Open Agenda

# Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 30 June 2010
7.00 pm
Town Hall, Peckham Road, London SE5 8UB

**Membership**

Councillor Neil Coyle (Chair)
Councillor Michael Bukola
Councillor Denise Capstick
Councillor Victoria Mills
Councillor David Noakes
Councillor the Right Revd Emmanuel Oyewole
Councillor Keadean Rhoden

**Reserves**

Councillor Poddy Clark
Councillor Dan Garfield
Councillor Eliza Mann
Councillor Darren Merrill
Councillor Althea Smith

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**Contact** Rachael Knight on 020 7525 7291 or email: rachael.knight@southwark.gov.uk

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Members of the committee are summoned to attend this meeting

**Annie Shepperd**
Chief Executive
Date: 22 June 2010

PRINTED ON RECYCLED PAPER

# Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 30 June 2010
7.00 pm

# Order of Business

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**PART A - OPEN BUSINESS**

**1. APOLOGIES**

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

In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.

**3. DISCLOSURE OF INTERESTS AND DISPENSATIONS**

Members to declare any personal interests and dispensation in respect of any item of business to be considered at this meeting.

**4. APPOINTMENT OF VICE-CHAIR**

To appoint the vice-chair of the sub-committee for 2010/11.

Nomination received: Councillor David Noakes.

**5. MINUTES** 1 - 8

To approve as a correct record the Minutes of the meeting held on 17 March 2010.

**6. INTRODUCTORY OFFICER BRIEFINGS**

1. Jane Fryer, Medical Director, NHS Southwark
2. Sarah Feasey, Principal Lawyer, Southwark Council
3. Francis O'Callaghan, Director of Performance, King's Health Partners

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| **7.** | **PROPOSED SERVICE VARIATIONS** | 9 - 12 |
| | Proposed variations to vascular surgery services - King's Health Partners | |
| **8.** | **WORK PROGRAMMING AND SCOPING** | 13 - 19 |

**DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.**

**PART B - CLOSED BUSINESS**

**DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.**

Date: Tuesday 22 June 2010

Agenda Item 5

# HEALTH AND ADULT CARE SCRUTINY SUB-COMMITTEE

MINUTES of the Health and Adult Care Scrutiny Sub-Committee held on Wednesday 17 March 2010 at 7.00 pm at Town Hall, Peckham Road, London SE5 8UB

**PRESENT:** Councillor Lorraine Zuleta (Chair)
Councillor Jonathan Mitchell
Councillor Caroline Pidgeon

**OTHERS PRESENT:** Phil Boorman, Stakeholder Relations Manager, KCH
Ann-Marie Connolly, Director of Public Health, SPCT
Jane Fryer, Medical Director, SPCT
Malcolm Hines, Dep Chief Executive & Finance Dir, SPCT
Sally Lingard, Head of Corporate Communications, KCH
Patricia Moberly, Trust Board Chair, GSTT
Sean Morgan, Dir of Performance & Corporate Affairs, SPCT
Michael Parker, Trust Board Chair, KCH
Michael Marrinan, Medical Director, KCH

Rachael Knight, Scrutiny Project Manager



## 1. APOLOGIES

Apologies for absence were received from Councillors Dixon-Fyle, Holford and Lauder.

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

There were none.

## 3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

Councillor Mitchell declared a personal, non-prejudicial interest – that he is chair of the local campaign group 'Keep Dulwich Hospital'.

## 4. EFFECTIVENESS OF FOUNDATION TRUSTS

4.1 The chair explained that this item had been discussed throughout the year and that the discussion this evening was an opportunity to consider further information related to the local Foundation Trusts' (FTs) performance targets, as overseen by Monitor.

4.2 Patricia Moberly, Trust Board chair, Guy's and St Thomas' (GSTT), explained that the performance of Foundation Trusts is assessed against mandatory targets. This includes an element of self-certification based on performance indicators. Risk ratings are then awarded in line with the performance data.

4.3 Michael Parker, Trust Board chair, King's College Hospital (KCH), added that, whereas trust's capital funds came from the state under the former system, FTs are now expected to create an operating surplus and can also borrow funds on the open financial market to fund major capital projects.

4.4 Members queried what impact a new government could have on FTs. The GSTT Trust Board chair responded that the key impact will be determined by what PCTs choose to commission from the acute trusts. The KCH Trust Board chair commented that treatment prices are set by the government; and that for emergency admissions the FTs will be paid according to the activity levels of 2008/09, and will therefore have to subsidise the increased levels of treatment themselves, as output increases year on year. He added that the establishment of the Academic Health Sciences Centre (AHSC) allows for a number of back office costs to be reduced; as work is realigned across the AHSC members.

