possible at a borough level: health care commissioning is interdependent and intertwined with the commissioning that local authorities undertake;
- It is recognised that commissioning for certain clinical pathways, health specialities and tertiary services needs to be done on a broader geographical basis to improve health outcomes, ensure cost effective procurement and contracting and achieve value for money;
- However, it is acknowledged that much acute commissioning has care pathways that begin and end in localities and that to develop effective care commissioning involves the input of local authorities; and
- The contribution of local authorities can be direct in terms of prevention or post hospital discharge but also indirectly through a council's well being agenda or work to promote health improvement. It also considered that links with GP and practice based commissioning can be maximised at a borough level.

[1] South west London covers the boroughs of Croydon, Merton, Kingston, Richmond, Sutton and Wandsworth.

The following working arrangements are proposed:

- Boroughs and PCTs to establish joint commissioning units (to undertake joint needs assessment, public engagement, policy development and planning and determining local investment priorities at borough level, as well as examine scope for integration of some business support functions).

- Boroughs and PCTs jointly to promote the career prospects and benefits for health commissioning staff based at borough level.

- Public health leadership and delivery to remain at borough level, with greater integration between borough and PCT health and health inequalities work.

- The scope of joint commissioning a borough level to be: older people, people with disabilities, people with learning disabilities, children's services, substance misuse and community services.

- Commissioning community health services will take place on a borough basis and be the responsibility of an integrated borough/PCT leadership.

- Boroughs are fully included in the examination of options for PCT's new provider arrangements post 2010, including the potential for integrated provider development of council and PCT provision within borough boundaries.

- Children's trusts to include representation from both commissioning and providing health functions to ensure specialist expertise continues to inform the commissioning agenda going forward.

The following approach to investment is proposed:

- Boroughs and PCTs will develop a protocol for sharing the dividend from more effective acute commissioning processes and from savings to acute services from strengthened prevention programmes and community services.

- PCTs as statutory bodies will retain decision making on investment. PCTs and Councils will establish mechanisms to discuss all their investment decisions in advance.

It is proposed that PCTs and Councils would seek to secure integration at a borough level around:

- Commissioning
- Public engagement
- Provision; and
- Corporate functions.

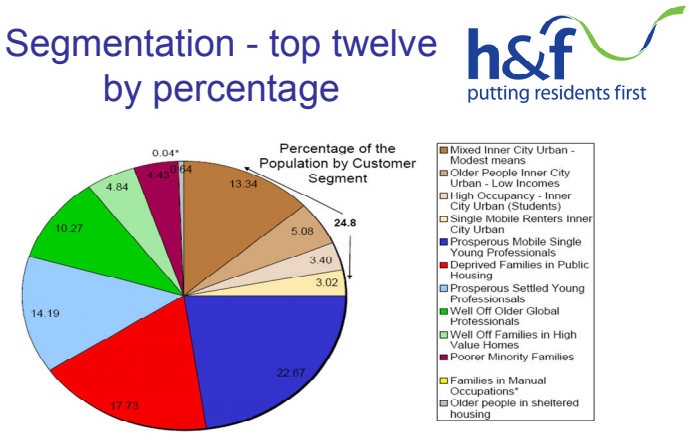
Appendix Three

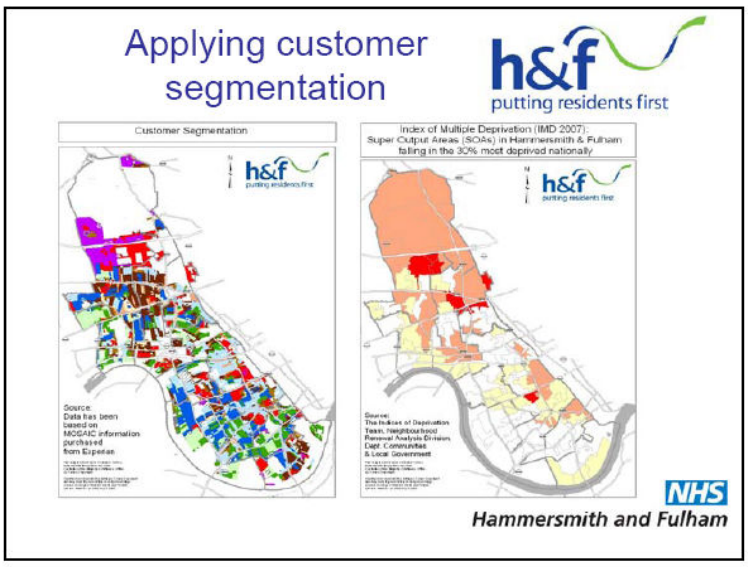
An example of joint borough – PCT work to better understand the needs of the population

As a prelude to closer working, local authorities and PCTs may choose to undertake work to better understand the needs of the population they both serve and the opportunities this presents to work together to meet these needs.

As just one example, in Hammersmith and Fulham, a joint strategic needs assessment provided a clear picture of the health and well being needs of residents. This involved the use of customer segmentation work, using MOSAIC, to drill down to a deeper level than the IMD (Index of Multiple Deprivation) map to understand the different population groups that live in the borough and what their corresponding needs are likely to be.

This information was used to assess the impact of each segment on financial metrics for the Council and the PCT, as well as for identifying opportunities for shared access, shared delivery, shared outcomes and shared outreach.





London Borough of Barking & Dagenham

Ref: RW/WP
Date: 19 May 2009

LB Chief Executives

Chief Executive's Office
Civic Centre
Rainham Road
Dagenham
RM10 7BN

Dear Colleagues

I write to update you on CELC's most recent regular meeting with Ruth Carnall. Following discussion of the policy paper at the Leaders' Committee, London Councils will write to Ruth shortly to seek her endorsement of the approach set out toward borough based primary and community commissioning. Ruth briefed us that she is happy to receive such a request, and welcomes the opportunity to endorse the need for joint work between London Councils/Capital Ambition and NHS London to gather momentum.

