Open Agenda

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 6 October 2010
6.30 pm
Town Hall, Peckham Road, London SE5 8UB

Membership

Councillor Neil Coyle (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Michael Bukola
Councillor Denise Capstick
Councillor Darren Merrill
Councillor Victoria Mills
Councillor the Right Revd Emmanuel Oyewole

Reserves

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

INFORMATION FOR MEMBERS OF THE PUBLIC

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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: 28 September 2010

PRINTED ON RECYCLED PAPER

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 6 October 2010
6.30 pm
Town Hall, Peckham Road, London SE5 8UB

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.	**MINUTES** To approve as a correct record the minutes of the Health and Adult Social Care scrutiny sub-committee meeting held on 30 June 2010.	1 - 19
5.	**RESTRUCTURE OF DRUG AND ALCOHOL SERVICES**	20 - 48
6.	**RESTRUCTURE OF SLAM SERVICES**	49 - 66
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Date: 28 September 2010

Agenda Item 4

HEALTH AND ADULT SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES of the Health and Adult Social Care Scrutiny Sub-Committee held on Wednesday 30 June 2010 at 7.00 pm at Town Hall, Peckham Road, London SE5 8UB

PRESENT:	Councillor Neil Coyle (Chair) Councillor David Noakes (Vice-chair) Councillor Michael Bukola Councillor Poddy Clark Councillor Darren Merrill Councillor Victoria Mills Councillor the Right Revd Emmanuel Oyewole
OFFICER SUPPORT:	Jane Fryer, Medical Director, NHS Southwark Sean Morgan, Dir. Performance and Corp. Affairs, NHS Southwark Susanna White, CE NHS Southwark & Strategic Dir. Southwark Health and Community Services Sally Lingard, Assoc. Dir. Communications & Marketing, KCH Frances O'Callaghan, Dir. Performance & Delivery, KHP Sarah Feasey, Principal lawyer Cathryn Grimshaw, Senior lawyer Rachael Knight, Scrutiny project manager
LOCAL REPRESENTATIVES:	Emma Beamish, Albany Action Group Ann Fox, National Childbirth Trust Martin Saunders, Southwark LINk Tom White, Southwark Pensioners' Action Group

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Denise Capstick. The chair also announced a change to the sub-committee's membership: Councillor Darren Merrill has replaced Councillor Keadean Rhoden.

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

2.1 There were no urgent items.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 Disclosures of personal non-prejudicial interests were declared as follows: Councillor Coyle as a member of the Guy's and St Thomas' Foundation Trust (GSTT); Councillor Noakes as a member of the King's College Hospital Foundation Trust and former member of the GSTT board of representatives; and Cllr the Right Reverend Emmanuel Oyewole as member of GSTT and the Dr Hossain & Dr Persadh Surgery, Lister Primary Care Centre.

4. APPOINTMENT OF VICE-CHAIR

4.1 Councillor David Noakes was appointed as the sub-committee vice-chair.

5. MINUTES

5.1 The minutes of the Health and Social Care scrutiny sub-committee meeting held on 17 March 2010 were accepted as a correct record.

6. INTRODUCTORY OFFICER BRIEFINGS

6.1 As an introduction to this item, the chair shared statistics on Southwark's demographics and related health issues. For example; that the borough is the ninth most deprived nationally, a measurement of economic factors that significantly impact health; and that despite the borough's comparatively young population Southwark has an increasing prevalence of dementia. He highlighted that the sub-committee has just five further meetings during the 2010/11 civic year and that members are likely to be presented with many issues regarding changes to local health services, in addition to the topic(s) that they select to review.

6.2 Susanna White, chief executive of NHS Southwark and strategic director of Southwark's health and community services, welcomed the new members and remarked that the sub-committee has never faced such difficult circumstances as at present, or been as needed, in helping to work out how people in Southwark can be provided with the right care, with less money: The council's current budget for health and community services will be reduced by 25% over a period of three years - from approximately £90 million to £65 million. She explained that this impels the need to look carefully at how a different system could still keep people safe. The new personalisation scheme will be brought into an environment of more controls but smaller budgets. She hopes that the sub-committee will be able to help identify how this can be achieved.

6.3 Regarding the budget for services provided by NHS Southwark, this will not be reduced, but there are financial pressures due to Southwark's changing

demographics and the need to provide additional procedures, etc. The chief executive stated that this similarly compels re-modelling, as budgets would be approximately £90 million adrift in five years time, unless there are changes. The proposals for re-modelled and altered services will therefore be brought to this sub-committee.

6.4 NHS Southwark will also be looking for South London and Maudsley (SLAM) to reduce the costs of their mental health services. This is already outlined in the strategic plan, but members will be informed about the emerging details for service change.

6.5 The chief executive also noted that a Health White Paper will soon be published by the new government, which is expected to outline proposals for GPs to lead commissioning. She commented that Jane Fryer, the NHS Southwark medical director, is a GP herself and will attend the sub-committee's meetings, providing a key link to the PCT.

6.6 Members requested further information about the potential change in the White Paper regarding GPs taking up the commissioning role that is currently held by the PCT. The chief executive responded that she cannot really clarify until the White Paper is available, but that the Secretary of State's intention is for the approximately £80 billion NHS budget (including ½ billion in Southwark) to go to GPs to commission local services via consortia, as they are most in touch with local people.

6.7 She also confirmed that some GP lead commissioning has existed in Southwark for the last four to five years and that GPs are key in leading discussions, so would be extending beyond an advisory role to having real budgets and responsibilities. The medical director commented that the PCT would need to ensure that GPs are prepared as commissioners.

6.8 Members queried how much thought at this stage the PCT had given to how it would manage consultation with the scrutiny sub-committee and public engagement, in view of the scale of expected changes.

6.9 The chief executive responded that this is something for scrutiny to discuss. She added that the PCT has not before been asked to do anything as significantly different as this; that it will need to set out an overview of its plans, but will also need to make changes more quickly than in the past,- even to manage this year's budget.

6.10 Members commented that the council as a whole will need to think about how to include the public more in such decision-making. The medical director reasoned that it would be wise to wait for the Health White Paper, but emphasised that another key message from the Secretary of State for Health is his intention to strengthen public and patient involvement.

6.11 The chair welcomed Frances O'Callaghan, director of performance and delivery, King's Health Partnership (KHP). The director circulated booklets about KHP and its strategic framework, and briefed members on the key points (see Appendix A). She noted, for example, that KHP is one of only 5 Academic Health Science

Centres in England; that it includes 21 clinical academic groups (CAGs); and that a major agenda for the partnership within the context of the economic turndown is to support efficiency while also supporting excellence.

6.12 In response to members' queries, the director explained that KHP is funded equally by the four partner organisations. This provides a core budget of close to £1.5 million, which covers salaries, support costs and allows some discretionary spending on research projects. At this stage there is no formal guarantee for the level of future funding: the partners have agreed to re-negotiate the budget annually.

6.13 The director added that KHP is currently working on Key Performance Indicators, and would be happy to share these in due course. She added that the partnership aspires is to ensure that research results from King's College London are adopted in practice as early as possible and used to shape best practice; and to work out how to cross the apparent divide between physical and mental health.

6.14 Sarah Feasey, principal lawyer, Southwark council, explained her role in supporting the sub-committee by providing legal advice on constitutional points; the sub-committee's statutory powers; and substantive issues. She introduced her colleague, Cathryn Grimshaw, who is likely to attend subsequent meetings in this capacity.

6.15 The principal lawyer explained the sub-committee's powers in relation to local health services and the impact of the current financial climate. NHS trusts, PCTs and Foundation Trusts have a statutory duty to provide Health scrutiny committees with requested information and to consult with them on proposed service changes or developments. It is up to the sub-committee to decide whether a proposed change is a substantial variation and this impacts the requisite level of consultation. However, even when members deem a proposed change to be a substantial variation, this does not oblige the sub-committee to scrutinise the proposal.

6.16 The sub-committee also has a role in considering the quality of an NHS trust's planned consultation. Consequently, if members are not satisfied that the proposed change is in the interests of the health service, or has concerns that the consultation was inadequate, it can ultimately refer its concerns to the Secretary of State, who can potentially challenge the trust. Members were informed that there are exceptions, however, such as when a trust believes that there is a risk to patient welfare or safety: It can then immediately terminate a service without consulting either the sub-committee, service users or local residents, etc. It should, however, inform the health scrutiny committee of its decision and actions, - and of its plans for replacement services.

6.17 Officers have recently discussed how the trusts inform the sub-committee about proposed changes. A template format is proposed to help members decide if they require further information, or want to discuss with the trusts the plans for consultation. The template included in the agenda papers for item 7 was flagged as an example.

6.18 Tom White, Southwark Pensioners' Action Group, spoke to the sub-committee about the proposed changes to drug and alcohol treatment services at Marina

House. [The 2009/10 sub-committee had responded to formal consultation on these changes in January 2010.] Mr White was concerned that there are outstanding issues about the changes and about the adequacy of the consultation. In particular, he raised queries about the provision for self-referral. He proposed that the sub-committee hold a meeting specifically about the changes, as he believed that the concerns warranted referral to the Secretary of State. He suggested that the additional meeting be used for members to consider all the relevant information from officers and his related correspondence.

6.19 Members opted to discuss this issue further when considering the sub-committee's work programme under item 8.

RESOLVED:

1. That members are invited to suggest improvements to the 'trigger template' for substantial variations on an on-going, ad-hoc basis;

2. That the 'trigger template' could be amended to request more information about the service user perspective of proposed changes; for example that the trust be requested to list the groups/individuals to be consulted if this is still to take place; or to outline the response to date from people needing support;

3. That regarding service variations outlined on future trigger templates that are circulated via email between meetings, members are invited to forward related questions or requests for more information to the scrutiny officer (rachael.knight@southwark.gov.uk), for these to be submitted to the relevant trust before meetings occur. This will help ensure more detailed answers are available prior to and when the sub-committee meets.

4. That should members raise several questions on a future issue, the chair and vice-chair would decide in consultation with other members whether a trust representative be requested to attend either the next scheduled meeting or a special meeting to provide a fuller briefing.

7. PROPOSED SERVICE VARIATIONS

7.1 The NHS Southwark medical director referred to the trigger template on proposed changes to vascular surgery services at King's Health Partners (KHP). She commented that this is an example of the type of service change notification that the sub-committee is likely to receive more often. She explained that currently both Guy's and St Thomas' hospitals (GSTT) and King's College Hospital (KCH) provide vascular surgery services and that the proposal is to concentrate these on one site. This would achieve savings and patient benefits, as the combined volume of treatments would increase associated learning for the consultants. She clarified that the template provides a broad outline of the proposed changes and that the sub-committee was being asked whether it agrees.

7.2 Members discussed the proposals and whether to request further information. It was felt that the changes do not amount to a substantial variation, partly due to the numbers of patients involved, and as this type of surgery is not similar to ongoing treatments that require patients to attend regular appointments.

7.3 Members also commented that there seemed to be no specific reason to challenge the proposals, but that it would be of interest to know whether doctors with the necessary expertise would still be based at the King's site, should emergency surgery be necessary. It was agreed that this query be raised with KCH.

RESOLVED:

1. That a response be sent to KHP stating that the sub-committee is broadly in agreement with the proposed process, including the plan not to undertake formal consultation; and

2. That KHP be requested to clarify, however, whether staff with the requisite expertise will still be based at the King's site, in order to carry out emergency vascular surgery.

8. WORK PROGRAMMING AND SCOPING

8.1 The chair proposed, and members agreed, that the sub-committee interview the cabinet member for Health and Adult Social Care at its 29 November meeting.

8.2 The scrutiny project manager outlined the process for health scrutiny committees to provide feedback on Quality Accounts (QAs). These are performance reports that NHS providers are required to publish annually. She commented that Southwark and a number of other local authorities are raising queries with the Department of Health regarding the provision for Health OSCs to assess QAs for national NHS providers: Southwark had been requested in 2009/10 to provide the national scrutiny response (in effect on behalf of health OSCs across the country) to the QA for NHS Direct, as their head office is located in the borough. The sub-committee would be informed of the DoH response.

8.3 Regarding the proposal from Tom White for an additional meeting regarding services at Marina House, members suggested that clarification first be sought from NHS Southwark, in particular about the provision for self-referral. It was agreed that the reply be shared with all members and an informal meeting held to decide whether to arrange a separate formal meeting.

8.4 Members discussed the issues that they would request PCT officers to clarify. These included, for example, the adequacy of the related consultation and the viability of co-locating across both sites the services that were to be moved to Blackfriars centre.

8.5 Members considered again the issues raised earlier in the meeting by the Albany Action Group. It was highlighted that the women who had used the Albany midwifery seemed very happy with the service, however, that KCH seems to be consulting widely about what replacement would be provided. Members also queried what aspect of this issue the sub-committee would scrutinise, in order to help ensure that people in Peckham have high quality services, as the mothers have openly admitted that they accept that the practice has been dissolved and are not expecting it to be re-instated. There was also discussion on whether to review the KCH decision, and so assess whether the trust should change its website statement regarding the cause for the closure.

8.6 Members suggested that the sub-committee write to KCH raising some of the concerns that the Albany group had highlighted and asking whether the trust would consider altering its website statement.

8.7 The chair invited members to propose review topics for the 2010/11 year. Three key suggestions were made as follows:

- an assessment of the use of Equality Impact Assessments (EIAs) – to focus on examples from health and/or social care services;
- NHS Southwark services for older people, - in particular personalisation and how Southwark will respond to a significantly reduced income;
- how to improve integrated services.

8.8 The members who had suggested these topics agreed to develop a scoping document to share with the sub-committee, in order to clarify their review suggestion and outline how it could be approached.