4.5 Malcolm Hines, finance director, NHS Southwark, reported that the financial settlement to the PCT for 2010/11 of 5% growth may appear to be very positive, but this is not the case in real terms, as the money is already committed and will not cover the span of local joint initiatives that the PCT is wanting to take forward. He added that the current economic outlook is bleak; that the whole health system will be contracting significantly through the next year and to an even greater extent in 2011. He also referred to the 5 year health strategy and financial strategy for Southwark and explained that this would be considered by the PCT Board the following week.

4.6 A member queried what the FTs are doing regarding community engagement. The chair commented that the sub-committee's most recent report relates to aspects of the local FTs' community engagement. She explained that aspects of the local trusts' public consultations over the past year have caused concern and that the sub-committee therefore decided to put in writing what lessons might be learned. She added that copies would be sent to the key trust partners in the following week.

4.7 The chair also commented that it would be useful for the local health trusts to involve local communities when trying to identify new ways to provide current services when needing to attain budget efficiencies.

4.8 The GSTT Trust Board chair stated that the 2008 Health and Social Care Act binds all trusts to consult and engage with their communities and that GSTT takes this duty very seriously. She referred to the letter from the GSTT chief executive, Ron Kerr, (see agenda pp. 24 – 26) and added that in view of the scale of efficiencies to be achieved, GSTT has established a new board and is taking a long hard look at new ways to deliver services. She emphasised that the financial stringency will not affect the need to attain the same performance targets, and that any proposed changes will be rigorously tested.

4.9 The GSTT Trust Board chair added that medical care in the 21st century is increasingly shifting to the use of treatments such as laser and keyhole surgery, with the objective to treat more people and at the same time decrease the need for admitting patients to hospital beds.

4.10 The KCH Trust Board chair commented that 10% savings may appear to be a very high percentage, but KCH has had to make significant savings before, and the Academic Health Sciences Centre was established with the objective to increase innovation and pioneering work.

4.11 A member argued that Dulwich Hospital is being closed down, that patients going there now are being redirected to KCH and that local people are seeing a diminution of services. He added that looking to the future, there is an approach to increasingly use out-of-hospital care, which means care in the community and which to some extent must also mean private care. He also observed that as services such as those provided at Marina House are being closed, there is a need to boost GP services; and that as options such as self-referral disappear, patients will not approach a GP with the same problem and will not access treatment.

4.12 Michael Marinnan, medical director, KCH, emphasised that the quality of care provided for King's patients is not negotiable, and challenged any implication that patients were being treated without due care. He added that KCH treats all patients - those who live locally and those from a distance - indiscriminately to the best of its ability and referred to particular services, such as the major trauma centre as providing exemplary care.

4.13 The KCH medical director also commented that he does not share the confidence that achieving 10% savings year after year will be easy. However, he indicated that bringing together services across King's Health Partners ought to allow increased expertise and research opportunities, providing more specialist treatments.

4.14 A member queried why it is necessary for all maternity and all diabetic services to be centralised with King's as an acute hospital, and whether these services could also be dealt with in a smaller setting, such as at the Dulwich hospital.

4.15 Jane Fryer, medical director, Southwark PCT (SPCT), responded that KCH has almost the highest home-birth rate in the country, at approximately 8%, compared with the GSTT rate, which is close to 4%. She added that some work has been undertaken with mothers about improving their choice for maternity care and it is clear from the outcome that parents are wanting midwifery units

alongside acute units, in case of unpredictable complications requiring a full hospital service. She also explained that much of the care for pregnant women already happens within the community, in people's homes and in GP practices and health centres and that another hospital setting is not needed.

4.16 A member queried whether there were any plans to extend the scope of maternity services at KCH. The SPCT medical director responded that birth rates in Southwark are currently increasing to such an extent that there are plans to increase the capacity of all maternity services. The KCH medical director confirmed that there will be an increase and that maternity services are based in the acute hospital because KCH wants to provide services according to mothers' preferences, which show that women who prefer not to use an obstetric unit still prefer to be within close proximity to one. He also emphasised that while KCH is looking to make radical savings, the trust will not compromise the safety of mothers or newborn babies.

4.17 The SPCT medical director remarked that the treatment of diabetes is also a useful example, as it is a very common disease and particularly prevalent in Southwark. She explained that most diabetic health services are not provided in a local hospital because patients need to have diabetes managed well in GP settings and that the majority of diabetic problems are routine type cases in general practice. She added that there is a very small number of diabetes patients who require treatment in a hospital setting, and that the PCT is currently working with KCH and GSTT to have consultants and diabetic nurses working in community settings.