As you know Ruth has already given a commitment to London Councils that no substantive PCT Chief Executive post will be advertised without the agreement of the relevant borough in order to encourage discussions at local level. Ruth reiterated that this commitment remains.

This letter asks you to respond briefly, if you wish to do so, in relation to your borough's optimal choice for integration with your local PCT. Please do not feel the need to reply if you do not wish to do so, but if your council would like to take forward integration, please let us know at which level:

- Back-office integration, for example in relation to support services
- Integration of commissioning with joint posts etc.
- Wider corporate integration between the two organisations in order to address broader policy aims such as regeneration

Our intention is to arrange an event in July with NHS London to share learning from existing joint working and integration, share current thinking, and consider next steps including how more detailed discussions can be taken forward. At such an event you would ideally attend with your PCT counterpart, but if there is not agreement between your council and the PCT on the optimal way forward, you are of course welcome to attend in order to discuss the best way forward.

Phone 020 8227 2789
Email rob.whiteman@lbbd.gov.uk
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Minicom 020 8227 2685

London Borough of Barking & Dagenham

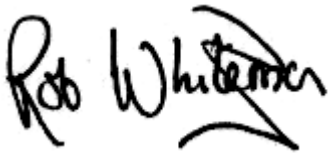
Ruth Carnall is writing to PCT Chief Executives to update them of our discussion, reiterate her expectation that all PCTs will actively engage with local councils to maximise the opportunities for joint working and integration and to advise them of the forthcoming workshop.

I am sure you would agree that this is a very positive way forward and constitutes Ruth Carnall's clear signal to London local government that NHS London would like to work with us in order to quicken the momentum of borough commissioning proposals.

I look forward to hearing from you, and we will then let you know as soon as possible the proposals for an event. At the same time when we are aware of the quantum of work that boroughs would like to take forward, this will be raised with Capital Ambition in terms of capacity to support the work needed.

With very best regards.

Yours sincerely



Rob Whiteman
Chief Executive

To: Members of Southwark Health and Social Care Board (Southwark Council's Executive and Southwark PCT Board)	**Date: July 2 2009** **Meeting name: Southwark Health and Social Care Board**
Report Title:	**Finance Update**
Classification:	**Open**
From:	**Malcolm Hines, Director of Resources Southwark PCT and Mike Watson, Assistant Director of Social Care Finance**

1. Recommendations

1.1 The Health and Social Care Board is asked to note the current financial position of health and social care and the three operational pooled budgets set up under s75 of the National Health Service Act 2006.

2. Purpose of report

2.1 This report updates the Health and Social Care Board on the overall financial position of the PCT, Southwark Adult Social Care Services and the three operational pooled budgets.

3. General Finance update – Council and Social Care budgets

Social Care Budgets 2008/09, 2009/10 and 2010/11

3.1 The Council Medium Term Financial Strategy required departments to exemplify savings equivalent to 5% of their net controllable budget each year for three years starting 2009/10.

3.2 The social care controllable budget in 2008/09 amounted to £89.9m and the savings target 2009/10 after adjustments was £4.125m. The savings target for 2010/11 is £4.706m. This represents a considerable challenge and will require major re-design in ways of working and patterns of service.

3.3 Adults Social Care overspent by £891k in 2008/09. This largely related to unresolved issues from 2005/06. However, it was a very difficult year for containment of expenditure. At month 2 the department is projecting an overspend of £1.56m as a result of slippage on savings proposals. This will have to be managed down to breakeven by year end.

4. Update on PCT Budgets: Outturn for 2008-09 and Forward Look for 2009-10 onwards

4.1 The final revenue position for 2008/09 was an underspend of £218,000 on a budget of circa £50 million.

4.2 This was achieved after significant cost pressures, particularly in acute hospital referrals rising by up to 9%, much faster than the rate of population growth, and including achievement of the national 18 weeks treatment target. Reserves and other budgets were applied to offset these issues, but included non recurrent sources of funds.

4.3 For 2009-10, the PCT has received an uplift of circa 5.2%, and has applied this to recurrently fund cost pressures, and a limited range of targeted investment set out in the Commissioning Strategy Plan.

4.4 This has left a net requirement for savings of £10million, and all areas of the budget have contributed to meeting this target. At Month 2 a breakeven position is predicted, but very little real activity data is available yet on commissioned services.

4.5 Looking forwards, the PCT will get 5.1% in 2010-11, the last year of the current CSR round. Even at this level of increase it is expected that additional savings will be required on top of the Department of Health efficiency target which increases to 3.5%.

4.6 The years 2011 onwards are dependent on the next CSR round this autumn, and how economic factors are incorporated into future uplifts. The efficiency target will increase again to 4% per annum from 2011, as set out in the recent Treasury "Operational Efficiency Programme" report.

5. Pooled Budgets

Hosting Arrangements

5.1 Social Care is the lead organisation for the Learning Disabilities and Integrated Community Equipment Service whilst the PCT hosts the Mental Health pooled budget. An update on the financial position of these budgets is given below:

5.2 The pooled budget final positions for 2008/09 were as listed in the following table:

2008/09		Budget	Outturn	Variance
		£000	£000	£000
LD Pool	Social Care	21,462	22,782	1,320
	PCT	10,293	10,973	680
	Total	31,755	33,755	2,000
MH Pool	Social Care	10,613	10,812	199
	PCT	42,537	43,333	796
	Total	53,150	54,145	995
ICES Pool	Social Care	1,067	1,198	131
	PCT	298	335	37
	Total	1,365	1,533	168

ICES

5.3 A modernisation project via the Government's Care Services Efficiency Review, "the retail model", is being trialled this year as part of the plan for quicker, more economic services.