RESOLVED:

1. That Cllr Dixon-Fyle, Cabinet Member for Health & Adult Social Care, be invited to be interviewed at the sub-committee's 29 November 2010 meeting.

Quality Accounts

2. That a paper be prepared for the 6 October meeting that outlines:

- the sub-committee's role and options in relation to Quality Accounts;
- the related timeframe;
- a list of the service providers from whom the sub-committee expects to receive a QA in early 2011; and
- the response from the DoH regarding the role of local scrutiny committees in reviewing regional or national service providers, such as NHS Direct.

Changes to drug and alcohol treatment services at Marina House

3. That NHS Southwark be requested to provide the following information within two weeks:

- Whether officers have looked 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 (as requested at the previous sub-committee's 17 March 2010 meeting), and if so, what has been the outcome;
- whether NHS Southwark believes that it carried out the consultation on this service change according to the relevant statutory requirements and good practice guidance;
- whether the issue regarding the reduction of self-referral has been properly consulted on and resolved.

4. That Tom White, Southwark Pensioners' Action Group, be invited to submit related documents regarding the quality of the consultation and the issue of self-referral.

5. That members be invited to an informal meeting in July, to consider NHS Southwark's response to the above request and the papers from Tom White, with the view to decide whether to schedule an additional formal meeting to further explore this issue.

Albany Midwifery Practice

6. That a letter be sent to King's College Hospital (KCH) requesting the following:

- that KCH review the statement on their website that the Albany Midwifery Practice was closed due to safety concerns, and considers whether it would amend this to statement to refer to management rather than safety reasons;
- that KCH provide appropriate details about whether it responded formally to the AIMS and NCT critique of the CMACE report; and if it didn't whether it will do so now;

7. That KCH be encouraged to include as many of the positive elements of the Albany Midwifery Practice in the replacement service as possible.

Reviews

8. That the 3 members who offered to each scope a proposed review topic, submit their proposal to all members within two weeks of the meeting - i.e. by Wednesday 14 July (Cllr Coyle on Equality Impact Assessments; Cllr Noakes on Older People's Services and Personalisation; Cllr Bukola on Improving integrated services);

9. That all sub-committee members be invited to comment on and suggest amendments to the proposals within a week; and

10. That all members then be requested to rank the 3 proposals according to their preferred priority – with the highest ranked suggestion forming the basis for the next HASC sub-committee scrutiny work.

9. DEPUTATION FROM ALBANY MIDWIFERY PRACTICE

9.1 Note: the sub-committee agreed to a change of the agenda sequence so that this deputation followed item 5.

9.2 Emma Beamish, a founder of the Albany Action Group of parents who had used the Albany Midwifery Practice, was invited to address the sub-committee as the deputation's key speaker. She outlined the reasons for the deputation and explained features of the practice that had been particularly valued: when an expectant mother booked in, for example, she was appointed a midwife to care for her throughout her pregnancy, as well as throughout labour and for 30 days after the child's birth. Regarding the closure of the practice, she commented that when King's College Hospital (KCH) had terminated the practice's contract it was stated that this was necessary for safety reasons. She added that the KCH risk assessors had not raised problems with the midwifery and that to date the Action Group felt that the hospital had not sufficiently explained what the problems were.

9.3 Ms Beamish further stated that KCH had commissioned a report from the Centre for Maternal and Child Enquiries (CMACE) with recommendations, but that the report did not recommend that the practice be closed. She added that because safety reasons were used, this meant that there was no need to consult with local parents; that the practice was therefore terminated very quickly; and that parents have not in the meantime had access to any service comparable to that provided by the Albany midwifery. She requested that the sub-committee look at the process used by KCH to reach their decisions about closing the practice.

9.4 Ann Fox from the National Childbirth Trust (NCT) explained that the NCT would not normally become involved in local decisions, but was doing so in this case as the Albany Practice had received national and international awards and had used a model that was about to be copied across the country. She added that representatives of the NCT had met with KCH and had requested that the statement on the KCH website regarding the safety reasoning for the closure be changed to issues regarding management.

9.5 It was clarified again that the deputation was requesting the sub-committee to scrutinise the process by which KCH had reached their decision to close the practice, including the evidence on which the decision was based.

9.6 Members responded to the deputation with comments and queries. Key points raised included as follows:

9.7 Members referred to the notes from a meeting on 28 April 2010 between members of the Action Group and officers from NHS Southwark and KCH. It was asked whether KCH has recruited new midwives and whether there is currently a gap in the service. Ms Beamish responded that the gap had been covered but not with the same service.

9.8 Members queried whether the next steps by KCH as outlined in the minutes had taken place, - such as the involvement of local mothers in the recruitment of

maternity staff. Ms Beamish confirmed that those steps had been taken. She emphasised, however, that the more significant issue was the KCH allegation that the Albany practice model had been unsafe. She commented that the Albany model saves money and that it is important that the reputation of the Albany practice remains clean, so that the model can be contracted elsewhere.

9.9 Members asked whether mothers were satisfied with the process going forward for replacing the service and suggested that if the sub-committee were to scrutinise the decision process members would be interested to see what replacement had been established and to consider the transition. Ms Beamish stated that there had been an immense vacuum in the service when the Albany practice was first closed and that mothers in Peckham who used the service had waited a long time for a replacement. She added that there were currently two midwives at the Lister practice (where the Albany midwifery had been located) who will provide booking appointments, but should a mother request a homebirth, she would be referred to another of the community maternity teams, which are understaffed.

9.10 Sally Lingard, associate director of communications and marketing, KCH, explained that an aspect of the Albany service that mothers had wanted to retain was that a named midwife be on call 24/7. She said that this was problematic due to the EU working directive regarding working hours, but that new recruitment for the replacement practice would be started at the end of the summer and would include the provision for 24/7 on-call cover. She added that regarding homebirths, if a mother were to request this option she would be given that choice.

9.11 Members queried why KCH had offered to employ the Albany practice midwives when the service had been withdrawn due to safety concerns. Ms Beamish referred to the 28 April meeting notes which state that KCH would be happy to employ any of the Albany midwives and that parents had hoped that KCH would be able hire the midwives and then allocate them back to the mothers they had been working with through the Albany service. It was confirmed however, that none of the seven midwives wanted to take up the recruitment offer from KCH. She commented that the safety allegation therefore remains vague – as to whether the model or the midwives were deemed unsafe. Sally Lingard responded that the formal statement on the KCH website refers to patient safety.

9.12 Members asked whether KCH had responded to the NCT's and the Association for Improvement in Maternity Services' (AIMS) critique of the CMACE report. Ann Fox noted that CMACE had responded to the critique on its website and that the NCT had had an email exchange with KCH, but neither NCT nor AIMS had received a formal response to date.

9.13 The chair thanked the members of the Action group and the KCH officers for their contributions and said that they would be notified of the sub-committee's decision.

The meeting closed at 10.20pm.

KING'S HEALTH PARTNERS

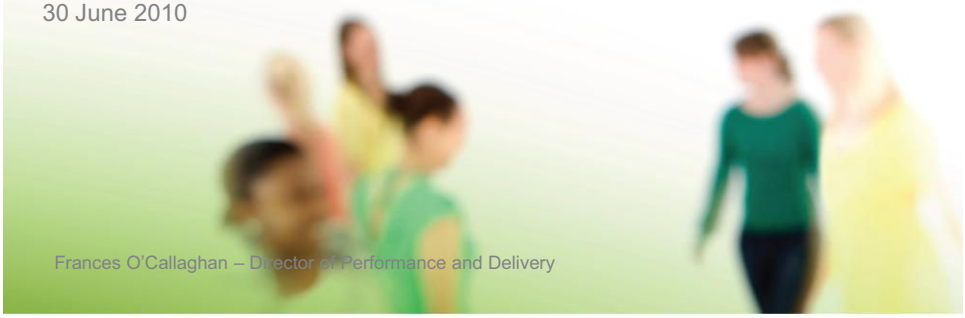
An Academic Health Sciences Centre for London

Pioneering better health for all

Kings Health Partners – An Overview

Southwark Overview and Scrutiny Committee

30 June 2010



Frances O'Callaghan – Director of Performance and Delivery

King's College London | Guy's and St Thomas' NHS Foundation Trust | King's College Hospital NHS Foundation Trust | South London and Maudsley NHS Foundation Trust

The partners – four highly-performing institutions

Guy's and St. Thomas'

South London and the Maudsley

King's College Hospital

KING'S HEALTH PARTNERS

South East London Heat Map

Health Indicator	Lambeth	Southwark	Lewisham	Greenwich	Croydon	Bromley	Bexley
Binge drinking adults							
Deaths from smoking							
Drug Misuse							
Early deaths: Cancer							
Early deaths: Heart disease & stroke							
Healthy eating adults							
Hospital stays due to alcohol							
Infant Mortality							
Life expectancy							
Mental Illness							
Obese Adults							
Obese Children							
Physically active adults							
Teenage Pregnancy							
Tuberculosis							
Violent Crime							

Key

Worse than London average

In line with London average

Better than London average

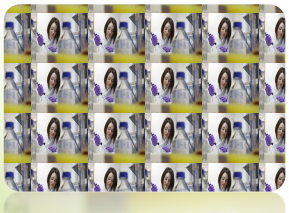
Source : Department of Health Community Health Profiles 2009

KING'S HEALTH PARTNERS

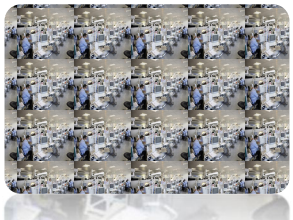
Our Vision

King's Health Partners is pioneering better health and well-being, locally and globally, through integrating excellence…

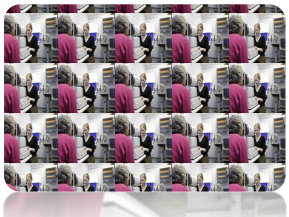
in research



in education/training



in patient care



KING'S HEALTH PARTNERS

Our Mission

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King's Health Partners will become the UK's leading AHSC. We will:

•**Drive the integration** of research, education and training and clinical care, for the benefit of patients, through our new Clinical Academic Groups (CAGs).

•**Consider all aspects of the health needs** of our patients when they come to us for help.

• **Improve health and well-being** across our ethnically and socially diverse communities and work to reduce inequalities.

•**Develop an AHSC that draws upon all academic expertise** in medical science and also in basic science, social science, law and humanities.

•**Deliver a radical shift in healthcare** by identifying 'at risk' groups, based on genotype and lifestyle, and helping them to avoid illness.

• **Work innovatively with stakeholders** in the redesign of care pathways, including the delivery of care closer to home.

Our Values and Guiding Principles

Page 5

- **Always put our patients first**
- **Focus on pioneering research:** by rapidly and efficiently translating new discoveries.
- **Provide innovative learning opportunities:** by bringing together educational, academic and clinical expertise.
- **Work in partnership:** by building on and extending clinical and academic collaborations.
- **Transform the nature of healthcare:** by moving from treatment towards population screening and disease prevention.
- **Deliver excellence**
- **Disseminate knowledge**
- **Exercise scholarship in everything we do:** by being enquiring, reflective and challenging to ensure that everything we do adds value.
- **Be inclusive**

Our Strategic Objectives (1)

Page 6

- Mental health services and physical health services work collaboratively to treat the entire individual.
- Constantly seek to reduce costs and improve quality for the benefit of patient care across the partnership and the wider health and social care system.
- Underpin all these objectives by working with our stakeholders to build information technology and resources to support our efforts.
- Establish, in collaboration with our stakeholders, an 'Academy of Apprentices' to offer training opportunities to our local population in a range of health related skills.
- Develop education programmes for staff and share with wider healthcare community of south London and beyond

Our Strategic Objectives (2)

Page 7

- We will be in the top 10 globally, both clinically and academically, in the fields of:
  - Cardiovascular disease
  - Transplantation, immunity and inflammation linked to disease
  - Mental health and neurosciences
- We will build our capacity to address diseases that have a particularly large impact on our **local community**, but also are important on a global scale, in the areas of:
  - Childhood diseases
  - Diabetes and obesity
  - Cancer
- Ensure our academic expertise is applied to all our clinical services to pursue our tripartite mission.

The whole patient pathway

Page 8

Available evidence suggests that healthcare systems must cover, in an integrated way, the whole patient pathway if we are to achieve:

- Optimal clinical care pathway design and implementation
- Engagement/commitment from all healthcare/social care professionals involved in an individuals care
- A shift in the mindset of staff – to focus on the performance of the system, rather than an institution
- Public health goals
- Control of costs
- Effective commissioning

King's Health Partners wishes to work with commissioners and partner providers to achieve an integrated high quality cost-effective sustainable healthcare system for south London.

KING'S HEALTH PARTNERS

Development and engagement

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Developing the proposals to become an AHSC

- Commitment by partners in 2008 and DH announced accreditation process in autumn 2008
- Stakeholder events from October to December 2008
- Hosted international conference in March 2009

Strategy Development

- "Summer of Dialogue 2009" included events for all stakeholders
- Representation from all local Commissioners
- Mental health commissioner workshop Dec 2009 and quarterly workshops through 2010

On going engagement

- Mental Health Partnership Board
- Commissioner Stakeholder Forum
- Representation on Clinical Academic Groups

KING'S HEALTH PARTNERS

Guiding Principles for CAGS

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Partner organisations are now focusing on becoming “CAG ready” via an internal accreditation process and developing local engagement plans.