4.18 A member queried whether the KCH Trust Board chair had inferred that he would happily relocate some of the KCH beds and services if there was a suitable facility locally that would have the capacity. The KCH Trust Board chair responded that patients are sent to KCH by the PCT and that King's treats people where appropriate. When asked whether KCH would have services based at Dulwich hospital had it remained a functioning hospital, he added that KCH previously ran services from there and that he would happily work in collaboration with the PCT about the potential and future of the premises. He also commented that it would be difficult to impose on the PCT what it should be doing with its own asset and that the trust's focus is to provide a great service to patients.

4.19 The chair thanked the FTs for their attendance and provision of information throughout the year. She commented that Southwark is privileged to have three local Foundation Trusts, and that it is useful to be informed and so provide reassurance to constituents when they approach councillors with questions.

## 5. ACUTE TRUSTS' SAVINGS PLANS

5.1 The discussion of this item was included within item 4.

## 6. PCT / COUNCIL BUDGETS

6.1 Ann-Marie Connolly, director of public health, NHS Southwark, presented additional data on the South East London public health 'heat map' that members had considered with papers submitted to the 18 November 2009 meeting (see Appendix A). She explained that the data for the heat map is derived from various sources, such as mortality data and statistics from GP surgeries; that some of the local area detail is not available. Key findings and issues were highlighted, and members responded with comments and queries as follows:

6.2 Life expectancy in the borough is generally increasing, especially for women, although the gender gap is also narrowing. Regarding the life expectancy for men, however, there is currently a gap of 17 years between the best and worst scoring wards.

6.3 The chair queried how the calculations for life expectancy are made and what they are based on. She commented that Southwark residents born elsewhere may come from places where life expectancy averages are considerably shorter, and that there may be further discrepancies due to people new to the country not having had the consistency of health care services available here. The director of public health responded that the calculation is made by applying the current adjusted death rates to the age profile of the current Southwark population. She added that she would look into some of the statistics used, but explained that if a borough were being considered that had a relatively stable population, it would still be usual to see quite a marked variation between areas of lesser and greater deprivation and that these figures are therefore not likely to be considerably awry.

6.4 The director of public health pointed to the three major causes of premature death in Southwark, namely cancer, chest disease, and circulatory diseases. She commented that the figures for chest and circulatory diseases are improving and approaching the national average.

6.5 Comparative to physical illnesses, less information is available about mental health. Analysis of the effect of mental health problems on quality of life free of disability, however, indicates that a significant number of years of life free from disability are lost through mental disorders.

6.6 The obesity rates of Southwark children in year six were highlighted as the highest in the country – rates that are not getting worse, but are likewise not yet improving. The director of public health commented that children who are obese are not at an immediate health risk, but are at risk in the longer term to serious diseases including heart disease and diabetes.

## 7. MATTERS ARISING

7.1 Matters arising at the 20 January 2010 meeting – request 1:

A member referred to page 40 (item 4) of the minutes of the sub-committee's 20 January 2010 meeting and noted that Susanna White had agreed to report back early in 2010 on the "outcome of the commissioned cost assessment for

renovation and repair work at Dulwich Hospital, which would allow again the provision of former services such as intermediate care." He stated that there had been no report back to date, excepting the two sentences on page 36 of the agenda papers which do not provide a proper answer nor deal with the outcome of the assessment. He raised the following questions:

a) has the outcome of the commissioned cost assessment for renovation and repair work at Dulwich Hospital enabled intermediate care services to be resumed; and
b) will intermediate care beds be available for patients at Dulwich hospital when the Health and Safety improvement works have been completed this summer?

7.2 Malcolm Hines, director of finance and deputy chief executive, NHS Southwark, accepted that in terms of the work that the PCT is undertaking the answer given is short, and explained that an appraisal of costs related to health and safety issues was completed and that repair work to the approximate value of £1.3 million has commenced. He said that these works are due to be finished in the summer but that it was not yet feasible to outline a more exact timescale or completion date. He added that the renovation will enable departments that were based on the first floor to be considered to be returned to that space. The medical director added that there would then be no building reason for intermediate care not to be located at the hospital, but that a separate process was underway to review the provision of intermediate care across the borough.

7.3 A member contended that the condition of the building had been the only issue that had lead to closure of the intermediate care beds. The medical director explained that the beds for intermediate care had to be closed urgently due to building issues, but there had always been notice of the intention to review the provision of intermediate care. She emphasised that, in view of the review, she could not state whether there would or would not be intermediate care re-located at the hospital, and that this decision was now separate from the building issue.