Learning Disability

5.4 The budget position was predicted, but represents a major cost pressure across the whole system. A major service redesign away from residential care towards supported living will take place in this financial year, as part of the approach for a more personalised and economic service. However, cost pressures remain, and the number of young people moving from children's services will mean additional budget requirement of circa £1-1.5 million in each forthcoming year.

Mental Health

5.5 The final position had not been anticipated in-year and has been investigated. A range of smaller pressures combined to produce this position, and this budget will need careful focus in this year.

6. Pooled Budgets Update 2009/10

Learning Disabilities

6.1 The position at Month 2 is a small projected underspend – effectively breakeven. This is on a budget of:

	£000
LB Southwark	23,323
Southwark PCT	11,224
Total	34,547

Integrated Community Equipment Services

6.2 At Month 2 ICES is projected to break even on the following budget:

	£000
LB Southwark	1,209
Southwark PCT	338
Total	1,547

Health and Social Care Risk Sharing Arrangements – Mental Health

6.3 The risk sharing arrangements for Mental Health, as agreed on Feb 7th 2008, and subsequently reaffirmed as continuing to apply for 2009-10, at the Health and Social Care Board, are:

- 20% Council:
- 80% Primary Care Trust.

6.4 At Month 2 the Mental Health budget is projecting a breakeven position based upon the following budget:

	£000
LB Southwark	10,448
Southwark PCT	43,867
Total	54,315

Agenda Item 10

Item No.	Classification: Open	Date: July 2nd 2009	Meeting: Health and Social Care Board
Report title:		**Integrated Health and Social Care Performance Report Quarter 4 2008/09**	
Ward(s) or groups affected:		**All**	
From:		**Adrian Ward, Acting Director of Performance, Southwark Health and Social Care**	

1. Recommendation to the Board

1.1 That this report is noted.

2. Background/ context

2.1 This report sets out the performance position for Quarter 4, 2008/09 and draft full year outturn in accordance with the integrated performance management framework of Southwark Primary Care Trust (PCT) and Southwark Council's Adult Social Care services. The table in **Appendix A** sets out the full scorecard of indicators.

3. Key issues for consideration

3.1 Local Area Agreement (LAA) targets: See separate report on the agenda.

3.2 **Adult Social Care indicators:** as previously reported to the Board, problems with the system for recording client information have become apparent this year, creating difficulties with in-year performance monitoring. In addition, the finalisation of 2008/09 performance indicators for social care has highlighted a number of important areas of concern. These are:

- **Timeliness of social care assessment** (period from initial contact to completion within 28 days): provisional performance is 64.5% is disappointing compared to performance on the equivalent PI last year 86%, (although the PI has been subject to some technical changes and is not strictly comparable). Further analysis is being undertaken to check the accuracy of end-date recording, and qualitative work is underway to identify the sorts of issues causing delays. The key factor identified so far is around Occupational Therapy capacity, accounting for around half of the longer waits. This is an issue around which there have been some initiatives this year, and has been linked to the high volume of referrals arising from the high levels of social housing. There are also practice issues around holding assessments open longer than required which can be resolved with relative ease. The target will be the subject of an improvement plan taking these findings into account.
- **Timeliness of care packages** (period from completion of assessment to care package being put in place within 28 days): 85% of service users had their service in place within 28 days, a slight decline from 87% last year. However this had been an area for improvement with a local target of 95%. Again the reasons behind this will be analysed further and subject to an improvement plan.

- **Delayed transfers of care:** performance was within target and remains comparatively strong, but there was an upward trend in the year, which needs examining. There has been a 3.5% increase in acute admissions during the year which is clearly a factor.
- **Admissions of older people to care homes:** The rate of admissions of older people to care homes has increased slightly during the year, with 207 admissions compared to 197 last year. This runs contrary to the strategic direction we are seeking but is not out of line with the growing levels of need arising from the increased over 85 year old population in particular. **Admissions of younger adults to care homes** have declined, although the completeness of this data is being checked.
- **Reviews of clients:** although no longer a National Indicator, the % of clients reviewed during the year is an important local measure which fell from 77% to 69% on the latest data. Further work is being undertaken to establish the extent to which this may be a recording issue. Qualitative work is underway to identify more effective ways of ensuring that clients are reviewed, and this will be built into improvement plans.
- **Carers whose needs were assessed or reviewed by the council in the year who received a specific carers' service, or advice and information:** Headline performance has dropped significantly, although underlying performance has not. In previous years Southwark had included self assessment undertaken by known Carers which enabled them to fix breaks or respite funded by the Carers Grant, an approach that is in line with personalisation i.e. self determination of support and care requirements. Southwark has continued to allocate funds at a significant level, but in the calculation stricter criteria have been applied to the definition of what constitutes a carer's needs assessment, which is a pre-requisite for the service to be counted in this PI. This year the stricter definition that there must be a more formal carer's community care assessment undertaken was applied. These are relatively few in number compared to the 1775 carers' service users, so headline performance has reduced. Applying the old criteria performance would not have been so significantly reduced.

- **Self-directed support:** there has been some improvement from 159 to 219 users of direct payments but this is significantly below the target. See LAA report on this agenda for further analysis.