- **Partnerships with stakeholders** – high level of engagement with service users and others.
- **Care pathway development** is a cornerstone of CAG development – key to meaningful engagement of stakeholders
- **Bring together clinical and academic staff** to deliver the ‘tripartite’ agenda – clinical, research, education and training working together to improve the quality of services
- **Success measured by outcomes and satisfaction** for service users
- **Development of joint plans –** strategy, developments and efficiencies
- **Integrate physical, psychological & social** – emphasis on social care, recovery and interface between acute and mental health services
- **Enhance multi-disciplinary approaches** – leadership & team working

KING'S HEALTH PARTNERS

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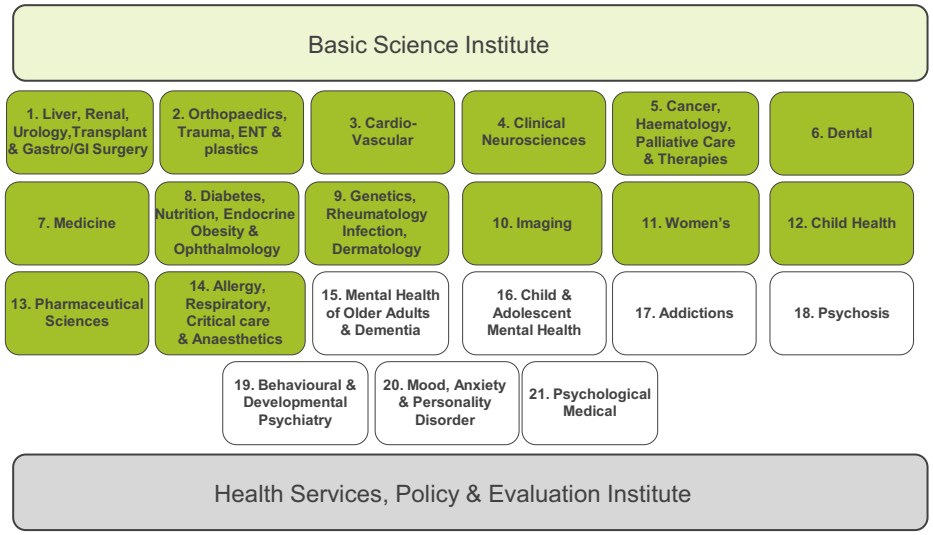

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Engaging with primary care

Primary Care and Public Health Research Group

- Membership includes: Professors of Primary Care & Public Health, PCT Medical Directors, PEC & DPHs, provider Trusts, primary care practitioners
- Group aims: promoting health gain in the local population, prioritising areas for future primary care/public health research and developing supporting infrastructure, provide primary care/public health expertise to KHP CAGs (identified members to provide input to CAGs)

Primary care representation on planning & development groups

- GP involvement currently being sought & funded
- Building on existing links and relationships at a service and planning level
- Identifying how to engage GPs and others where strong links are necessary at the CAG level e.g. Mood, Anxiety and Personality Disorder CAG
- Welcome suggestions about developing this further

Engagement with broader stakeholders

- Broad and different stakeholders for clinical, teaching and training and research and development aspects of King's Health Partners.
- Some stakeholders to be engaged on King's Health Partners wide basis e.g. pharma, MRC, Wellcome Trust, HIEC
- King's Health Partners partner organisations continue to use mechanisms developed at organisational level (including contributing to borough based groups and committees)
- CAGs to develop plans for stakeholder engagement based around their particular theme/services
- Particular opportunities based on care pathway development in SLaM

KHP Executive

Professor Robert Lechler	Executive Director
Professor John Moxham	Director of Clinical Strategy
Professor Anne Greenough	Director of Education and Training
Vacant	Director of Research
Frances O'Callaghan	Director of Performance and Delivery

Engagement and Involvement

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- CAG Development
- Integrated care provided across a system
- Care provided out of hospital
- What can KHP do for the community it serves to add value?
- What are the markers of success?

Agenda Item 5

4th August 2010

Dear Ms Kinnair

Restructure of Drug and Alcohol Treatment Services in Southwark

Thank you for your response to the scrutiny sub-committee's questions arising from our June 30th meeting and for providing copies of much of your correspondence with Tom White. However, committee members continue to have concerns about both practical questions surrounding the service and the robustness of the decision-making process.

We are considering devoting a special meeting of the committee to this matter and wish to collect further evidence from the PCT/SLAM as to how the service will work and the process undertaken to reach your decision. We would therefore be very grateful if you could promptly provide the fullest information you can on each of our questions below.

GP support

The January report to the PCT board noted that Southwark has 23 practices where at least 1 GP has undertaken specialised training in the management of substance misuse. Please can you advise whether more practices have developed such capacity or plan to, and what is the geographical spread?

The committee is also interested to know if there are GPs or practices which resist additional training or a specialism in this area and your plans to ensure anyone seeking support can access it.

Satellite clinics

We note that the new model requires an additional 100 clients to be supported in satellite clinics. What progress has been made on this? The committee is keen to learn how satellites were identified, how staff are trained, how many people are using the new support and where the new clinics are if possible please?

Self referral

We are aware that the ability of clients to self refer has been raised by a number of stakeholders, and the PCT response has been that this was a development of the Primary Care Strategy, and subject to separate

consultation. However, the chair of Southwark NHS has stated on an email to Mr White that “self referees at Blackfriars will continue to be seen”. Please could you confirm whether this is the case, whether it represents a shift in position and if so, whether it has an impact on the number of satellite clinic places that will be required?

Consultation process
Thank you for responding to our previous question on the consultation process. Please could you set out what impact assessment was undertaken in respect of the client group, and whether there was any specific consultation with or involvement of disabled people? It is the committee’s understanding that the Disability Discrimination Act 2005 would require specific involvement in this area as the outcome affects disabled people disproportionately (as service users). Information on how this obligation was met would reassure the committee that you have addressed all your statutory duties. Apologies for not being clearer on this issue n the initial question which has meant you were unable to provide a sufficient response previously.

Yours sincerely

Cllr Neil Coyle Cllr David Noakes

Cc: Cllr Dora Dixon-Fyle, Cabinet Member for Health and Adult Social Care
Dr Jane Fryer, Medical Director, NHS Southwark
Sean Morgan, Director of Performance and Corporate Affairs, NHS Southwark
Susanna White, Chief Executive, NHS Southwark
Tom White, Southwark Pensioners Action Group

SOUTHWARK HEALTH & SOCIAL CARE

Commissioning Directorate
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London SE1 2TZ

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Cllr Neil Coyle and Cllr David Noakes
c/o Shelley Burke
Head of Overview and Scrutiny
Communities, Law & Governance Department
PO Box 64529
London SE1 5LX

26th August 2010

Dear Cllrs Coyle and Noakes

Re: Restructuring Drug and Alcohol Treatment Services in Southwark

I write in response to your letter of 4 August 2010 requesting further information and clarity regarding the consultation processes for the restructuring of drug and alcohol treatment services. I appreciate that members of the committee continue to have concerns about both practical questions surrounding the service and the robustness of the decision-making process regarding the restructure and I hope the answers I have set out below address these concerns fully.

GP support
Training to enable GPs to provide effective treatment to patients is provided – Royal College of Genral Practitioners (Level I). We currently have 23 GPs trained covering 49 practices and we are planning to provide support to other practices through the development of polysystem hubs. Further training for a cohort of GP's to undertake RCPG level 1 is to take place this month.

The PCT and its partner agencies such as SLAM and Blenheim Community Drug Project (BCDP) have ongoing contact with GP practices across the borough. For example, BCDP provide specialist psycho-social and other support to surgeries and SLAM provides specialist support on alcohol-related problems.

This type of contact will, in itself, enhance a GP's capacity to manage clients with substance misuse problems. It is particularly attractive to those GPs who have very small substance misuse caseloads and therefore would not see specialist training as a priority. However, specialist training continues to be available and the PCT and its partners continue to encourage surgeries to undertake this.

It should also be noted that anecdotal evidence from within and outside the borough indicates that some GPs manage clients with substance misuse problems without recourse to specialist training or specialist services. For example, some people with substance misuse problems are reluctant to attend specialist services through fear of stigmatisation.

The PCT has encountered GPs who are reluctant to manage clients with substance misuse problems and this is addressed in a number of ways including peer interventions. Where these are not successful, practices are requested to clearly signpost substance misuse clients to other practices that are willing to see them. We have experienced no resistance to this latter strategy.

Satellite clinics
It should also be noted that SLAM substance misuse services have been providing satellite clinics in venues such as hostels long before the current proposal was mooted. These clinics are staffed by existing substance misuse workers therefore additional training is not required.

Progress on identifying the numbers of patients who will require treatment in the south of the Borough, together with possible venues for delivering this treatment, has begun. Re-assessments and reviews of the care plans of those patients with complex needs are being undertaken by the clinical teams within SLaM.

In terms of the location of future satellite clinics, a number of factors will be taken into consideration. Central to this is the history of community opposition to the establishment of new drug and alcohol services. In consequence, venues are likely to be premises that are already used to provide similar services. These would include:

- GP surgeries
- Community drug services (e.g. the Kappa Project on Old Kent Road)
- Probation offices
- Hostels

Furthermore, once the precise configuration of the proposed Integrated Offender Management Service is established, there may be capacity to provide a number of satellite clinics at Marina House.

Self referral
Clients self referring to SLaM services will continue to be assessed and given any treatment that is immediately necessary.

As part of our strategy to increase the number of people entering into and remaining in drug treatment, we have recently reviewed the model of service access, including direct access self-referral. Self referral is likely to remain in place at all servicers staffed by workers from a range of treatment providers

This will not have an impact on the number of satellite clinics that will be provided.

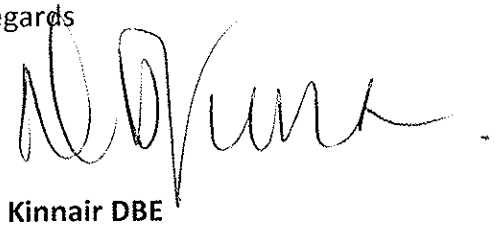
Consultation process
SLAM services see a number of clients whose drug use has led to their becoming disabled. For example, a number of clients are now amputees as a consequence of injecting in their groin and legs. That being the case, the needs of people with disabilities have always been integral to any service planning and, in consequence, are not addressed as a separate issue.

Additionally, it is the experience of SLAM services that people with disabilities – and particularly those with mobility issues – are often best served in satellite and community services. This has been the practice in the past and it is felt to have been highly successful. The current proposals seek to build on these practices, not undermine them.

The refurbished Blackfriars Road site will be full DDA compliant with enhanced provision for patients

I hope the above responses address the concerns of the sub-committee and I hope that we are now able to move forward with fully implementing these changes which we believe will improve services for people with drug and alcohol dependency.

Kind regards



Donna Kinnair DBE
Director of Commissioning and Nursing

Copy to: Cllr Dora Dixon-Fyle, Cabinet Member for Health and Adult Social Care
Dr Jane Fryer, Medical Director, NHS Southwark Tessa Jowell MP
Sean Morgan, Director of Performance and Corporate Affairs, NHS Southwark
Susanna White, Chief Executive, NHS Southwark
Tom White, Southwark Pensioners Action Group

PAGE 1

1 Background

Drug and Alcohol Services in Southwark

In Southwark, drug and alcohol misuse is managed across a range of specialist and generalist agencies in both the public sector and the voluntary sector. These services include community-based structured programmes such as counselling and methadone maintenance, community-based informal programmes such as needle exchange and advice and information services, and in-patient services such as in-patient detoxification programmes.

Increasing emphasis is also being placed on the management of appropriate cases of drug and alcohol misuse within primary care services such as general practices.

Blackfriars Community Drug and Alcohol Team (CDAT) and Marina House are two specialist drug and alcohol agencies provided by the South London and Maudsley NHS Foundation Trust (better known as SLAM). Both agencies provide a range of community-based services from their respective locations in Southwark - CDAT in the North of the borough (Blackfriars Road) and Marina House in the South (Camberwell).

The History of SLAM Substance Misuse Services in Southwark

Both CDAT and Marina House existed before the creation of the SLAM NHS Foundation Trust. CDAT was established in 1990 as part of the South London and Guys Health Service. Marina House was established around the same time as part of what was then the Bethlem and Maudsley Health Service.

In 1999 the two Health Services were merged as part of the creation of SLAM but CDAT and Marina House continued to operate from two separate sites.