7.4 A member queried, why, when questions were earlier asked about the closure of intermediate care at Dulwich Hospital, only the building issue was raised. The medical director responded that, as outlined in the Transforming NHS Southwark consultation, officers had been clear about the need to review intermediate care across the borough. The chair commented that she could recall discussing the planned review of intermediate care with the medical director and NHS Southwark chief executive at an earlier meeting, and that the issue of intermediate care had been an area of the Transforming NHS Southwark consultation that the sub-committee thought was insufficiently covered.

7.5 A member queried when the review of intermediate care would be complete. The finance director offered to provide a written response within the next week that would outline the expected timeframe for the review.

7.6 Matters arising at the 20 January 2010 meeting – Request 2: That officers provide details on the proportion of PCT budgets spent on consultation.

7.7 The chair referred to the figure of £94,700 spent over the last year on consultation of a total Southwark PCT budget of £530 million. She commented that this seemed to be a very small proportion in light of some of the changes introduced. She added that while she understood that the PCT needs to try to manage tight budgets, she expected that there would be some pay back by investing more in consultation, - especially given the multitude of challenges and increasing financial constraints.

7.8 The director of finance stated that the main spend of the £94,700 was on the Transforming NHS Southwark consultation, and explained that there are officer teams reporting to himself and to the medical director that are working on communications on an ongoing basis whose pay costs are not included in the figure. He added that there is a significant level of industry in terms of the volume of consultation promotion work carried out and that there were lessons to be learnt from pan-London NHS consultation work, under which larger sums had been spent on top media companies to produce, for example, television campaigns. He noted that despite the significantly higher spend, the response rates for such consultations had not differed considerably from the PCT's response rates, which indicated that the issue with promotion is not so much the amount spent, rather the methods used for communicating the consultation.

7.9 Matters arising at the 20 January 2010 meeting – Request 3: That an update be provided on the Southwark PCT decision regarding the re-structuring of drug and alcohol treatment.

7.10 A member commented that the sub-committee had been confronted with a fait accompli, as although members were told that there would be a consultation on this issue, the decision had effectively already been taken. Moreover, the consultation was started without officers notifying the sub-committee of the start date. He added that the issue of self-referral had not been fully considered by the sub-committee and that the favoured system appeared to be one that would abolish self-referral and therefore oblige patients to go to a GP, who may or may not have the requisite specialist knowledge.

7.11 Sean Morgan, director of performance and corporate affairs, NHS Southwark, commented that the number of patients who self-refer directly to SLaM is a very small percentage and that the vast majority of patients access treatment via other routes. Moreover, patients still have access to third sector providers and can self-refer to those. GPs decide with patients the best care plan for their condition and circumstances. The changes also correspond with the established strategy for the increased use of primary care services. The objective of the strategy is to enable SLaM's specialist services to be able to focus on clients with the greatest need.

7.12 Regarding the consultation on the changes to services at Marina House, the director of performance and corporate affairs added that officers had attended the sub-committee's 7 October 2009 meeting to discuss the proposed re-structuring; that officers attended other public meetings and were very open to receiving consultation responses. He emphasised that the re-location of the services will not include any reduction in capacity; that specialist services will still be provided on two sites; and that several months are still needed for the

preparatory work to the buildings before the changes will be implemented.

7.13 The chair queried whether patients would still be permitted to self-refer, if they were to turn up at the Blackfriars or Marina House services. Officers responded that patients would not be turned away, but that this is not being publicised, as it is no longer policy to encourage self-referral to specialist services.

7.14 Members raised concerns about patients going to a GP in extreme circumstances, when they may be tending towards violence for example. It was also queried why the criminal justice system could not establish services on both sites, and the current treatment for drug and alcohol use be retained at Marina House at a reduced capacity. This could also allow for the skills of the two types of services to be linked. The medical director explained that patients in extreme circumstances would not go to Marina house; rather they would go to A&E. She added that in the case of a very dangerous patient, the police and an ambulance would be called for, to bring the person to a place of safety. She also reiterated that SLaM has made clear that no one would be turned away in extreme circumstances.

7.15 Regarding the co-location of the criminal justice system and more standard services, the medical director remarked that this could be explored with partner agencies; although the previous planning had focused on the need for one integrated site.

7.16 The chair thanked all officers for their contributions and for attending.

**RESOLVED:**

That officers look further into the viability of co-locating the provision of the original services for drug and alcohol treatment based at Marina House, and those provided by the criminal justice system, at both the Marina House and Blackfriars sites.