Good performance was maintained in the following adults social care areas:

- **Achieving independence through rehabilitation and intermediate care:** this new National Indicator measures the proportion of older people discharged from hospital to their own home or to a rehabilitation service, with a clear intention that they will move on/back to their own home who are at home three months after their discharge from hospital. Although benchmarking data is not available the Southwark result of 93% appears to be a good outcome.
- **Intensive homecare PIs:** good rates of intensive homecare continue to be recorded.
- **Community equipment:** delivery within timescales further improved during 2008/09, from 91.8% to 94.8%, which is strong performance.
- **Homecare user survey:** Although national benchmarking data is not available to assess performance, the key PI arising from this survey for Southwark is encouraging in that there is an 83.9% net satisfaction rate. Within this, out of 458 service users replying to the question **"Overall, how satisfied are you with the help from Social Services that you receive in your own home?"** 15.5% were

extremely satisfied, 34.1% very satisfied, 34.3% quite satisfied, 8.7% neither satisfied or dissatisfied, 4.8% quite dissatisfied, 0.9% very dissatisfied and 1.7% extremely dissatisfied.

3.3 **World Class Commissioning Outcomes**

There are 10 key outcomes on which Southwark PCT will be assessed as part of the world class commissioning process. Good performance is considered to be achieved when the rate of improvement on the baseline exceeds comparable rates of improvement. The next assessment will be in 2010. For this first year the following summary of results is as follows:

- **Deprivation indices:** Southwark's 2007 position is 25th most deprived borough nationally (up from 17th in 2004) and 8th in London (6th in London). This is not likely to be subject to a refresh until national data is released in 2010/11.
- **Life expectancy:** Southwark 2005-07 rates show that the targets set centrally to contribute to the health inequalities target have been exceeded by a comfortable margin. Male life expectancy has increased to 77 years, 0.9 years below the London average. Female life expectancy has increased to 82 years, in line with the London average.
- **Infant mortality:** data released for 2007 shows a significant increase after a period of steady decline and the 3 year pooled rate for 2005-07, on which the outcome measure is based, has increased from 6.0 to 6.4 (deaths of children under 1 year per 1000 live births). Southwark's relative position has worsened as a result and has increased to 2nd highest in London. Although this data relates to a period before the World Class Commissioning process commenced it is likely to have an adverse impact on the next assessment.
- **Healthy weight in Children:** as previously reported on in detail the 2008/09 results confirmed that rates remain amongst the highest in the country, despite an improvement in the Year 6 rate in line with targets to 26%, and 14.4% in reception. The 2009/10 heights and weights survey results should be available in October to assess if there has been any improvement.
- **CVD mortality rates:** as previously reported the operating plan targets met for 2005-07
- **Cancer mortality rates:** as previously reported the operating plan reported operating plan targets met for 2005-07.
- **Patient survey:** results not published at time of drafting this report
- **Diabetes:** latest performance (2007/08) on this measure relating to blood sugar monitoring of registered diabetics is in line with target. 2008/09 is being confirmed.
- **Increased Access to Psychological Therapies:** the numbers accessing the new service are beginning to build up as the number and capacity of those in post gains momentum, staff training is completed and the first users complete treatment. As a result performance is currently under the initial trajectory at this stage, as would be expected, and it is too early to assess whether longer term trajectories will be met.
- **Substance misuse numbers in effective treatment:** the problems with this target are discussed in the separate report on LAA targets on this agenda.

3.4 **Quality and Outcomes Rating Qtr 4 and Annual Health Check forecast**

It has been a target for the PCT to deliver on its Operating Plan targets sufficiently for the Annual Health Check quality rating to move from Fair to Good. At present it is not possible to accurately predict the final results as some PIs have not been finalised and there is uncertainty about the threshold the Care Quality Commission (CQC) will apply to mark certain indicators. However there are some notable achievements that will contribute towards this as follows:

Targets expected to be met (subject to final CQC ratification) include:

- C.Difficile rates
- 18 weeks referral to treatment (acute sector – but not audiology, see below)
- Stroke care
- Existing cancer wait targets (Mar-Dec 08)
- Mortality rates (all ages all causes)
- CVD mortality
- Cancer mortality
- Smoking quitters (the first time the target has been achieved)
- Early access to maternity services
- Breastfeeding continuation
- Chlamydia screening
- Staff satisfaction
- Dental access
- A&E 4 hour waits
- Delayed transfers of care
- Ambulance response times (Category A - urgent)
- Diabetic retinopathy screening
- Early intervention in psychosis and Crisis resolution (mental health)
- Data quality on ethnic group

Targets not expected to fully met are:

- 18 weeks – data quality check paediatric audiology
- New cancer wait targets (January – March 09)
- Teenage conception rate (see also LAA report)
- Substance mis-use (see also LAA report)
- Ambulance (Cat B – non –urgent)

- Immunisation (although it should be noted that there has been progress in the year, in particular for MMR for 2 year olds for which the target of 75% was achieved)

There are also 2 patient survey PIs yet to be published which may have an adverse impact on the overall rating.

Overall it is not possible to make a firm prediction on the Fair/Good rating. Much depends on how the Care Quality Commission set the amber/red thresholds on those targets that have not been met, which is not yet known.

The chances of achieving "Good" overall have been greatly improved by achieving the targets in the previously identified risk areas of smoking cessation, maternity services access and breastfeeding continuation.

3.5 **Detailed indicator table –** the full table of performance indicators in the integrated framework is attached in appendix B with a commentary in Appendix A. Specific additional issues of interest in the table are:

- Mortality from suicide and undetermined injury (outcome 1): continued decline evident from 2005-7 data
- Mortality rate from causes considered amenable to healthcare (outcome 6): apparent gradual increase to be investigated further.
- Smoking in Pregnancy (outcome 7): apparent gradual increase needs considering
- Cervical screening and Breast screening (outcome 9):rates largely unchanged and below target.
- 'Flu' vaccinations (outcome10): the 2008/09 campaign was much more effective than previous years, with a 5% increase in uptake to 69.8% (just short of the national target). This makes Southwark's performance more mainstream but there is still scope for improvement by addressing poor performing GP practice areas.
- Outpatients waiting over 13 weeks (outcome 25): 12 breaches bring us close to the amber threshold which would have impacted on the annual health check. These relate mostly to Barts' hospital where there was a considerable waiting list problem.
- GP practices offering extended opening: target of 50% met
- Productivity PIs: recent PIs suggest improvements can be made in GP referral rates and length of stay in hospital.