Current Service Provision

Substance misuse services are currently provided as follows:

Service	Marina House	CDAT
Community Detox – Drugs/Alcohol	√	√
Community prescribing by specialist	√	√
Stimulant Service	√	√
Harm Reduction Service	√	√
Psychology Service	√	√
Structured counselling	√	√
Keyworking	√	√
Advice and Information	√	√
Advice on safer drug use and safer sex	√	√
Coffee morning	√	√
Service user group/coffee morning	√	√
Complementary therapies	√	√
Liaison ante natal clinic	√	√
Art Group	√	
Injecting clinic	√	
On-site dispensing	√	√
Needle exchange for clients		√
Alcohol group		√

RESTRUCTURE OF SLAM AND ALCOHOL SERVICES

IN CASE ANY DETAILS HAVE BEEN MISSED, I THOUGHT IT MIGHT HELP TO SEND YOU A REVIEW OF THE CONSULTA THAT NEVER WAS! I WOULD ASK YOU TO REMEMBER THAT ALL THE WORDS USED ARE ALL EITHER SLAM OR THE PCT AND ALL IN BLACK AND WHITE FROM OFFICAL DOCUMENTATIO FROM SLAM AND THE PCT. IN JULY 2009, I WAS TOLD THE MARINA HOUSE STAFF HAD BEEN TAKEN TO A HOTEL WHERE THEY WERE TOLD MARINA HOUSE WAS MOVING ITS SERVICES TO BLACKFRIARS RD (EXCEPT "RIOT" DRUG SERVICES. NOT THAT IT WANTED TO, BUT I KNEW THAT THE TERMS OF THE LEASE STATED THAT SOME FORM OF DRUG SERVICE HAD TO BE PROVIDED! AT THIS TIME SOUTHWARK NHS HELD A MEETI AT MILLWALL FC, A SORT OF CONFERENCE TO EXPLAIN WHAT NHS SOUTHWARK WERE DOING. A FRIEND OF MINE ASKED THE QUESTION "IS IT TRUE THAT MARINA HOUSE WERE MOVI ITS SERVICES, AND WHY HAD THEY NOT HAD A CONSULTATIO THE COMMISSIONER FOR SERVICES SAID THIS WAS NOT TRUE NO DECISION HAD BEEN MADE, AND THERE WILL BE A CONSULTATION! OBVIOUS LIES, BECAUSE I HAD ONE OF THE POSTERS IN MY HANDS STATING "MARINA HOUSE IS MOVING, ON THE POSTER IT ALSO STATED THERE WOULD BE A MEETING IN MARINA HOUSE ON THE 25TH OF JUNE. WE WERE GIVEN DOCUMENTATION FROM NHS SOUTHWARK STATING "CONSULTATION ON CHANGES TO SERVICE PROVISION". TO MY AMAZEMENT THE DOCUMENT STATE IN HEAVY PRINT "THE CONSULTATION PROCESS. WHAT WE ARE NOT CONSULTING ON. WE ARE NOT CONSULTING WHETHER OR NOT WE SHOULD PROVIDE ALL SU DRUG AND ALCOHOL SERVICES FROM ONE SITE INSTEAD OF TH TIME FRAME (THE LAST DAY RESPONCES WILL BE ACCEPTE WILL BE FRIDAY THE 14TH AUGUST.) JUNE THE 28TH TO AUGUST 14TH MUST BE THE SHORTEST ON RECORD! GOVERMENT GUIDE LINES FOR CONSULTATIONS STATE 3 MONTHS!

2 PAGE 3

I INFORMED SOUTHWARK HEALTH SCRUTINY COMMITTEE, WHO DULY ASKED THE PCT AND SLAM TO ATTEND A MEETIN AT THIS MEETING THEY WERE HARSHLY TOLD THAT THE ACTIONS THEY HAD TAKEN WERE APPALLING! THEY ASKED THAT THERE SHOULD BE A PROPER CONSULTATION, AND SUGGESTED THAT THE PCT AND SLAM SHOULD CONSULT WITH SCRUTINEE TO GET EVERYTHING WORDED PROPERLY. AT THIS MEETING, THE KEY WORRY WAS THAT SLAM AND THE PCT WANTED TO WITHDRAW SELF-REFERAL. SO IT WAS AGREED THAT THEY WOULD ALL CONFIRM. THE NEXT SCRUTINEE MEETING WAS HELD IN JANUARY, 20 AT THIS SCRUTINEE MEETING, CLLRS WERE SURPRISED THAT THE PCT AND SLAM HAD PRODUCED ANOTHER CONSULTATION PROCESS DOCUMENT, AND INSTEAD OF CONFORMING, HAD IN FACT STARTED ANOTHER CONSULTATION, IGNORING THE ADVI OF SCRUTINEE, WAS ALSO GOING AGAINST QUITE A FEW GOV AND DEPT OF HEALTH GUIDELINES. THE CONSULTATION LASTED ONLY 9 WEEKS, IGNORING GOV GUIDE LINE THA THEY SHOULD AT LEAST BE 3 MONTHS! TO THIS DATE SCRUTINEE AND OTHERS HAVE NOT BEEN TOLD OF THEIR FINAL DECISION! HOWEVER, THEY INFORMED THE LOCAL PRESS THAT THEY WERE GOING WITH THEIR PREFERED OPTION, THE ONE THAT WAS OPPOSED BY MPS, COUNCILLOR OF ALL PARTIES, EXECUTIVE MEMBER FOR HEALTH, AND OTHE ORGANISATIONS LIKE OURSELVES! THEY ALSO TOLD THE PRESS THAT SELF-REFERMENT HAD NOT BEEN CONSULTED ON. THIS IS BECAUSE IN 2008, THE PCT CONSULTED, AND SET OUT THE NEW CARE PATHWAY WHICH HAS A MUCH GREATER EMPHASIS ON GPS MANAGING THEIR PATIENT HEALTH, INCLUSIVE OF SUBSTANCE MISUSERS. REGARDING THIS, ON PAGE 131 OF SCRUTINY MEETING OCT 2009, IT STATES, THE PRIMARY CARE STRATEGY WAS DEVELOPED FOLLOWING EXTENSIVE CONSULTATION WITH SERVICE USERS,

INCLUDING THE SUBSTANCE MISUSE COUNCIL. THIS IS NOT A PROPER CONSULTATION, IT'S A CHAT WITH A FEW FRIENDS I BRING YOUR ATTENTION TO PAGE 77, ANOTHER PART OF NHS SOUTHWARK, IT STATES. IN JUNE 2009, AN IMPLEMENTATION STEERING GROUP WAS ESTABLISHED TO TAKE THE PROJECT FORWAR HOWEVER, WHILST SOME WORK HAS BEEN UNDERTAKEN ON THIS, PROGRESS ON A KEY ELEMENT – THE CLOSURE OF THE SELF-REFERRAL SERVICE AT SLAM – HAS BEEN DELAYED PENDING THE OUTCOME OF THE CURRENT SLAM CONSULTATION. THIS PROVES QUITE CLEARLY THIS WAS PART OF THE CONSULTATI TO TAKE IT OUT IS OUTRAGEOUS! I AM INCLUDING THE RELEVANT EVIDENCE, I SAID ALL THE WORDS I WOULD USE ARE NOT MINE – ONLY SLAM OR THE PCT. ON BEHALF OF SPAG, I HAVE WRITTEN TO SUSSANA WHITE, AND THE CHAIR OF THE PCT, PLUS THE CHIEF EXECUTIVE OF NHS. WE ARE ASKING THAT NOTHING SHOULD CHANGE UNTI THERE IS A PROPER CONSULTATION. IF THE GOVERMENT ALLOW'S THIS TO GO THROUGH, WE SHALL BE SAYING TO THE WHOLE OF THE COUNTRY, DO NOT WASTE YOUR TIME JOING IN ON A CONSULTATION.

YOURS SINCERELY

TOM WHITE

SOUTHWARK PENSIONER

ACTION GROUP

Tom White
28 Thompson Road
SE22 9JR

Susanna White
Chief Executive
NHS Southwark
160 Tooley Street
SE1 2TZ
Tel: 020 7525 0400
Susanna.white@southwarkpct.nhs.uk

March 16th 2010

Dear Ms White,

Restructuring Drug and Alcohol Treatment Services in Southwark

I am writing to formally complain about the process adopted by the PCT in relation to your plans to introduce a significant variation in services for users of drug and alcohol services in Southwark.

At a meeting of Southwark Health Scrutiny Panel in December 2009, members of the OSC made it clear to the PCT and SLAM representative that the curtailment of self-referral and other drug and alcohol services at Marina House was a matter of great concern to the OSC. Tessa Jowell has also written to you and the Secretary of State for Health expressing her considerable concern that services would be curtailed.

As I am sure you know, those who self-refer are more likely to be vulnerable and many have chaotic lives. The capacity for effective self-referral and access to services is of great importance in reducing harm to this client group and those who care for them.

Although self-referral was part of the consultation, which began on November 16th 2009, when the consultation finished on January 15th 2010, the PCT announced to the local press that self-referral had not been consulted on.

We are concerned about the following issues:

- The consultation only lasted for two months giving insufficient time for the community to get fully involved. As you know Cabinet Office guidance is that consultation should last for at least three months.

- There has not been a full needs assessment amongst service users to determine how their needs would best be met in a reconfigured service.

- Primary care services generally do not have the capacity or expertise to take on the service currently provided at Marina House.

- The Blackfriars service is too far from South Southwark and users are much less likely to travel to Blackfriars than Marina House. This will result in many users falling away from the service.

After the 2008 consultation finished the PCT reported to the PCT Board that MPs, councillors and users and other voluntary sector organisations did not support the termination of self-referral and other services at Marina House.

In reality, there has never been an appropriate and adequate consultation process relation to self-referral and other drug and alcohol services at Marina House.

We believe that you have failed to carry out involvement and consultation as required by the legislation. We thought we were being consulted, but now believe we have been robbed of the consultation process and that you are trying to rob users of the services they need at Marina House.

As you know the duties of the PCT to involve the public and to undertake public consultation is very clearly laid out in Section 242 of the NHS Act 2006 as amended in Section 233 "Duty to involve users of health services" of the Local Government and Public Involvement in Health Act 2007. This requires you to make arrangements to ensure that users of services are fully involved in the planning of the provision of services, the development and consideration of proposals for changes in the way services are provided, and decisions to be made affecting the operation of services; if any proposed changed would have an impact on—

- the manner in which the services are delivered to users of services, or
- the range of health services available to users.

The PCT has clearly failed to comply with your duties in this respect.

Furthermore, the obligation of the PCT to involve the public is reinforced in World Class Commissioning competency 3, which states that the PCT must: "Engage with public and patient: Proactively seek and build continuous and meaningful engagement with public and patients to shape services and improve health".

In view of the serious breaches of your duties under these Acts of Parliament and WCC 3, I would be grateful if you would immediately withdraw all and any plans that you have for the closure or the termination of drug and alcohol service at Marina House. Furthermore, we request that in consultation with patients, carers, the local voluntary and community sector and clinicians, that you establish the means by which you will involve patient and the public in any plans to vary or close services at Marina House,

provided for patients who live in or benefit from services commissioned by Southwark PCT.

I also wish to remind you that your actions undermine the PCTs duty to ensure that patient safety is your highest priority. As you know NPSA Step 2 requires you to establish a clear and strong focus on patient safety throughout your organisation and Step 5 requires you to involve and communicate with patients and the public - this includes "listening to patients." which you have clearly made little serious attempt to do.

I look forward to receiving your assurance that the PCT Board at its meeting on March 25th 2010, will abandon its plans to close or vary self-referral and other drug and alcohol services at Marina House, and follow the procedures outlined above to secure fully, patient and public involvement and consultation in any future proposals for the service.

Yours sincerely
Tom White
Southwark Pensioners Action Group

Copies to:

- Tony Lawlor, Substance Misuse Commissioner, Southwark Drug and Alcohol Action Partnership (NHS Southwark)
- Donna Kinnair, Director of Commissioning
- Tessa Jowell, MP

THE RT. HON. TESSA JOWELL M.P.
Member of Parliament for Dulwich & West Norwood

14 January 2010

HOUSE OF COMMONS
LONDON SW1A 0AA

Our Ref: 01100101

Tel: (020) 7219 3409 Fax: (020) 7219 2702
Email: jowellt@parliament.uk Website: www.tessajowell.net

Rt. Hon. Andy Burnham MP
Secretary of State
Dept. of Health
Richmond House
79 Whitehall
London SW1A 2NS

Dear Andy,

The Restructuring of Drug and Alcohol Services in Southwark

NHS Southwark is nearing the end of a consultation on the restructuring of drug and alcohol services. I enclose a copy of its consultation document and background information for your ease of reference. There is an issue that has arisen from this consultation process that I hope you will consider and which is detailed in the penultimate paragraph of this letter

The restructuring of drug and alcohol services is set against the context of a changed national funding formula which has reduced funding by 4%. By way of a response to this, NHS Southwark is proposing:

- Reorganising South London and Maudsley's (SLaM's) specialist services
- Establishing the Integrated Offender Management Service (IOMS)
- Completing the rollout of the Primary Care Strateg.

This will mean that SLaM's Community Drug and Alcohol Teams will be based in one site at Blackfriars Road in the north of Southwark whilst the IOMS service will operate from Marina House in Camberwell (close to King's College Hospital and the Maudsley Hospital).

My primary concern is one of access for my constituents in the south of Southwark to the community teams which will be based at the opposite end of the borough. The proposed compensation - the expansion of the use of community pharmacies and satellite clinics in GP practices - is something that has been met with some resistance in the past among my constituents. This is a factor that, I feel should be taken into account as part of this process.

I am also concerned that the ease of self-referral will be curtailed. This is a user group which includes vulnerable and often chaotic individuals. Any further obstacle in their path to seeking treatment would simply reduce the likelihood of such treatment being sought. This would be highly regrettable.

NHS Southwark has suggested, as part of its consultation, that a non-preferred option would be to make no changes to SLaM services whilst finding the savings elsewhere. The consultation document notes that "In effect, this is likely to be alcohol-related programmes".

continued....

The benefits to the community of drug treatment is well established with every £1 spent resulting in the community receiving £9.50 in benefits such as uncommitted crimes.

I do not believe however, that we should look at the provision of drug and alcohol treatment as an 'either or' argument as seems to be the case here. In the past decade, the death rate from chronic liver disease, including cirrhosis, has risen by one third across the country **but by 500%** in Southwark. I cannot accept, given these statistics, that there is any scope to reduce the funding to alcohol related care.

I am aware that your Department intends to appoint a national clinical director for liver disease which demonstrates the high priority that you place on taking action in this field. I would request that you consider whether a direct and imaginative approach might be taken in the interim which the new national clinical director could build upon. This would bring extra funding to Southwark by building on local work and developing a centre for expertise and study that could inform the work that is required in this extremely important area. There can be no doubt that Southwark is an area of extreme need and this strategy makes logical sense given the presence nearby of King's College Hospital which has one of the finest liver units in the country, if not the world. I will, of course, support any local initiatives that might be taken to identify increased funding for these services, but I would be grateful if you might give consideration to the suggestion I have outlined above.