## 8. MINUTES

**RESOLVED:**

That the minutes of the Health and Adult Care Scrutiny Sub-Committee meeting held on 20 January 2010 be agreed as a correct record.

The meeting closed at 9.25 pm.

# Agenda Item 7

***Trigger template for proposed variations to health services***

| **NHS Trust & lead officer contacts:** | |
|---|---|
| **Mark Tyrrell**<br>Lead Consultant Vascular Surgeon<br>King's College Hospital NHS Foundation Trust<br>Email: **mtyrrell@nhs.net** | **Nick Kirby**<br>General Manager – Cardiovascular<br>Guy's & St Thomas' NHS Foundation Trust<br>Tel: 020 7188 1031<br>Email: **nick.kirby@gstt.nhs.uk** |

| **Trigger** | **Please comment as applicable** |
|---|---|
| **Reasons for the change** | |
| What change is being proposed? | Clinical staff at King's College Hospital and Guy's and St Thomas' Hospital have outlined a case for changing the current configuration of inpatient Vascular Surgery services. In summary, the proposal is to relocate the majority of inpatient Vascular Surgery from King's College Hospital to St Thomas' Hospital. Outpatient and daycase services would not be changed as a result of this proposal. |
| Why is this being proposed? | There are three main reasons driving the proposed change:<br>(1) **Clinical quality:** a recent review by Healthcare for London recommended that to optimise patient outcomes, the proposed model of care will advocate consolidation of abdominal aortic aneurysms (AAA) carotid endarterectomises (CEA) and lower extremity bypass grafting (LEAB) into high volume centralised sites. Furthermore, literature reviews of best practice guidance demonstrate that clinical outcomes improve in vascular centres where there are high volumes.<br>(2) Improved opportunity for patients to access **new treatments**: concentrating vascular activity on one site facilitates maximising patient access into trials of new treatment as well as minimising overheads by eliminating duplication related to multi site trials. Opportunities to partake in commercial trial activity are also likely to increase as the integration of KHP Vascular Surgery provides a platform for developing more robust relationships with industry.<br>(3) Ability to deliver a **more efficient** service through benefiting from economies of scale, for example:<br>(i) Theatre utilisation: can be increased by planning for |

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| | Consultant cross cover within their job plans. This is made a viable option from having a much larger Consultant team available on site.<br><br>(ii) Length of stay: intensity and efficiency of ward rounds can be improved both by having a greater number of senior medical staff on site as well as through managing all vascular inpatients on dedicated vascular wards, where nursing teams have the opportunity to develop specific vascular skills.<br><br>All of the above will deliver key benefits to patients and improve their experience of vascular services. |
| What stage is the proposal at and what is the planned timescale for the change(s)? | We have agreement from the hospital Boards and Executives that this proposal should proceed to the development of a full business case. We are very keen to involve users and key stakeholders (ie. patients, public, OSC, commissioners, partner hospitals and others) in developing a business case to agree the viability of the proposals, ensure that it meets the needs of our patients, confirm the details of any proposed change to service and to quantify the costs, benefits and risks associated with any change.<br><br>The proposal is currently being developed with the aim of engaging patients and public representatives during July 2010. Depending on the feedback received from these groups it is anticipated that a full business case can be completed in September 2010. |
| Are you planning to consult on this? | Including stakeholders is critical to informing this proposal. A forum is being set up comprising patient representatives with the remit of informing the direction and detail of the proposed changes. Other stakeholders (for example, primary care trusts and district general hospitals in SE London) will also be included in developing the proposals into a full business case. In addition to a user forum, we are also considering a patient survey of vascular patients and group discussions.<br><br>We are planning this as a process of public engagement and involvement, not formal public consultation. |