4. Risk implications and Actions Taken (to include financial, legal and human resources)

4.1 The key performance risks identified in this report are subject to action plans to improve performance.

5. Impact statements (Public and User involvement and implications and Equality and Diversity implications)

5.1 A large number of the new Vital Signs are classified as 'Health improvement and reducing health inequalities', and as a Spearhead Group PCT many of our Vital Signs focus on reducing inequality between different groups in the community. For example, aside from reducing the all age all cause mortality rate, the target also incorporates a reduction in the inequality between male and female mortality in Southwark.

5.2 For a number of Vital Signs, data may be broken down into groups (e.g. gender, ethnicity) and this will be monitored as part of our assessment of outcomes for different groups.

6. Appendices

6.1 The following appendices are attached to this report:

Appendix A: Health & Social Care Performance Indicators – Quarter 4 (2008/ 9)

Agenda Item 11

Item No.	Classification: Open	Date: July 2 2009	Meeting: Health and Social Care Board
Report title:		**Performance Update – Local Area Agreement Targets relating to Health and Social Care – Quarter 4 2008/09**	
Ward(s) or groups affected:		**All**	
From:		**Adrian Ward, Acting Director of Performance, Southwark Health and Social Care**	

1. Recommendation

1.1 That this report is noted.

2. Background/context

2.1 As part of Southwark's Local Area Agreement (LAA) (2008/09 to 2010/11) 35 Improvement Targets have been selected from the basket of 198 National Indicators. Of these, 10 targets are of direct relevance to the delivery of Health and Adult Social Care priorities. Separate targets have been set for 2008/09, 2009/10 and 2010/11 in agreement with the Government Office for London. Delivery against the targets will clearly be important to the outcome of the Comprehensive Area Assessment (CAA) for Southwark.

2.2 The purpose of this report is to present a brief summary of these targets and latest performance against them as at Quarter 4 of 2008/09.

2.3 Each target is subject to multi-agency action plans and monitored closely by the Council and its partners under LAA arrangements.

3. Key Issues for Consideration

3.1 Social Care Clients Receiving Self-Directed Support

This target is for the number of social care clients receiving services through direct payments or personal budgets to increase to around 1000 by the end of 2011. It is an ambitious target reflecting the priority given locally to the personalisation agenda. In Quarter 4 there was an increase to 219 users, an overall increase of 40% on last year's result (159 adults). However this was from a comparatively low baseline and was around 30% short of the 2008/09 target.

The target for 2009/10 requires an increase numbers of around 250% on 2009/10. Whilst challenging there are grounds for confidence that this change can be achieved, as the

implementation of personal budgets is being prioritised and, along with other aspects of the personalisation and transformation agenda, is being subject to focused programme management. As well as increasing direct payment numbers it is expected that most new users will be offered personal budgets by the year end under these arrangements, enabling a quicker build up of numbers than was previously possible.

The 219 direct payments users in 2008/09 fall into the following categories:

- Physical Disability (age18-64): 72
- Learning Disability (age 18-64): 26
- Mental Health (age 18-64): 7
- Older People (age 65-74): 50
- Older People (age 75-84): 40
- Older People (age 85+): 24
- Total 219

The above represents 3.3% of community based service users and carers potentially eligible for the service, whilst the revised national target is 30% for 2011, although there are unresolved issues about which categories are included in the eligible cohort. The Southwark target is for 1000 clients to represent 30% of eligible clients.

3.2 **Mortality rates: all ages all causes -** no update on previous report. The next data update is due in December 2009.

This target is to reduce age standardised mortality rates (per 100,000 population) from all causes and for all age groups by around 8% (males) and 7% (females) by 2010/11 from the 2006 baseline of 734 (males) and 441 (females). It is part of a national target and the contribution for Southwark was calculated centrally.

For **males** the annual mortality rate has declined from 734 in 2006 to 717.5 in 2007. This meets the Year 1 LAA target of 727 and is in line with expectations based on recent trends.

For **females** the annual rate has increased from 474 in 2006 to 499, which means the LAA year 1 target of 472 has not been met. This result was out of line with expectations given recent material reductions that have been achieved on a year by year basis. However, the overall long term trend as measured by the rolling 3 year pooled rate remains downwards and it is hoped that the 2007 increase proves to be an isolated blip. Analysis of the underlying mortality rates suggest the main increases were in circulatory disease, cancer of the lung and throat and liver disease.

Note: The related key health inequalities targets on **life expectancy** have been met for both males and females locally.