I look forward to hearing from you on this matter which I would, of course, be happy to discuss with you in more detail.

Yours,

Rt. Hon. Tessa Jowell MP

MARINA HOUSE IS MOVING

Because of budget cuts, SLAM's (South London and Maudsley) services have to be streamlined and it had been decided recently to move Marina House (except RIOTT, which will stay here) to CDAT at Blackfriars Rd. The two clinics are to be merged, but you will still get the services you have been getting here at the same times as here at the new location. The Primary Care Trust and Marina House, together with Southwark User Council, are holding 2 meetings to consult with service users here about how these changes will affect them and what can be done to help.

On:

TUESDAY 28th JULY

at: **12 midday and 6 pm**

HERE at Marina House

COME AND TALK TO US!
ASK QUESTIONS!
HAVE YOUR SAY!!

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Marina House/Blackfriars CDAT
Service Users Questionnaire

The Southwark User Council would like to take this opportunity to inform you of changes in drug treatment in Marina House and CDAT.

Because of budget cuts, SLAM's (South London & Maudsley) services have to be streamlined and it has been decided recently to move Marina House (except RIOTT which will stay at Marina House) to CDAT on Blackfriars Road.

The two clinics are to be merged, but you will still get the services you have been getting here at the same times in the new location. It is possible that provisions such as satellite clinics will be also be developed for people with particular difficulties, but no decisions will be made on these until we are clear what those difficulties are likely to be.

To that end, we would encourage you to complete the questionnaire below and return it as soon as possible (there is a list of ways you can return it at the end of the questionnaire). **Please note this survey is anonymous: we do not require your name or any other personal details.**

1. Where do you currently receive your treatment?

   Blackfriars CDAT **Marina House**

2. What issues are there for you when the two services merge into one?

3. What issues does this raise for you regarding the change in location?

4. How would you like to be kept up to date and informed about these changes?

5. How do you think these changes will affect your treatment?

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6. How do you think these changes will impact on other areas of your life?

7. What could be done to lessen the impact of these changes?

8. Is this the first time you have heard about the changes? If so what have you heard?

9. During this time, do you think you will need extra support?

10. If so, which support would be useful to you?

11. Do you have any further comments?

Please make sure you return this questionnaire by Friday, August 14th 2009. You can do this in one of the following ways:

- BY HAND. Drop it into the box in the reception areas of either Marina House or Blackfriars CDAT.
- BY FAX. Fax it to Colin Clews at Southwark PCT on 020 7981 9756.
- BY EMAIL. If you have completed this on the internet, email it to Colin Clews at colin.clews@nhs.net. (Please put 'SLAM Survey' in the subject box).
- BY POST. Post it to Colin Clews, Unit 208, Great Guildford Business Square, 30 Great Guildford Street, LONDON SE1 0HS.

Thank you for your time

Consultation Activity

A formal consultation document was drawn up detailing the proposed new model. This was distributed to local drug and alcohol services, general practices, Southwark LINk, the Mental Health Partnership Board and the OSC. The proposal was also advertised on the 'Get Involved' website and in the Southwark PPI newsletter,

A member of the Substance Misuse Commissioning Team also attended service user meetings at various drug and alcohol services with representatives from the Service User Council to discuss the proposal.

In June 2009 an Implementation Steering Group was established to take the project forward. However, whilst some work has been undertaken on this, progress on a key element – the closure of the self-referral service at SLAM – has been delayed pending the outcome of the current SLAM consultation.

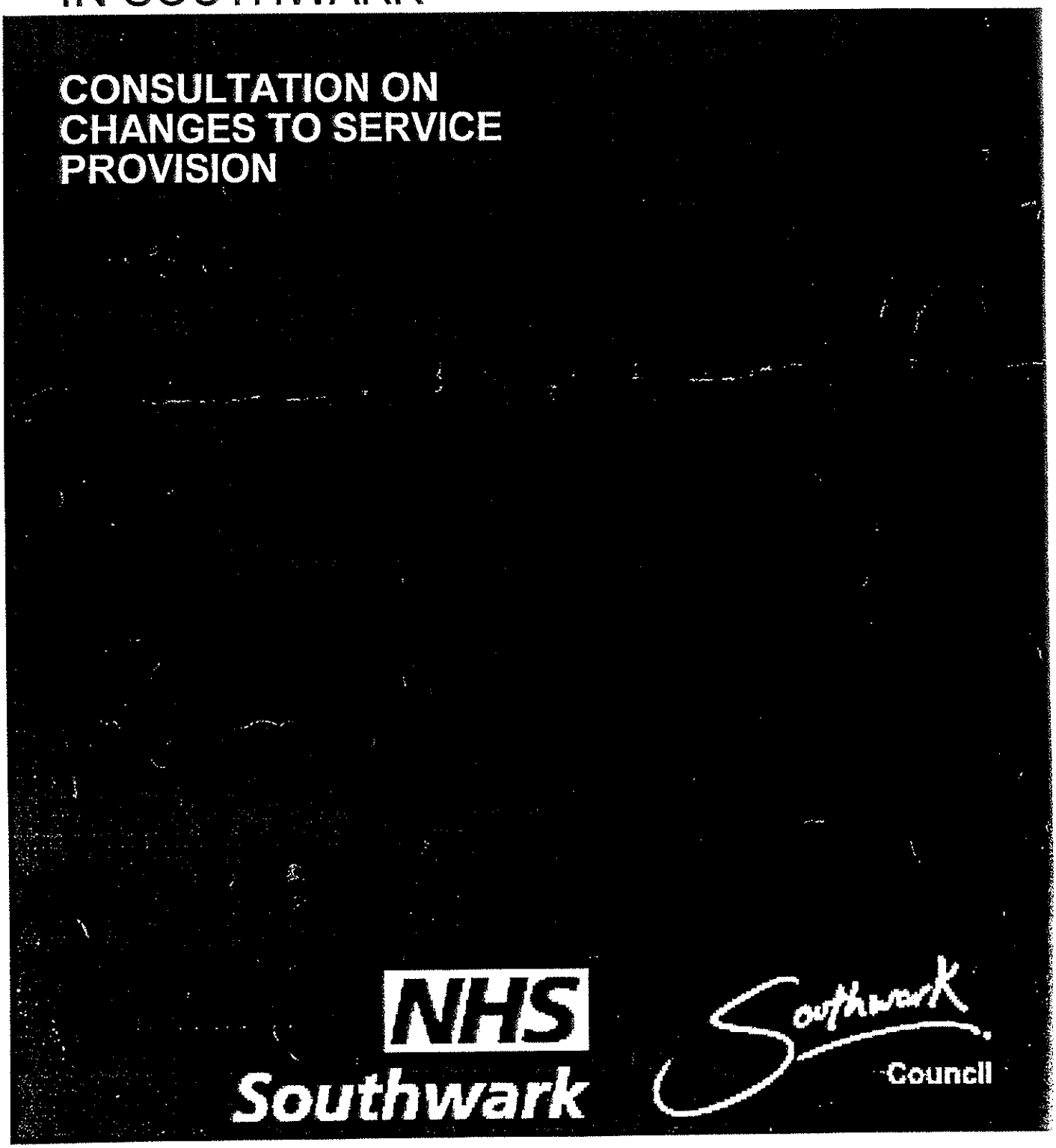
Costs

There have been no significant costs involved with this consultation other than officer time and small room hire fees.

SOUTHWARK HEALTH & SOCIAL CARE

THE RE-STRUCTURING OF DRUG AND ALCOHOL TREATMENT SERVICES IN SOUTHWARK

CONSULTATION ON CHANGES TO SERVICE PROVISION



2 The Need to Re-structure SLAM Drug and Alcohol Services

Funding for drug and alcohol treatment services has been affected by a number of issues in recent times.

Since 2008/09 the national substance misuse budget has been allocated on a new performance-based system. Key features of this system are:

Funding is linked directly to numbers in treatment.

Funding is also linked directly to the type of drug misuse being treated: twice as much money is allocated for each user of crack cocaine and/or heroin in treatment as it is for users of other drugs such as cannabis and powder cocaine.

Prior to 2008/09, the national treatment budget took into account other factors such as local levels of deprivation and the differing costs of providing treatment in different parts of the country. This is no longer the case.

Additionally, NHS Southwark, which allocates and oversees funding to all local health services, is also subject to budget pressures and is seeking to make cost savings in response.

These funding pressures mean that SLAM is seeking to provide the same level and standards of service with a reduced budget.

3 What Are We Going to Do?

The central feature of the re-structure is to move the majority of Marina House services to the CDAT premises in Blackfriars Road. In practice this means all of the services listed in the table above with the sole exception of the RIOTT injecting clinic, which will remain at Marina House. (RIOTT will remain where it is because it is funded from different sources to all the other services).

No services will be cut, nor will there be any reduction in opening hours.

4 The Consultation Process

What We Are Consulting On

We know that moving all of SLAM's community-based drug and alcohol services to CDAT will affect service users. However, we also know that different people will be affected in different ways. Some people may feel that there is little difference; for others the changes may raise all kinds of issues.

We need to know as much as possible about these issues so that we can look at the best way of dealing with them.

What We Are NOT Consulting On

We are not consulting on whether or not we should provide all SLAM drug and alcohol services from one site instead of two.

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We are not consulting on whether or not CDAT should be the site from which we provide SLAM drug and alcohol services.

How We Are Consulting

We have asked Southwark Substance Misuse Service User Council to help us develop an effective consultation process. So far we have decided to run service user meetings at both CDAT and Marina House and also to distribute a questionnaire (which is also attached to the end of this document).

SLAM and Southwark NHS managers will attend the service user meetings, which will be held as follows:

CDAT

12 noon (after the coffee morning) on Thursday 30th July.

Marina House

12 noon (after the coffee morning) on Tuesday 28th July and again at 6pm on Tuesday 28th July.

Representatives of the Service User Council will also be involved in meetings between SLAM and NHS Southwark to discuss the finer details of the new service at CDAT. In order to best represent service users' views it is essential that they have the clearest possible picture on how the changes will affect people. They will be available to talk to people at the above meetings and also the regular service user meetings and coffee mornings at CDAT and Marina House.

5. Time Frame

We would appreciate a response from you as soon as possible. This will give us as much time as possible to feed service users' issues into the decision-making process. **The very last day that responses will be accepted is Friday, 14th August 2009.**

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6.8 The Executive member added that the adult safeguarding board is very aware of the problems caused by financial abuse, which is the biggest area of abuse affecting vulnerable adults. He stated that any referrals are investigated, with the view to prosecute where appropriate, and that this is a priority issue on the adult safeguarding agenda.

Question 4.
Can the Executive Member for Health and Adult Care give an update on NHS Southwark and SLaM's proposals to re-structure substance misuse services?

6.9 The chair informed members that the related information requested at the previous meeting had not yet been received, and that the consultation period and dates had been agreed and that the consultation had already started, without the sub-committee being notified.

6.10 The chief executive apologised that the consultation was not submitted to the sub-committee before being published. She felt sure that the final document addressed all of concerns that members had raised at the last meeting and commented that her understanding was that the proposed 8 week period for the consultation had not been an issue of contention.

6.11 A member commented that the concerns raised had centred on the clarity of the wording used and the options, and that members still wanted a list of everyone to be consulted.

6.12 The vice-chair observed that relevant officers and health professionals had attended a recent Camberwell Community Council meeting, as this is a significant local issue for the area, and that there had similarly been assurances that the points raised at the meeting would be addressed and that officers would follow up with the Community Council on these and the plans for the consultation. She commented that to date no one had reported back. She added that her first impressions of the consultation document was that it was not very user-friendly. [Copies were tabled that had been received that day.]

6.13 Councillor Mitchell cited a document from July 2009 that had been given to people who were accessing services at Marina House for substance mis-use. He highlighted that it made evident that the decision regarding the re-location had already been made, prior to any attempt to consult with local elected representatives or with the sub-committee. The chief executive responded that the document should not have not been produced or published in that way and that it has been made clear to staff that proper consultation is requisite for such issues.

6.14 The chair asked what outcomes from the consultation would be necessary to make officers rethink the preferred option. The chief executive responded that a different way of re-structuring the services would need to be proposed that still delivered the savings.

6.15 A member asked that if 100% of the consultation feedback favoured option 2, would officers implement their preferred option anyway? S White replied that officers would be obliged to re-assess their preference in light of such a result,

but that no amount of discussion will be able to replenish the required funds. Members therefore queried whether the alternatives listed were genuine options. S White responded that options were requested, but it does not make all options affordable.

6.16 A member remarked that he had heard that the number of staff at Marina House had already been reduced. Paul Calaminus, SLaM, explained that Marina House had provided services for residents of both Lambeth and Southwark, but that all Lambeth users have since been invited to access services from a different location, which may have affected staff numbers.

6.17 Councillor Noakes commented that he sees this as a significant issue that concerns him as the relevant Executive member and as a ward member for the area. He emphasised that the last outcome he would like to see would be any changes that would reduce the number of people who could be treated.

Question 5.

6.18 Members asked what were the key outcomes of the debate. The Executive member explained that the government is now at the phase between the green and forthcoming white paper. He recounted that he had been keen for a local care debate and that an event was therefore held at Kingswood House which attracted a good range of residents and representatives from the voluntary sector. He said it was interesting to note that most people were not happy that the option of direct taxation had been ruled out, and that there was little favour for the other options which revolved around voluntary contributions.

Question 6.