| **Are changes proposed to the accessibility to services?** | **Briefly describe:** |
|---|---|
| Changes in opening times for a service | Service opening times will remain the same. |
| Withdrawal of in-patient, out-patient, day patient or diagnostic facilities for one or more speciality from the same location | The proposal is not for a withdrawal of services, it is for a relocation of services. |
| Relocating an existing service | The proposal is to relocate the majority of inpatient Vascular Surgery activity from King's College Hospital to St Thomas' Hospital, with the following exceptions which will continue to be provided at King's with full support of the vascular team:<br>• Emergency vascular surgery for those patients who are clinically unsafe to move between sites<br>• Vascular support for kidney & diabetic patients<br>• Day case diagnostics and treatments<br><br>Outpatient and daycase services are not impacted by these proposals. |
| Changing methods of accessing a service such as the appointment system etc. | No changes proposed. |
| Impact on health inequalities - reduced or improved access to all sections of the community e.g. older people; people with learning difficulties/physical and sensory disabilities/mental health needs; black and ethnic minority communities; lone parents. | We are in the process of completing a rigorous equality impact assessment (EIA). This is being completed alongside the public and patient involvement work to ensure that the EIA is properly informed. The EIA is a mandatory component of the business case; no business case is considered viable without completing a comprehensive EIA. |
| **What patients will be affected?** | **Briefly describe:** |
| Changes that affect a local or the whole population, or a particular area in the borough. | During 2009/10 the number of patients who would have been impacted who live in Lambeth and Southwark is as follows:<br>Southwark – 98 patients<br>Lambeth – 80 patients |
| Changes that affect a group of patients accessing a specialised service | Most of the patients identified above will be receiving a specialist inpatient vascular surgery treatment. |
| Changes that affect particular communities or groups | We expect the equality impact assessment to identify any communities or groups who are particularly affected by the proposals. |
| **Are changes proposed to the methods of service delivery?** | **Briefly describe:** |
| Moving a service into a community setting rather than being hospital based or vice versa | Not part of proposal as the focus is on an acute inpatient service. |
| Delivering care using new technology | A core expected benefit from the proposed integration of inpatient services is that it will enable a much more systematic approach to developing innovative patient treatments. |

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|---|---|
| | This is a result of Consultant teams being able to sub specialise and from having a coordinated approach to research and development including partnerships with academic institutions (especially King's College London University) and industry partners. |
| Reorganising services at a strategic level | For patients receiving a planned, non urgent treatment, their admission will be directly to St Thomas' hospital rather than to King's.<br><br>For patients requiring urgent transfer from King's, this will take place according to existing transfer protocols with the London Ambulance service.<br><br>For patients requiring transfer (both urgent and non urgent) from a third hospital, this will be directly to St Thomas' according to existing transfer protocols. |
| **What impact is foreseeable on the wider community?** | **Briefly describe:** |
| Impact on other services (e.g. children's / adult social care) | In scoping external stakeholders we have not identified any detrimental impact to community services. There is likely to be a positive impact in the following areas:<br><br>(1) Social services: for patients requiring social care post discharge from hospital, social services will need only liaise with one rather than two acute hospital site across Lambeth and Southwark.<br><br>(2) District nursing services: a proposed development is to establish a training programme in wound management for nurses in the community. This is to help avoid readmission to hospital and reduce the need for patient follow in hospital outpatient services. Having an integrated service will facilitate this as we will have a larger pool of specialist nurses available to deliver the training. |

Agenda Item 8

# Southwark Health and Adult Social Care Scrutiny Sub-Committee Background basics at a glance:

## NHS Southwark and PCTs

NHS Southwark is also called Southwark Primary Care Trust (PCT). PCTs are key to the NHS, responsible for the planning and securing of health services and improving the health of the local population.

PCTs must ensure the provision of health services in their area such as hospitals, dentists, mental health care, population screening, pharmacies, opticians and GPs.

Collectively, PCTs are responsible for spending around 80% of the total NHS budget. They have their own budgets and set their own priorities, within the overriding priorities and budgets set by their relevant Strategic Health Authority (SHA) and the Department of Health.

## Southwark Health and Social Care

Southwark Health and Social Care is a partnership between Southwark PCT and Southwark Council, designed to deliver integrated health and social care services. The integrated senior management team includes both health and social care managers who hold responsibilities across both areas. This is headed by Susanna White, who is one of the few PCT chief executives in the country who is also a strategic director of social care services.

## Acute trusts

Acute care is medical and surgical treatment usually provided by a hospital. Acute trusts, alias NHS hospital trusts, provide these secondary health services within the NHS.

Trusts judged to be performing with outstanding efficiency may apply to Monitor to become NHS Foundation Trusts (FTs). This status gives a trust greater independence and financial autonomy. There are 3 key acute trusts in Southwark, which are all FTs (see below).

## Social care

Social care includes a wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships. Some of the main groups using the services include children or families who are under stress, people with disabilities or mental health problems, and older people who need help with daily living activities. The services deal with many issues and are offered in many locations, such as hospitals, schools, residential homes, or people's own homes.

Social care services are normally run by local councils, sometimes in conjunction with local NHS organisations.

This sub-committee reviews social care issues related to adult care only.

## LINks

LINks are independent local involvement networks made up of individuals and community groups who work to improve local health and social care services.
A LINk's role includes:

- Asking local people what they think about local health and social care, and suggesting improvements directly to the service providers;
- Looking into specific issues (such as a dirty hospital), making recommendations and getting a response;
- Asking for information and getting answers in a specified amount of time;
- Being able to carry out spot checks to see if services are working well;
- Referring issues to the local 'Overview and Scrutiny Committee' if it seems action is not being taken. (In Southwark the Health and Adult Social Care scrutiny sub-committee would consider referrals from the local LINk.