3.3 Teenage Pregnancy rates

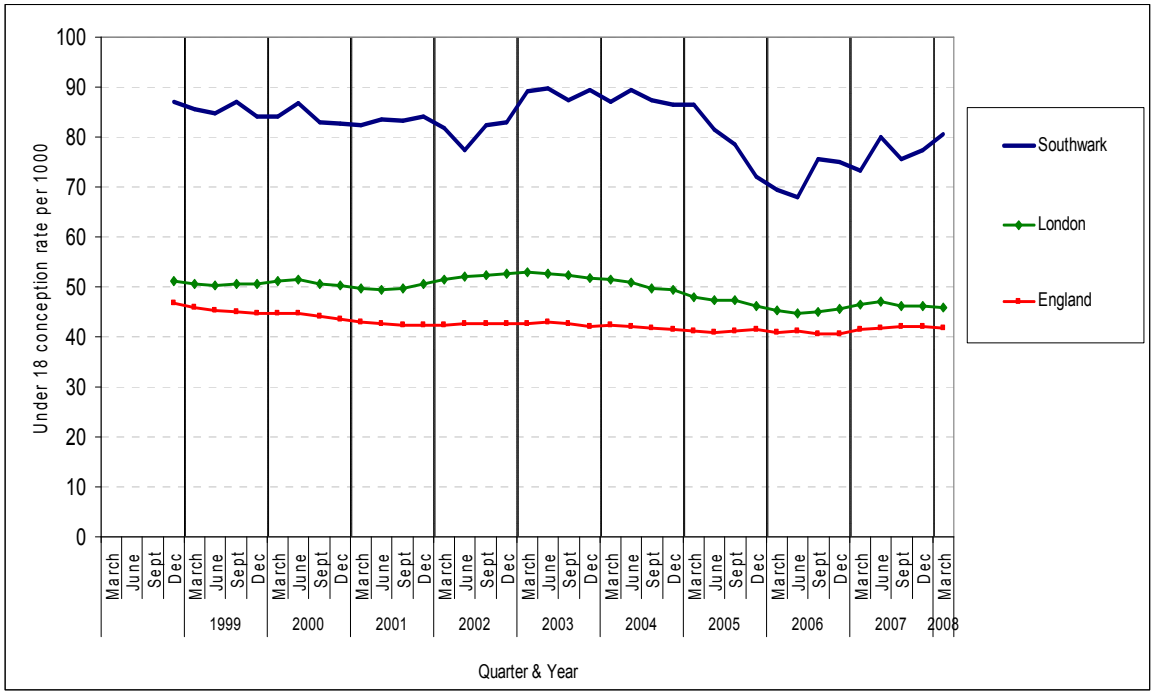
The long established target on teenage conceptions that has been incorporated into the LAA is to reduce the rate by 60% by 2010 from the 1998 baseline of 87.2 (rate per 1,000 population females aged 14-17). In numbers this rate is an annual reduction from 318 conceptions to around 130. In the refresh process a revised target of 49 was requested. The latest data to be issued relates to January – March 2008 (Quarter 1). For Southwark this was a worse quarter with 74 conceptions recorded, compared to 66 in Quarter 4 2007 - giving 303 in the last 12 months. The annual rolling rate has increased to 80.5 from 77.3. Whilst still a reduction of 7.7% on the 1998 target baseline rate, this is clearly very much off the original and refresh target. This is disappointing, especially given that promising reductions were achieved in 2005. The chart (table 1) below illustrates this issue. Furthermore, Southwark on the latest data remains highest nationally.

Teenage pregnancy strategy is under review following a recent multi-agency conferencve on the issue.

Analysis of birth data for Southwark residents, looking at the numbers of new mothers who conceived at age under 18, provides evidence that headline teenage conception rates will not decrease significantly over 2008.

Table 1: Teenage Conception Rates (rolling 12 months) 1998-2008 :

Southwark, London and England



3.4 Smoking Quitters

The target for 2008/09 is for there to be 1,225 smoking quitters (defined as service users who have still quit smoking 4 weeks after using a smoking cessation service). This **has been met** in Southwark, with the latest outturn at 1,277. This required a big jump in performance given that there were only 706 quitters recorded at Quarter 3. It is the first

time that Southwark has met its smoking cessation target since they were established five years ago.

Suggestions made at the last Board to target services at people fined for dropping cigarette butts have been considered and taken into account. However the small numbers involved mean that this is not likely to make a significant impact in overall quitters.

3.5 Healthy weight in children – no update on previous report - next data due October 2009.

The childhood obesity target is to reduce the rate of increase in Year 6 children who are classified as obese. The target actually allows for a small but reducing increase each year. The methodology was agreed nationally by the Department of Health who recognised the challenge inherent in reversing the upward trend in this particular area in the short term.

The 2008/09 results are now collated, and all 71 primary schools in Southwark participated in the annual measurement programme. An improvement was in fact seen in the percentage of year 6 pupils who were obese, decreasing from 27.1% last year to 26% (with an 87.8% sample size). The LAA target of 27.5% has therefore been met for 2008/09, but as our 2007 year 6 rate was the highest nationally it is important that this is not seen as a cause for complacency, and further improvements are being sought as a priority. It should also be noted that 14.3% of reception year children were obese, a 1% increase on last year, although the LAA target does not apply to this age group.

Note: A strategy covering healthy weight in early years, as discussed at the last Board, is near completion.

3.6 Early access to maternity services

This target is to increase the percentage of women who have received an assessment of their health and social care needs by a midwife or obstetrician within 12 weeks and 6 days of pregnancy to 50% in 2008/09, 65% in 2009/10 and 90% by 2010/11. This target was selected because access to maternity services has been identified as an issue locally, and is a possible contributory factor to higher than average infant mortality rates. The baseline performance was poor, estimated at 27%, and this has improved steadily throughout the year to 63.5% in Quarter 4. As a result the 2008/09 target has been met. The PCT is investing in increased maternity services capacity in Kings to help achieve this target, and actions to encourage earlier GP referral and self-referral are planned.

An analysis was undertaken at Kings College Hospital of women who breached the target due to the fact that their first referral to maternity services (via GP or other source) was too late for the first appointment to be within target. This showed that of all women referred in February, 24% were referred after 11 weeks, and 18.5% over 12 weeks. For these clients ensuring the first appointment is within target is difficult in logistical terms. A further 14% were referred after 12 weeks and 6 days meaning the target would not be possible for these women. Whilst 7% were referred in the 13-14 week band, 10% were very late (over 20 weeks) and 2% presented after 36 weeks.