6.19 The chair queried how judgements were reached about people with the most need and at the highest risk. Councillor Noakes explained that the council has a statutory responsibility to provide for people with a particular level of need and that the focus now is on those whose needs are critical and substantive. He reiterated that much of the way that the budget is allocated is already prescribed, and that the relatively few discretionary services are those more susceptible to cuts when finances get tight.

Supplementary question

6.20 Please give us an update as to what is happening at the Dulwich Community Hospital Site (Eastern End) setting out what is presently happening to the buildings;

- Aside from the GP services, what other functioning health services are being provided in the Eastern Section of the Central Block, and what proportion of the space there is being used for health purposes;
- Do you intend to put any new building on the empty site at the Eastern end, and are you presently negotiating with any builders for any new health service

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2.11 Recent letters from Guy's and St Thomas' and Kings College Hospital regarding the scale of impending changes due to changing financial circumstances are also strongly welcomed. Similarly, the short briefing from Susanna White, NHS Southwark chief executive, at our 7 October 2009 meeting about imminent cuts and consequent changes was a useful signal of the likely volume of forthcoming consultation issues.

Lessons to be learned / further good practice to establish

Timing

2 * 2.12 The sub-committee's experience as a consultee that has prompted the most concern relates to the consultation on the proposed re-structuring and relocation of drug treatment and addiction services based at Marina House.

3 2.13 This issue first came to the attention of this sub-committee at its July 29 2009 meeting. One member had become aware by chance of a consultation document posted at the Marina House premises, prior to any notification of the proposed changes to the sub-committee or local elected representatives. The paper was later identified by officers as a pre-consultation document, designed to seek the views of current users. It took as its premise, however, that Marina House would no longer be a location for addiction counselling and the related treatments currently provided, and included the following statement: "We are not consulting on whether or not we should provide all SLaM drug and alcohol services from one site instead of two." It therefore seemed evident that a decision had already been taken without appropriate consultation.

4 2.14 The above citation also reflects an apparent officer misperception, that as the re-structuring intends a change to the location of some services and not to the actual services provided, it was not considered necessary to bring the issue to the sub-committee. This is contrary, however, to the Department of Health guidance on section 7 of the Health and Social Care Act 2001 (now section 244 of the NHS Act 2006), which outlines four key issues that should prompt officers to confer with scrutiny members when deciding whether proposed changes are substantial and what could comprise the appropriate scope of consultation. The first of these issues is change to "service accessibility", which in this case would be affected by the relocation.

5 2.15 We therefore wrote formally to NHS Southwark, requesting, - at the earliest opportunity - details of the scope and timeframe for the discussions with service users; and the estimated timing for formal consultation with the sub-committee, with the view to decide whether the changes would be deemed a substantial variation, and to agree an appropriate consultation process.

6 2.16 Officers highlighted at the sub-committee's subsequent 7 October 2009 meeting that the purpose of the related agenda item that evening was to seek the sub-committee's agreement on the proposed consultation, as had been agreed by the PCT Board at their 24 September 2009 meeting.

7 2.17 Following the discussion, we agreed with officers that they undertake as follows:

require assessment", and that this option was not included in the consultation, despite previous suggestions that it be added.

2.3 The sub-committee consequently recommended that "the needs of patients with mental health issues be carefully considered in final design factors and that no decision is taken until mental health service users groups are in agreement with the proposed changes." Members also made clear that they would like "to be satisfied that the issues raised by such groups have been fully addressed."

2.4 At our 29 July 2009 meeting, current members of the sub-committee requested an update on the proposed redesign of the ED, having heard that the proposals affecting mental health patients were being altered. It was reported that there had been considerable positive feedback on the overall model of care, but that responses about the provision for mental health patients (and for paediatric users) had generally been negative and that these comments had impelled a revision of the action plan. KCH had decided, for example, to expand the footprint of the new development into its Jubilee Wing, giving greater flexibility on how to provide for mental health and paediatric patients.

2.5 It was also explained that a mental health working group would be helping to plan patient flows, and working with the architects and user groups to effectively plan the ED redesign for mental health users.

2.6 At the our subsequent 7 October 2009 meeting, we were informed that the redesign plans had been revised to include separate space for ambulatory and mental health patients; that the meet and greet area for all patients would be the same, but that mental health patients would then be directed immediately to a separate waiting area directly off the main atrium.

2.7 Members were also encouraged to hear that Southwark Mind had been speaking very favourably to the press about the proposed changes for mental health patients, and that the new plans had been unanimously well received. We believe that this outcome merits attention as an example of a genuine consultation.

2.8 While we recognise that health scrutiny committees have a statutory right to require information and attendance from senior council officers and staff, we would similarly like to highlight the consistent cooperation from all trust partners to send relevant senior officers and board members to attend scrutiny meetings in order to present proposed services changes and respond to member questions.

2.9 In response to a letter on behalf of the sub-committee (17 August 2009), requesting further information, NHS Southwark arranged an informal meeting with several senior staff members from SLaM and the PCT regarding the restructuring of community drug and alcohol services. This was a useful means for conveying a professional understanding of the proposed changes and provided an opportunity to discuss what additional information could assist members in our consideration of the key clinical, financial and social issues.

2.10 We have also found considerable benefit from the opportunities to make site visits to affected trust premises, and have appreciated the willingness of LINk members to attend.

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i. to clarify the wording used in the proposals, and clarify the consultation options;
ii. to outline the proposed length of the consultation period;
iii. to provide a list of the groups and individuals with whom the PCT will consult, and a list of the groups that are likely to be impacted by the changes;
iv. to address the concerns raised in the September 24 2009 letter from Councillor Noakes to the PCT Board.

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2.18 Despite further contact, we first received a copy of the revised consultation document at the sub-committee's next meeting (18 November 2009) which was also when we first learned from officers that this had been published and that the consultation period had been finalised and had in fact started.

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2.19 We therefore emphasised that we should be made aware of proposed changes as early as possible: This would be in keeping with Department of Health guidance, - but more significantly, the sooner members are informed about problems that are likely to trigger changes and about proposals themselves, the more likely we will be inclined to respond as constructively as possible rather than critically.

2.20 To be promptly and properly informed would also help us to effectively respond to related issues of difficulty with service users, and to feed back to the trusts evidence of any issues of sensitivity.

2.21 Given the prospect of immense changes necessary by each of our local NHS partners, we would likewise request that the sub-committee is made aware of any changes being considered as early as possible to give us time to consider the extent to which we wish and are able to become involved. This will allow members to assess where we can best add value to such decisions and agree on suitable criteria that the sub-committee can use for selecting those issues which they can most effectively influence.

Basic data

2.22 In order to effectively respond to service user and related constituent issues, there is a span of core information that would help us to more swiftly understand and assess the likely impact of the proposed changes. At times this has either been absent or unclear in consultation documents and related briefing papers. We would therefore request that basic information, such as the following, be consistently included and clear:

- An outline of who and how people are expected to be affected, including a list of the likely most affected wards or areas in the borough; the predicted number of residents / service users affected; and whether particular communities or age groups etc will be impacted more than others;

- An outline of any specific research/ surveys undertaken or commissioned by the trust that underpin or have significantly influenced the consultation options; including any that have been critical of the proposals or equivalent proposals elsewhere;

- An explanation of whether the changes result from policy or financial imperatives etc;

- An equalities impact assessment.

Consultation content and genuine options

2.23 At its 24 June 2009 meeting, the sub-committee was briefed on the report that synthesised and analysed the consultation feedback on the Transforming Southwark's NHS strategy, regarding a five to ten year strategy about the shape and constellation of local health services. We also used this as an opportunity to discuss aspects of the consultation methodology.

2.24 While members realised that the objective of the consultation had been to obtain feedback on the proposals at a broad strategic level, we believe that the consultation survey was overly simplistic, to the effect that this undermined the consultation's validity:

- Many of the survey questions were very general and devoid of context, to the extent that they seemed designed to elicit responses that could only favour the proposals;

- The survey failed to substantiate why respondents supported or doubted the merit of the proposals: For instance, where as many as 30% of respondents stated that they did not know whether the proposals would improve local healthcare, and approximately 8% believed that improvements would not be achieved, no further questions were asked to establish the reasons behind such reservations;

- As the consultation presented new plans about where and how to allocate resources, the survey should have made clear what alternatives exist, and particularly what services may be reduced or relocated.

2.25 As stated in the consultation report, respondents were not asked about their preferences for intermediate care, and this issue was deliberately omitted from the proposals and survey: "Intermediate care is due to be further reviewed and thus has not formed a major part of this consultation." (p. 63) In effect, the issue of intermediate care was left in a vacuum and respondents were left insufficiently informed about the broader outcomes of the proposals, and the implications for a key element of healthcare. We expect that the respondents could have answered in a significantly different way, had the relevant proposals for intermediate care been incorporated.

2.26 Regarding the content of the consultation document on the re-structuring and relocation of drug treatment and addiction services, we sought assurance from officers at our 7 October 2009 meeting that the document would reflect the needs of the local communities and not lead respondents to a preferred answer.

2.27 We queried again in November what outcomes from the consultation would be necessary to make officers rethink the preferred option, and were told that a different way of re-structuring the services would need to be proposed that still delivered the savings. While we acknowledge that the changes are impelled by the need to achieve savings to the value of £340,000 from SLaM,

and to redirect appropriate elements of the services back into primary care, we were concerned to learn that only one of the options outlined in the consultation document was actually viable and could potentially achieve these outcomes.

2.28 We think it should be basic that consultation documents are clear about a trust's proposed changes and equally clear about what viable alternatives or variations on the changes have been identified that could achieve similar outcomes. The range of feasible options should also be outlined as objectively as possible, without leading respondents to a preferred answer.

2.29 Moreover, alternative proposals should not be presented as options, where a trust does not in fact believe such an option to be practicable – unless this is transparent in the consultation document and respondents are invited, for example, to identify how such alternatives could be made viable.

2.30 As referred to above, we are grateful to have been informed early of the scale of savings that our NHS partners are compelled to achieve over the next financial year and onwards. Particularly in such cases, where the spectrum of services to be affected is so broad, we would like to receive details of where savings achieved beyond the requisite budget percentage will be re-directed. For example, where savings in one service area are achieved above the obligatory 10% at Guy's and St Thomas', - for instance to the value of 25% - how would the 15% 'surplus savings' in this case be re-directed?

2.31 We would similarly be grateful for an outline of the feasible trade-offs that would affect the consultation proposals, such as options to extend patient waiting times for certain treatments rather than relocate services.

Consultation feedback

2.32 While we have particularly welcomed the revisions to the King's hospital ED re-design that resulted from the consultation, members of the sub-committee first heard of these improvements for mental health patients via the local media, and subsequently sought further details from officers.

2.33 At our 20 January 2010 meeting, we agreed with officers that, at the Southwark PCT board meeting the following day, the sub-committee's request be relayed that the decision regarding the re-structuring of drug and alcohol services be delayed for a few days, to give the Health Secretary, Rt. Hon. Andy Burnham MP, the opportunity to respond to the related letter of January 14 2010 from the Rt. Hon. Tessa Jowell MP. To date we have not been informed whether the board agreed to this request and/or of the board's final decision regarding the re-structuring.

2.34 We recognise that the King's ED plans were subject to the assessment and input of streamed steering groups, as well as project and trust board approval before their finalisation, and that such processes can duly prolong the usual decision period. We believe it would be an appropriate courtesy, however, that we receive written notification of trust decisions on consultation issues for which we have submitted a written response, within a few days of the decision having been made. These should also include replies to the sub-committee's key recommendations, in particular where these are refused.

Recommendations:

1. That the sub-committee be informed of proposed changes to health services by the local NHS trusts as early as possible, in order to have a reasonable opportunity to contribute to plans for consultation and to be able to respond effectively to constituent queries.

2. That consultation documents or related briefing papers to the sub-committee include the following information:

   - An outline of who and how are people expected to be affected by the proposed changes, including a list of the likely most affected wards or areas in the borough; the predicted number of residents / service users affected; and whether particular communities or age groups etc will be impacted more than others;
   - An outline of any specific research/ surveys undertaken or commissioned by the trust that underpin or have significantly influenced the consultation options; including any that have been critical of the proposals or equivalent proposals elsewhere;
   - An explanation of whether the changes result from policy or financial imperatives etc;
   - An equalities impact assessment.

3. That consultation documents are clear about a trust's proposed changes and equally clear about what viable alternatives or variations on the changes have been identified that could achieve similar outcomes.

4. That the range of feasible options be outlined as objectively as possible, without leading respondents to a preferred answer.

5. That consultation documents do not include options for the proposed changes, where a trust does not believe the option(s) to be practicable.

6. That the sub-committee be invited to help shape service change options, where these are not impelled purely by clinical considerations, and in particular where they involve trade-offs with other services, or service levels, etc.

7. That the NHS trusts are more pro-active about informing community councils of proposed changes that would affect their local communities, and ensuring that the issues are aired in public.

8. That the NHS trusts inform the sub-committee of consultation outcomes and provide feedback on the sub-committee's response recommendations, where this is reasonable, and particularly where these are refused.

Health and Adult Care Scrutiny Sub-Committee

Councillor Lorraine Zuleta (Chair)
Councillor Dora Dixon-Fyle (Vice-chair)
Councillor Aubyn Graham
Councillor Michelle Holford
Councillor Lorraine Lauder
Councillor Jonathan Mitchell
Councillor Caroline Pidgeon

SOUTHWARK HEALTH & SOCIAL CARE

SHAPING THE FUTURE OF MENTAL HEALTH SERVICES IN HEALTH & SOCIAL CARE

Briefing paper on our commissioning intentions for 2010 onwards and the likely impact on community mental health services for people of working age

NHS Southwark

Southwark Council

Health and health care in Southwark have improved greatly in the last ten years – a period of record growth. Southwark people are living longer and enjoying a range of health care services. If we are to maintain and extend this, in a very different financial era, we will need a changed approach to how we will behave, and how services are delivered.