## Substantial Variations

In addition to work on issue-based reviews and performance monitoring, health scrutiny committees have a statutory role under the Health and Social Care Act 2001: NHS bodies are obliged to consult with health scrutiny on proposed variations or developments of health services that are deemed substantial. This means that health scrutiny committees can ultimately refer their related concerns to the Secretary of State or Monitor, where:

i. the committee is concerned that consultation on substantial variations or developments of services has been inadequate; [and/or]

ii. where the committee considers that the proposal is not in the interests of the health service.

## Southwark's local acute trusts

There are 3 key acute trusts in Southwark - which are all Foundation Trusts (FTs):

## Guy's and St Thomas' NHS Foundation Trust (GSTT)

GSTT provides a full range of hospital services for the local communities in Lambeth, Southwark and Lewisham, as well as specialist services for patients across London, the South East and further afield. It has more than 900,000 patient contacts each year and has close to 11, 000 staff at its hospitals. GSTT's annual turnover is £900 million and in financial terms it is one of the largest NHS organisations in the UK.

Earlier this year GSTT was selected as the preferred partner to manage community health services in Lambeth and Southwark from April 2010. This will include services such as district and school nursing, health visiting, elderly care and occupational therapy.

## Joint committees

In 2005 Southwark and Lambeth Councils formed a joint health scrutiny committee to consider a **substantial variation** – namely the proposed future of crisis services for people with mental health problems in Lambeth and Southwark. The committee referred their concerns to the Secretary of State for Health - with the outcome that £6 million was granted to King's College Hospital to support the remodelling of King's A&E to better accommodate mental health patients.

Southwark has also been involved in South East London and pan-London joint health scrutiny committees.

## King's College Hospital NHS Foundation Trust (KCH)

King's College Hospital NHS Foundation Trust is one of London's largest and busiest teaching hospitals, with a unique profile of strong local services and a focused set of tertiary specialties. KCH is recognised nationally and internationally for its work in liver disease and transplantation, neurosciences, cardiac care and blood cancers.

As a leading university hospital, KCH provides important local, regional, national and international services, as well as training and education for medical, nursing and dental students. The trust provides a full range of local hospital services for over 700,000 people in the London boroughs of Lambeth and Southwark as well patients from Kent, Surrey, Sussex and further afield. It is also a regional and national secondary and tertiary centre for liver disease and transplantation, foetal medicine, neurosciences and neurosurgery, cardiology and cardiac surgery.

King's directly employs approximately 6,500 staff and provides over a million individual patient contacts a year, including approximately 122,000 inpatient stays and day cases, and over 700,000 outpatient appointments.

The trust's annual turnover is £566 million.

## South London and Maudsley NHS Foundation Trust (SLaM)

SLaM provides "a full range of mental health services, for people of all ages, from over 100 community sites in south London, three psychiatric hospitals and specialist units based at other hospitals." Mental health and social care services are provided in partnership with local authorities. Close to 5,000 people annually receive hospital treatment and about 30,000 people receive support through SLaM's community services. Treatment is also provided for substance misuse.

SLaM's "local communities have very high levels of mental health needs - up to six times the national rate of psychosis in some areas. There are also high levels of social deprivation and substance misuse, and an ever-changing population, including high numbers of refugees." SLaM serves residents of Croydon, Lambeth, Lewisham and Southwark (and substance misuse

## King's Health Partners

King's Health Partners Academic Health Sciences Centre (AHSC) is a pioneering collaboration between King's College London, Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts.

"King's Health Partners [KHP] is one of only five Department of Health accredited AHSCs in the UK. The partnership brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health." KHP intends for these combined strengths to improve patient care, for example by applying breakthroughs in medical science at the earliest opportunity.