The figures above show the long term national target of 90% requires significant progress to be made in the speed with which people are referred into the service, which includes promoting early self-referral or access to primary care upon early signs of pregnancy, and ensuring there are no onward referral delays from primary care. Actions are in place to drive this forward.

Note: The London average performance for Quarter 4 was reported as 73%, although within this some PCTs are claiming very high rates and there are national concerns on data quality which have led the Care Quality Commission to drop this target form their Annual Health Check.

3.7 Adults with learning disabilities in employment

Target setting was deferred in the LAA process by GOL due to the lack of baseline data for this new PI. Data for 2008/09 has now been returned. In Southwark it shows 17.1% of working age people with learning disabilities known to the authority were in paid employment during the period. This is 105 out of 613 people. Of these 23 were in employment for over 30 hours per week. A further 48 were in voluntary unpaid work which is excluded from the target. All those in employment are in receipt of social care services to help maximise their independence.

The level of challenge to build into the target will be considered when benchmarking data is available. Consideration will be given to the economic position insofar as it impacts on job opportunities.

There are plans in place to improve the support given to people with learning disabilities to help them into employment. These include:

- focusing employment opportunities and support to young people with learning disabilities leaving school and college.
- short time limited employment preparation projects for people with learning disabilities.
- encouraging the use of self directed social care to support people with learning disabilities in employment
- Identify possible joint working and in reach with employers in terms of supporting job retention and link in with dedicated learning disability employment/vocational services

3.8 Adults in contact with secondary mental health services in employment

Target setting was deferred in the LAA process by GOL due to the lack of baseline data for this new PI. Initial data for 2008/09 has now been returned by SLAM. In Southwark it shows just 2.7% of mental health clients were recorded as being in paid employment. This is just 48 out of 1766 people. However, 1017 cases do not have an employment status recorded in their care record which is clearly an area for improvement. 680 are recorded as unemployed.

When benchmarking data is available targets will be set and agreed with GOL. However it is clear from the initial return that this is going to be a red light performance area.

The action plan includes:

- Making linkages with the Increasing Access to Psychological Therapies (IAPT) programme (a World Class Commissioning priority), ensuring attainment of employment is a targeted outcome.
- Widening existing mental health employment/vocational services to incorporate Council, PCT, SLaM and other major employers
- Close working with Job Centre Plus.
- Re-evaluating existing commissioned vocational services

3.9 Vulnerable people achieving independent living (Supporting People)

This target measures the % of people who are moving on through Supporting People services in a planned way into lower level services and independent living. It measures the performance of short term and temporary services such as temporary housing for the homeless. The target for 2008/09 was 75%. Quarter 4 performance was 80.3%, stronger than previous quarters, and full year outturn was 72.15%, just short of the target. In numbers this reflects 1,143 people moving on in a planned way out of 1,588 people moving on in total.

Benchmarking data for 2007/08 indicates that the top quartile was 72.6% which is close to Southwark's performance for 2008/09.

Although the target was not quite met this is within the context of national acknowledgement that move-on is becoming increasingly difficult due to slippage in projects and the reduced availability of move-on accommodation. Southwark has had additional challenges in 2008/9 due to the significant number of project decants in 2009 that the Programme has undertaken following Service Reviews in 2008. This work has delivered a decant to date of 118 units across the borough with further decants for 2009/10 which will be achieved by June 2009, which has added further pressure on the available capacity in the borough. Strategies are in pace to manage these challenges in their current and future context.

3.10 Drug users in effective treatment

This LAA target reflects a commitment to increase the numbers of people in effective treatment for crack/opiate use by 30% (on the 2007/08 baseline) by 2010/11. This gave a numerical target of 1698 clients for 2008/09 (12% increase), 1880 for 2009/10 (24% increase) and 1971 for 2010/11 (30%) based on the estimated baseline of 1516 when the LAA was set. Following a NTA refresh of the data Southwark's 2007/8 baseline figures was revised downwards to 1449. However the National Treatment Agency have not agreed to reduce the numerical target accordingly to retain the 12% equivalence, which in effect leaves us with a 17% growth target. Representations were made on this issue as part of the LAA refresh process but were not accepted and the target of 1,698 by the end of 2008/09 is highly unlikely to be met.

However leaving this issue aside, the rate of growth in the current year is poor at 3.6%, well short of the original 12% commitment and the revised 17% commitment. Current numbers in treatment (latest data is for December due to the 12 week time lag in the measure) is 1502. This has worsened from the Quarter 2 position due to a further data refresh. The reasons for this are being investigated.

4 Risk Factors

4.1 **Financial costs:** Not applicable

4.2 **Human resources:** Not applicable

4.3 **Legal:** Not applicable

4.4 **Community Impact**

4.4.1 The LAA priorities and the associated targets were set taking into account those areas that will have the maximum impact on the community in line with our strategic goals. Delivery of these targets is therefore key to having an impact on community priorities. A

number of these targets also have a strong health inequalities dimension and impact on more disadvantaged communities within the borough.