* * * *

With regard to mental health, our commissioning objective is to increase access to high quality mental health services, with a focus on early identification, admission prevention and an ethos of supporting recovery from serious mental illness. Psychological therapies and community mental health services will be delivered in future as part of the care offered in GP Led Health Centres.

NHS Southwark Strategic Plan 2010/11 - 2014/15

The new coalition government is putting general practice at the heart of health commissioning. The flagship policy of GP-led commissioning will transfer real budgets to groups of practices and create larger GP-led clinical collectives with more direct accountability for ensuring that high-quality and cost-effective care is delivered to local communities. This means that in future practice based commissioners will lead the work on clinically-led commissioning and deciding clinical outcomes.

NHS White Paper, Equity and Excellence: Liberating the NHS 2010

Southwark PCT has reviewed its Mental Health services in the light of changes in need and in order to establish services that increasingly delivered in the community; focussed on recovery and delivered in accordance with the personalisation agenda. The impact of the recession has affected Southwark services and the new financial context forms a core part of our future planning.

Southwark PCT's five-year Strategic Plan sets out the financial framework for purchasing and delivering healthcare services. In order to meet the growing and changing need for services certain changes are necessary to ensure this can be delivered within a budget that is unlikely to increase over the next four years. Southwark PCT spent £493m on healthcare in 2009/10. On the current configuration of our services, expenditure is forecast to increase to £653m by 2013/14. Our anticipated income in this period – in line with government forecasts – is £558m, a shortfall of £95m. Health will need to prioritise spend and redesign services in order to meet the challenge of gaps in funding.

The Council is facing significant budget pressures and are planning reductions of at least 25% over the next few years in the light of actions by the new government in its steps to cut the national budget deficit.

We are determined to provide effective mental health treatment to all those who need it, delivered in a way that meets or exceeds national standards and guidelines. We are working closely with our main provider the South London & Maudsley NHS Foundation Trust (SLaM) to agree how this can best be achieved.

We recognise that any form of service change generates concern amongst service users and within the wider community. For this reason we are committed to addressing concerns through open and meaningful engagement with all those affected. We intend to engage service users and other stakeholders in helping us make these changes and will ensure that this engagement remains ongoing as services develop and evolve.

Donna Kinnair DBE
Director of Commissioning and Nursing
Southwark Health and Social Care

August 2010

1. Summary

1.1 Overview

This document sets out the rationale for changes to Southwark's mental health services by:

a. Describing the changing demands upon mental health services
b. Outlines our response to new policy and financial drivers
c. Provides an overview of our plans to disinvest money from mental health services and consequently change the way we deliver treatment and care

In instigating these changes **we want to**:

a. Encourage people with mental ill health and those who care and support them:
   i. To be more actively involved in planning their treatment, care and support
   ii. To take advantage of increased personalised services
   iii. To have care that is focussed around the recovery model
   iv. To take up personal health/social care budgets where appropriate

b. Increase the treatment, care and support options within the community, particularly within primary care where more care will be delivered in the future

c. Cease our reliance on out-of-borough placements by placing people within Southwark

1.2 Policy Context

The publication of the previous Government's mental health strategy, *New Horizons*[1]*;* the emerging personalisation agenda (as set out in *Putting People First*[2]) - and the recovery model[3] in mental health together set out a plan that patients should have access to a range of evidenced-based talking therapies and pharmacotherapy treatments and should be supported, wherever possible, to self-help and understand the issues around their health. The *New Horizons* strategic approach is however under review and the Coalition Government are due to publish a revised strategy in autumn 2010.

The new government published its reforming White Paper on 12th June 2010. Its three Key Principles are: **1)** patients at the centre of the NHS; **2)** changing the emphasis of measurement to clinical outcomes; and **3)** empowering health professionals, in particular GPs as commissioners of services.

The NHS Southwark Strategic Plan 2010/11 – 2014/15 Professor Darzi's review *Healthcare for London: A Framework for Action* [4] set out our plans for commissioning local mental health services. Our aims are to increase access to high quality mental health services with a focus on early identification, admission prevention and to create an ethos of supporting recovery from serious mental illness. This Strategic Plan will be reviewed by GP Commissioners to ensure it has their support as the new commissioners of care in Southwark.

[1] ***New Horizons: A shared vision for mental health,*** Department of Health, February 2010, www.newhorizons.dh.gov.uk/assets/2010-02-04-299060_NewHorizons_acc2.pdf
[2] ***Putting people first: a shared vision and commitment to the transformation of adult social care***, Department of Health, December 2007, http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm
[3] ***The journey to recovery: the Government's vision for mental health care***, Department of Health, November 2001, www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058900.pdf
[4] ***Healthcare for London: A framework for Action,*** NHS London, July 2007, www.healthcareforlondon.nhs.uk/assets/Publications/A-Framework-for-Action/aFrameworkForAction.pdf

The local context for the delivery of sustainable mental health services in Southwark is governed by the Transforming Southwark programme and the Southwark Mental Health Strategy. NHS Southwark has also operationalised a new contract with SLaM which established a robust performance framework with incentives and penalties built in.

At the heart of Southwark's Mental Health Strategy and the driver for improvement in quality and choice of service delivery is the concept of personalisation. Our view is that personalisation helps to challenge some of the ways in which mental health is perceived since it supports a user-centred concept of 'recovery' in which recovery is a personal journey of learning to live well, despite the continuing or long-term presence of mental health support needs. Personalisation includes prevention, early intervention, and self-directed support which places service users in control of arranging and managing their own support services.

The Southwark's Mental Health Partnership Board is the multi-agency stakeholder group tasked with leading the development and implementation of the local mental health strategy. In December 2009 the Partnership Board hosted a stakeholder event to identify the key strategic objectives that would underpin the revised Southwark's Mental Health Strategy. They recommended local mental health service should:

a. Promote mental wellbeing
b. Are established within clear pathways of care
c. Are in the community and co located with other community provision
d. Develop self-directed support
e. Provide accessible services that respond to need
f. Develop alternatives to medication
g. Promote innovation and flexibility in service provision.
h. Make provision for Children and Adolescents with poor mental health that is specific to their needs and yet benefiting from being a part of a wider service
i. Make provision for Older Adults with poor mental health that is specific to their needs and yet benefiting from being a part of a wider service

1.3 Financial Drivers

The Coalition Government's national deficit reduction strategy will see social care expenditure reductions of the next few years greatly supersede those of the recent past with reductions of at least 25% expected.

Health will come under increasing pressure to response to gaps in funding, including the impact of reductions in local government funding which will require a review of resources to meet the needs of the most vulnerable.

2. Commissioning Intentions

2.1 Overview

During the autumn of 2009 SLaM undertook a review of the mental health services it provides to people of working age. This review was undertaken with stakeholder involvement and was widely consulted on. This review identified a number of service areas that could be revised in a way that would aid recovery as well as further embed the concept of personalisation in local mental health practice.

Following on from this review Southwark Health and Social Care intends to commission a revised model of treatment, care and support for people with mental ill health that shifts care towards a primary care focus where possible. This means that the future model of care will see more treatment provided as episodes of care that are supported by patients' GPs and other primary care services. This will support a move away from providing ongoing, infinite support to some individuals. The duration of time people stay in both 'community' and 'inpatient' treatment will also be reduced.

The majority of expenditure on mental health services by NHS Southwark is at the South London and Maudsley NHS Foundation Trust (SLaM). In order to create a more diverse range of provision and an environment where recovery and personalisation can be more easily facilitated, NHS Southwark intends to disinvest monies from SLaM over the next two years. The future financial landscape in the NHS means that we need to move ahead quickly with service redesign to deliver this agenda. The financial climate also means that the Local Authority will be looking for savings of between 25% and 40% over the next three years.

We have advised SLaM of our commissioning intentions and requested that they restructure their services such that:

- Clinical evidence and national best-practice are adopted to develop and implement revised clinical care pathways
- The philosophy of evidenced-based outcomes is embedded into the local treatment system
- The time that people stay within both community and inpatient treatment is reduced
- Treatment is provided as episodes of care in a way that supports GPs and other primary care services and that there is a move away from providing ongoing, open ended support
- Individuals are encouraged take a more active role in managing their own care

2.2 Equality Impact Assessment

In accordance with the Equalities Act (2010) we will ensure all the equality characteristics contained within the legislation are impact-assessed to meet the needs of this population group. The primary aim of the Equality Impact Assessment is to determine whether and how service change will impact on specific groups or individuals. In particular the EIA focuses on of the proportionality of the impact of change on people across categories of race, gender, disability, age, sexual orientation, transgender and transsexual people, religion and belief. Consideration will also be given to migrant workers, ex-offenders and the human rights agenda.

We will continue to seek the views of as many people as possible in order to qualify any decision which is made following completion of the Equality Impact Assessment.

3. Impact of Proposed Commissioning Intentions

The following SLaM services will be affected by the current proposed changes:

a. Support and Recovery Services
b. Assessment and Brief Treatment Services
c. Assertive Outreach Services
d. Psychological Therapies
e. Social Inclusion Services

Some SLaM services are not currently affected by the proposed changes but could be in the future, these are:

a. Inpatient Services
b. Crisis Services
c. High Support Services
d. Early Intervention Services
e. Staying Well Services

3.1 Redesign of Community Mental Health Teams

Background:
SLaM currently provides care for approximately 1,600 patients under a Care Programme Approach (CPA). This means that patients are allocated a care-coordinator to support the patient in management and recovery using a care plan and review meetings. There are a further 1,500 patients for which CMHTs provide case management and planning without a formal care coordinator. There are a number of patients on both CPA and non-CPA care plans that no longer require these services, but who have yet to be discharged.

Service Change will Result In:
1. The continued referral of people with non-complex mental health needs into primary care service. This means that the CMHT teams will discharge some patients back to primary care for management following the relevant episode of care. GPs will have and need access to support and training to enable them to safely discuss and hold those clients with less complex needs who were previously held within the CMHT teams. SLAM is intending to reduce their community caseloads by 500 – 800 over the next two years addressing this area of change.

2. The establishment of an Assessment and Liaison service which will provide support to GPs in their care of their patients with mental MH problems. This service will be delivered either at GP surgeries or from within the developing GP Localities. This new service will be organised into two teams (north and south). It will be set up by shifting resources from the present Community Mental Health Teams.

3. Those with the highest level and complexity of need – i.e. those on a Care Programme Approach (CPA) will continue to be supported by community mental health teams.

How the Redesign Would Work:
SLaM would retain the current 1,600 capacity for CPA services. For other patients, clinical teams will deliver services with an enhanced focus on support and recovery, enabling more people to live independently. The outcome of this will be reduced CMHT caseloads.

The redesign of care pathways for those in need of CPA and the provision of alternative treatment and support of non-CPA patients in the context of primary care or the third sector will result in the reduction in the number of clinical teams.
The reduction in clinical teams will mean that the current CMHT buildings configuration will need to be rationalised across the borough.

Issues that need to be Considered:

a. The Benefit system incentivises patients to remain on CPA

b. Appropriate preparation and support needs to be provided to enable patients to be supported within the context of primary care

c. Disposal of the property needs to be followed by tangible reinvestment

d. Need to a good level of GP support and training during transition period

3.2 Reorganising Support and Recovery and Assertive Outreach

Background:

Under the National Service Framework (NSF) for Mental Health, the assertive outreach service targeted the most difficult to engage people with psychosis. Services are delivered by teams whose members have comparatively small caseloads. Data on Assertive Outreach has to be reported under national monitoring arrangements to achieve nationally set targets.

Whilst assertive outreach services for psychosis are valued by users, there is little evidence to demonstrate improved outcomes for patients. Evidence suggests that the assertive outreach model in Southwark does not deliver beyond what could be provided (with some service development) by the current early intervention teams and support and recovery teams.

Service Change will Result In:

1. A change in the way SLaM provide assertive outreach services by reorganising the community mental health teams and the increasing role of Primary Care in managing more patients who have been discharged from the Community Mental Health Teams. This means there will be a reduction in the number of community mental health teams across Support and Recovery, Assertive Outreach and Assessment and Brief Treatment.

How the Redesign Would Work:

The delivery of assertive outreach services will be integrated with support and recovery rather than provided by a stand alone outreach team. The profile of the caseload for support and recovery will be closely monitored following the change.

We will ensure that Government targets for Assertive Outreach are still met by the service.

Issues that need to be considered:

a. Performance against the assertive outreach targets will need to be carefully monitored.

b. The workload of the integrated team will need to be carefully monitored.

c. The impact of Primary Care will need to be continually assessed.

3.3 Reducing length of Stay in Hospital and Community Services

Background:

We want to create a culture of recovery and self-determination, rather than one of dependency. The intention is to develop, in collaboration with GPs, an episodic model of care.

Service Change will Result In:

1. Changing the way we deliver treatment so that community services provide ‘episodes of care’ to people with mental health problems rather than on-going ‘treatment’. We believe that, for many, their mental health issues could be managed within a primary care setting in the context of general health needs

2. Reviewing the way we deliver treatment in inpatient settings to optimise the length of stay

3. Patients will be increasingly managed out of hospital, specialist communities or out-patient services where they do not require secondary care services.

4. Service redesign will focus on developing closer working between primary and secondary care, with greater outreach from primary care.

How the Redesign Would Work:
The Mental Health Advice and Liaison Service will be developed with consultants, and clinical teams working with GPs to ensure that GPs have good access to advice and support in managing patients in the community.