## Southwark Health and Adult Social Care Scrutiny - Reports to date:

| | |
|---|---|
| July 2001 | Promoting independence: Scrutiny Panel report of homecare services provided to older people and people with disabilities |
| April 2003 | Modernising Day Care |
| January 2004 | The Prevention of Teenage Pregnancy |
| July 2004 | The Nature and Level of Mental Health Services to Black Male Teenagers |
| July 2005 | Review of Direct Payments in Southwark |
| December 2006 | Adult Carers in Southwark – Identification and Support |
| July 2007 | Review of Older Adults Support in Southwark [OASIS] service |
| May 2008 | Review of 'A Picture of Health for Outer South East London' (Statutory Joint Health Overview and Scrutiny Committee) |
| March 2010 | Southwark Circle: A Brief Update |
| March 2010 | Consultation Report |

## SUGGESTED TOPICS FOR SCRUTINY 2010-11

| Committee | Topic |
|---|---|
| **Overview & Scrutiny** | |
| | Use of consultants and temporary staff – VFM of consultants |
| | Review of local and general election process |
| | Performance of Customer Service Centre |
| | Joint service delivery with Lambeth |
| | Customer care |
| **Regeneration & Leisure** | |
| | Fairness of distribution of resources incl S106 |
| | Progress of Canada Water scheme/overspend on Canada Water library |
| | Planning policy on tall buildings |
| | Car parking policies – impact on local businesses |
| | Management and delivery of small and large regeneration projects |
| | Housing investment |
| | Empty shop units |
| | Sports development for disabled & older people & other disadvantaged groups |
| | Access to employment |
| **Housing & Community Safety** | |
| | Anti Social Behaviour |
| | Noise |
| | Who controls shared spaces on estates – green areas, tenants halls |
| | Use and cost of CCTV |
| | Leaseholder service charges |
| | Student accommodation |
| | Community safety |
| | Repairs |
| | Housing transfers and overcrowding |
| | Estate parking |
| | |

| | |
|---|---|
| **Health and Adult Social Care** | |
| | Substance misuse services |
| | Older people's services |
| | Tackling isolation for older people and vulnerable adults |
| | Health inequalities strategy |
| | NHS Southwark services |
| **Environment, Transport, Communities & Citizenship** | |
| | Community cohesion for marginalised groups |
| | How the council involves local people in service delivery and planning and choosing service development |
| | Equality of opportunity for local people in accessing council programmes |
| | The edges of the borough – how do neighbouring councils work together to ensure that boundary areas receive high quality services? Fly tipping, street cleaning, repairs, traffic scheme management |
| | TfL - Quality of bus services across the borough, integration of local transport systems |
| | Voluntary sector funding |
| | Allotments |
| | Borough high Street |
| | Recycling targets |
| | Roadworks |
| | Lack of community facilities |
| **Education and Children's Services** | |
| | Childhood obesity |
| | Kingsdale School admissions policy (NB this is a foundation school - unlikely that the council has any influence – Shelley Burke) |
| | Primary school places and administration of admissions process |
| | Teenage pregnancy |
| | Youth provision and engagement - how will devolved commissioning work? |
| | Academies |
| | Parenting support |
| | Services and support for disabled children |

## Scrutiny review proposal

**1 What is the review?**

**2 What outcomes could realistically be achieved? Which agency does the review seek to influence?**

**3 When should the review be carried out/completed?** i.e. does the review need to take place before/after a certain time?

**4 What format would suit this review? (e.g. full investigation, Q&A with cabinet member/partners, public meeting, one-off session)**

**5 What are some of the key issues that you would like the review to look at?**

**6 Who would you like to receive evidence and advice from during the review?**

**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

**Southwark Health and Adult Social Care Scrutiny Sub-Committee:**

**Meeting schedule 2010/11**

| Meetings | Meeting date |
|---|---|
| Meeting 1 | Wednesday 30 June 2010 |
| August recess | |
| Meeting 2 | Wednesday 6 October 2010 |
| Meeting 3 | Monday 29 November 2010 |
| December recess | |
| Meeting 4 | Wednesday 2 February 2011 |
| Meeting 5 | Wednesday 23 March 2011 |
| Meeting 6 | Wednesday 4 May 2011 |

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| Councillor Vikki Mills | 1 |
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| Councillor Emmanuel Oyewole | 1 |
| Councillor Keadean Rhoden | 1 |
| Councillor Poddy Clark [Reserve] | 1 |
| Councillor Dan Garfield [Reserve] | 1 |
| Councillor Eliza Mann [Reserve] | 1 |
| Councillor Darren Merrill [Reserve] | 1 |
| Councillor Althea Smith [Reserve] | 1 |
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| Councillor Ian Wingfield [Deputy Leader] | 1 |
| Councillor Dora Dixon-Fyle [Health & Adult Social Care] | 1 |
| Councillor Lisa Rajan [Chair, OSC] | 1 |
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| Patrick Gillespie, Southwark Service Director, SLaM | 1 |
| Jo Kent, Deputy Service Director, SLaM | 1 |
| Marian Ridley, Guy's & St Thomas' NHS FT | 1 |
| Michael Parker, Chair, KCH Hospital NHS Trust | 1 |
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