Background Papers	Held At	Contact
Title of document(s)	*Title of department / unit*	
Performance documentation	Health and Social Care Performance Team	Adrian Ward 020 7525 3689
LAA targets – general LSP information	LSP co-ordinator	Steve Tennison 020 7525 7557

Lead Officer	**Adrian Ward, Acting Director of Performance, Southwark Health and Social Care**	
Report Author	**Adrian Ward, Acting Director of Performance, Southwark Health and Social Care**	
Version	Final	
Dated	18th June 09	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / EXECUTIVE MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Strategic Director of Communities, Law & Governance	No	
Chief Finance Officer	No	
Director Social Services/ CE PCT	yes	
Date final report sent to Constitutional Support Services/ PCT dispatch		June 25 2009

SOUTHWARK HEALTH & SOCIAL CARE PERFORMANCE INDICATORS: LOCAL AREA AGREEMENT - QUARTER 4 (2008/ 9)

Indicator code	Performance indicator description	2005/6 Outturn	2006/7 Outturn	2007/8 Outturn	2007/8 Target	2008/9 Q1 Target	2008/9 Q1 Outturn	2008/9 Q2 Target	2008/9 Q2 Outturn	Q3 2008/9 target	2008/9 Q3 Outturn	2008/9 Q4 target	2008/9 Q4 Outturn	2008/9 Full year	Traffic Light	Benchamrk Lonodn	Direction of travel	2008/9 Target	2009/10 Target	2010/11 Target
3.1 VSC17 LAA	Social care clients receiving self directed support (rate per wesighted population)	Not applicable	Not applicable	98	125	125	104.48 (172 adults)	150	105.58	175	112.42 (185 adults)	199	137.13 (219 adults)	**137.13 (219 adults)**	RED	156 (2007/08)	↑ better	199	349	601 (est. 1000 clients)
3.2 VSB01 NI 120 LAA	Mortality rate from all causes at all ages (All-Age All-Cause Mortality rate - AAACM) - males (reduce to 652 in 2011)	801.02 (2004)	794.12 (2005)	734.05 (2006)	Not applicable	Annual	Annual	Annual	Annual	727 (2007)	717.52 (2007)	727 (2007)	annual	**717.52 (2007)**	GREEN	672	↓ better	701 (2009)	676 (2010)	652 (2011)
3.2 VSB01 NI 120 LAA	Mortality rate from all causes at all ages (All-Age All-Cause Mortality rate - AAACM) - females (reduce to 426 in 2011)	542.73 (2004)	517.62 (2005)	474.01 (2006)	Not applicable	Annual	Annual	Annual	Annual	472 (2007)	498.86 (2007)	472 (2007)	annual	**498.86 (2007)**	AMBER	460	↑ worse	456 (2009)	441 (2010)	426 (2011)
3.3 VSB08 NI 112 NP 23 LAA	Teenage Pregnancy rates per 1000 female 15-17yr old population. (Reduce the 1998 baseline rate of teenage pregnancy by 60% by 2010)	86.7 (2004)	71.8 (2005)	75 (2006l)	60.9 (2006)	54.48 (2007)	72.9 (q1 2007)	54.48 (2007)	80 (Q2 2007)	54.48 (2007)	77.5 (prov Q4 2007/08)	54.48 (2007)	74 (Prov Q1 2008/09)	**80.5 (12 mnth roling to Mar08)**	RED	46	↑ worse	67.43 (2009) (refresh bid)	49.12 (2010) (refresh bid)	49.09 (2011) (refresh bid)
3.4 VSB05 NI 123 LAA	4-week smoking quitters (expressed as number) (* q1 adjusted for lates data after statutory return of 125)	1077	1243	1370	1827	250	161*	500	398	750	706	1,225	1,277	**1,277**	GREEN	915 (av. Qtr 3)	↑ better	1,225	1306	1,326
3.5 VSB09 NI 57 LAA	Obesity amongst primary school children in Year 6	New	23.5%	27.1%	Not available	27.5%	26%	annual	annual	annual	annual	annual	annual	**27.5%**	GREEN !	20.8	↑ better	27.86%	28%	29%
3.6 VSB06 NI 126 LAA	Early access to maternity services: Percentage of women who have seen a midwife or an obstetrician for health and social care assessment of needs and risk by 12 weeks of their pregnancy.	Not applicable	Not applicable	27% est	Not applicable	30%	30.2%	56.0%	45.8%	56.0%	45.5%	50.0%	63.5%	**60.3%**	GREEN	73 Qtr 4	↑ better	50% (Average during the year)	65% (Average during the year)	90% (Average during the year)
3.7 VSC07 NI 146 LAA	Adults with learning disabilities in employment	Not applicable	Not applicable	Not applicable	Not applicable	Not set			Collected from Sept; reported at end of Q4			To be confirmed	17.3 % (105 people)	**17.3 % (105 people)**	**n/a**	tbc		To be confirmed 2008/ 9	To be confirmed 2008/ 9	To be confirmed 2008/ 9
3.8 VSC08 NI 150 LAA	Adults in contact with secondary mental health services in employment	Not applicable	Not applicable	Not applicable	Not applicable	Not set			Collected from Sept; reported at end of Q4			To be confirmed	2.7% (48 people)	**n/a**	RED	tbc		To be confirmed 2008/ 9	To be confirmed 2008/ 9	To be confirmed 2008/ 9
3.9 NI 141 LAA	Vulnerable people achieving independent living (service users who have moved on from supported accommodation in a planned way)	Not available	Not available	79	70	75%	72.66%	75%	68.95%	75%	66.67%	75%	80.31%	**80.31%**	AMBER	72.6 (07/08)	↑ better	75%	77%	80%
3.10VSB14 NI 40 LAA	Numbers drug users using crack and/or opiates recorded as being in structured drug treatment in the financial year who were discharged from treatment after 12 weeks or more or discharged in a care planned way. Target is 1,799 by 2011	Not available	Not available	1,516 (baseline)	Not available	1,561	1,517	1,607	1,522	1,652	1,502	1,698	12 weeks lag	**n/a**	RED	tbc	↓ worse	1,698 (12% increase on 2007/8 outturn)	1,880 (24% increase on 2007/8 outturn)	1,971 (30% increase on 2007/8 outturn)