Issues that need to be considered:
a. The changes will need to take place in the context of Practice Based Commissioning and GP-Led Heath Centre development
b. GPs will need to be fully engaged in developing pathways of care

3.4 Redesigning Psychological Therapy and Therapeutic Counselling Services

Background:
Southwark has a long-standing counselling service based in GP surgeries and a newer psychological therapy service. There are synergies and some overlap in these services.

Psychological Therapies and Therapeutic Counselling are funded in different ways. Psychological Therapies are funded through the Governments flagship 'Improving Access to Psychological Therapies' initiative. Therapeutic counselling, which often provides similar therapeutic intervention, is funded from the budgets of GPs through 'practice based commissioning'. The Therapeutic Counselling service has developed differently in different locations with counsellors on varying terms and conditions and providing a range of specialisms.

Southwark, with the assistance of the Guys and St Thomas' Charitable Trust has commissioned a review and redesign of the way in which these related services are provided locally. The findings of this review are due in October 2010.

Service Change will Result In:
1. Review and redesigning these services to ensure maximum benefit to those with common mental illness.

How the Redesign Would Work:
During the review there will be full consultation with service users, GPs and other related services. Practice Based Commissioners will be fully engaged in shaping future psychological therapy and therapeutic counselling services.

Issues that need to be considered:
a. Careful consideration will need to be given to the way in which an integrated service is funded, staff employed and clinical supervision provided.
b. There will be increased delivery of therapies in primary care and managing the shift in capacity to the GP Localities
c. There will need to be careful monitoring of performance to ensure that an integrated service meets the Government's targets for 'Improving Access to Psychological Therapies' for which we receive funding
d. GP access for Psychological Therapy and Counselling for clients will need to be monitored to ensure equitable spread across Southwark

3.5 Managing the Changes in Mental Health Services

We have discussed our commissioning intentions with SLaM and together we are proposing to jointly manage a two-year programme of change which will ensure we deliver services in line with national, regional and local strategy, working within a recovery and personalisation framework. We intend to maintain the quality of care and performance against national targets while meeting the financial and strategic challenges of a reduced financial settlement and new developments in Mental Health.

These proposed changes to services would allow Southwark Health and Social Care to disinvest a minimum of £3.7m from SLaM over the next two years. Additional savings from both Southwark PCT and Social Care will be required during 2011-14 in the region of 25% - 40%. In addition, there may be future redesign and reductions in services of third sector and other providers of mental health services.

The proposed approach will see fewer people retained on long-term Community Mental Health Team (CMHT) caseload and more people being treated within primary care, in a treatment culture where recovery and abstinence is more actively encouraged.

We intend to provide the best services we can and this will involve making decisions that keep people with mental health problems at the centre of our policies. To do this:

- We need the views of all stakeholders
- We need imaginative solutions
- We need to approach this difficult time with strong commissioning intentions
- We need to ensure that mental health services are not marginalised in a time of economic restraints

4. Stakeholder Engagement

Our strategic plans and proposals for implementation have been set out in a range of documents and we have engaged service users, carers and wider stakeholder in discussions about these in a range of meetings and forums. Our local strategic direction matches that set out within national mental health strategy and we have engaged stakeholders widely in developing the strategy.

Locally there has been considerable engagement with service users and stakeholders regarding our plans for mental health services:

a. During the autumn of 2009, SLaM engaged widely on new ways of delivering adult mental health services.
b. In December 2009, we organised a stakeholder event including service users, carers and voluntary and community groups and agreed ten strategic objectives as the framework for Southwark's Mental Health Strategy
c. During May 2010 discussions took place with key stakeholders at the MHPB about our commissioning intentions and SLaM's response to these proposals. Key stakeholders include voluntary sector representatives, carer and service user representatives who report back to through their representative structure which is co-ordinated via Southwark Mind
d. In early August 2010, we organised a stakeholder event including users, carer and providers to outline the current context, SLaM's proposals for the structure of services and to review the strategic priorities from the December 2009 event.

As a consequence we do not intend to undertake further formal consultation on the proposals contained in this paper. We will work closely with Southwark's Health and Adult Social Care Scrutiny Committee and work within the Secretary of State for Health's recently announced framework for strengthening health service reconfiguration. To satisfy these requirements we will:

a. Ensure we engage and discuss our plans within public and patient engagement systems and with the local authority
b. Ensure our plans are supported by GP commissioners
c. Ensure that we publish the clinical evidence that underpins our plans
d. Ensure that our plans support patient choice.

NHS Southwark and SLaM plan to engage with users of services and other stakeholders to discuss the impact of the proposed changes. The groups we intend to talk with include:

1. Service Users
- Service Users currently receiving services
- Southwark Mind and User Council
- Southwark Local Involvement Network (LINk)

2. Service Providers
- Non-statutory mental health services

3. Other stakeholders
- The Probation Service
- Metropolitan Police

Staff Consultation
SLaM will formally consult with their staff regarding personnel changes that will result from the service redesign detailed in this document. NHS Southwark is planning an event in October 2010 for users and carers to further discuss the current context and planned changes to service, feedback from previous discussions with service user groups and to review strategic objectives.

Outcomes from the engagement work as outlines above will be presented and discussed at the Mental Health Partnership Board.

South London and Maudsley NHS Foundation Trust

South London and Maudsley NHS Foundation Trust pre-consultation paper on the restructuring of services to meet the requirements of NHS Southwark's mental health contract for 2010/12

Introduction

NHS Southwark has reviewed its Mental Health services in light of the changes in need and in order to establish services that are closer to the community, more focussed on recovery and more in line with the personalisation agenda.

NHS Southwark spent £493M on healthcare in 2009/10. The PCT Strategic Plan forecasts that by 2013/14, with the current configuration of services, expenditure is estimated to increase to £653m and the anticipated income in this period is £558m – a shortfall of £95m.

Southwark Council is also facing significant budget pressures. Since 2007/08 the money spent on adult social care has reduced in real terms by 10% reduction and a further reduction of 25% is being modelled over the period 2011/12 and 2013/14 in light of the new Emergency Budget.

NHS Southwark have informed South London and Maudsley NHS Foundation Trust (SLAM) that they intend to reduce the mental health contract by £3.7m over the next two years 2010 to 2012 as part of their recovery plan. It is also expected that further significant reductions to the SLAM contract will happen in 2012 to 2014. This disinvestment is on top of the reduction in substance misuse services which is addressed in a separate document.

NHS Southwark has also asked SLAM to address the New Horizons and Putting People First personalisation agenda in parallel with the disinvestment. This will mean looking at developing new ways of delivering mental health services that promote well being, putting people at the centre of planning, moving responsibility for health and well being back to individuals and preventing ill health where possible, but treating, caring and supporting people when necessary.

NHS Southwark have advised SLaM of their commissioning intentions and requested that they restructure their services such that:

- Clinical evidence and national best-practice is adopted to develop and implement revised clinical care pathways
- The philosophy of evidenced based outcomes is embedded into the local treatment system
- The time that people stay within both 'community' and inpatient treatment is reduced
- Treatment is provided as episodes of care that support GPs and other primary care services and that we move away from providing on-going, open ended support to individuals
- Individuals are encouraged take a more active role in managing their own care

NHS Southwark have asked that in the first instance we look at making the savings through re-designing adult community services as it is recognised that there are less opportunities to redesign crisis and acute services in the short term. The strategic direction outlined in the PCT Strategic Plan is that people are discharged to community services when they are well enough to be managed within primary care.

NHS Southwark also informed SLAM that they did not want to disinvest in the High Support Services but wanted to extend this model of provision into Supporting People accommodation. They were also clear that they wanted to continue with the current level of investment in the early intervention in psychosis services.

It was agreed that £700k would be found within SLAM central budgets and that an income target of £300k would be given to CAMHS and that the remaining £2.7m would be found by restructuring and reducing Adult community services.

Principles underpinning the consultation

Consultation differs from negotiation in that it does not aim to reach an agreement, which is satisfactory to all parties; rather it is a joint examination and discussion of issues of concern to both senior management in SLAM, staff, service users and carers. Ultimately, however, it is for senior management to make the decision it thinks best in the light of all the information and views expressed as they are accountable for the service; this may or may not be satisfactory in the opinion of everyone else.

In 2009, before disinvestment, Southwark SLAM embarked on an extensive consultation to get the views of service users, carers and other stakeholders on whether there was support for the plan to reconfigure community mental health teams into functional services, which in essence is developing assessment and liaison teams as well as separate treatment teams for psychosis and mood disorders.

This new way of organising services was generally well received, especially as these structures support the eventual move towards the national agenda of delivering outcome measured episodes of care within clustered pathways and the introduction of payment by results.

The level of disinvestment means that reducing activity and then top slicing the current community team structure to pull out the funding would create services too small to operate efficiently and effectively. However, reorganising services into fewer teams that are functional and organised to deliver episodes of care would ensure that people who are needing community mental health services are receiving them and people who are well can remain in primary care with the new liaison services ensuring easy access to secondary services when required.

Disinvestment in Services

SLAM has identified five main areas of redesign to address both the need to reorganise and disinvest. These are:

In 2010 / 2011 to carry out

- The reintegration of the assertive outreach services into the support and recovery teams
- The redesign of community services and introduction of Liaison and Assessment teams to support the reduction in secondary care and increase in primary care and third sector provision
- Introducing episodes of care and shortening lengths of stay in secondary care by introducing the Staying Well team

In 2011 / 2012 to carry out

- The reorganisation of psychological therapies in the borough
- The reduction in the community estate

2010/11

Based on recently published research by Helen Killaspy et al in the British Journal of Psychiatry 2009 it can be seen that there is no real advantage gained by using the assertive outreach community team model over support and recovery services and as such the delivery of assertive outreach services will be integrated back into the support and recovery teams. Support and recovery teams in turn will need to reorganise how they manage caseloads within the team and develop a team approach allowing an assertive delivery of care to those that need it.

NHS Southwark have also asked that the START homeless service concentrate on the liaison role it has with the homeless sector and that they move engaged and settled service users into mainstream support and recovery teams. They have also asked SLAM to develop a Supporting People team to ensure we use the SP provision in the borough as efficiently and effectively as possible.

In order to reduce activity in Support and Recovery teams in the borough SLAM will need to change the way they work with their service users and develop a much more fluid way of getting access to secondary mental health services when needed but also being discharged out of services when well. For this to happen SLAM have introduced the Staying Well team that supports people back to primary care with individual plans on how to stay well and how to access secondary services when needed. SLAM will also be reorganising their current Assessment and Brief Treatment teams into liaison and assessment teams to work jointly with primary care and other providers providing support and access into services when needed.

There is also a need to re-organise secondary psychological therapies in line with CAG structures and service areas changing the way services are funded which will release resources.

2011/2012

It is also necessary to review activity levels and funding streams for psychological therapies in the borough. In the first instance primary care have been informed that no more direct referrals can be made to SLAM psychological therapy services and that they will all need to go via Southwark Psychological Therapy Services (SPTS) or current Assessment and Brief Treatment services (ABT). As well as this NHS Southwark will be reviewing primary psychology services in 2010 which will include the SLAM SPTS contract and counselling in GP surgeries with the aim of reducing the spend by £500k.

The current condition of the estate in certain areas of the borough is quite poor and with the re-organisation of in services it is anticipated that one of the CMHTs bases will be surplus to requirements.

Restructure Plans and Reduction in Community Teams

Currently there are 18 teams:

5 x Assessment and Brief Treatment teams
5 x Support and Recovery teams
1 x Staying Well team
2 x Early Intervention teams
2 x High Support Teams
2 x Homeless Assertive Outreach teams
1 x Assertive Outreach team

The following 13 teams will be restructured:

5 x Assessment and Brief Treatment teams
5 x Support and Recovery teams
2 x Homeless Assertive Outreach teams
1 x Assertive Outreach team

To create the following 8 teams:

2 x Liaison and Assessment teams
2 x Support and Recovery for Mood Disorder teams
4 x Support and Recovery for Psychosis teams
1 x Supporting People team
1 x Homeless team

So that in future there will be 15 teams:

2 x Liaison and Assessment teams
2 x Support and Recovery for Mood Disorder teams
4 x Support and Recovery for Psychosis teams
1 x Staying Well team
1 x Supporting People team
1 x Homeless team
2 x Early Intervention in Psychosis teams
2 x High Support Teams

This will reduce the number of community teams and reduce caseloads in the following way:

Contracted activity for 2009/10 was 3,100 cases

Assessment and Brief Treatment		1,100
Support and Recovery and Staying Well	(SW)	1,300
High Support Services		340
Early Intervention		180
SCOT and Start Team (AO)		180

Contracted activity with disinvestment for 2010/11 is 2,600

Liaison and Assessment	320
Support and Recovery in Mood Disorders	520
Support & Recovery in Psychosis and SW	1,100
High Support and Supporting People	360
Early Intervention	180
Homeless Team	120

Financial Restructure

The above plan will reduce spend in the following service areas:

- Reducing community caseloads by 500 will reduce the number of community teams across Support and Recovery, Assertive Outreach and Assessment and Brief Treatment releasing a saving of **£1,750k fye**

- Reduction in Community management posts proportional to the reduction in community activity releases a saving of **£200k fye**

- Restructure of secondary care psychological therapy releases a saving of **£250k fye**

Year One 2010 / 2011

Total AMH full year effect reduction	£2,200,000
(Part year effect reduction from 1st October 2010)	**£1,120,000**
Total non AMH full year effect reduction	£1,000,000
(Part year effect reduction from 1st October 2010)	**£500,000**
Total full year effect reduction in 2010	**£1,160,000**

Year Two 2011 / 2012

Full year effect reduction in AMH from year one plans	£2,200,000
Full year effect reduction in non AMH from year one plans	£1,000,000
Reduction in psychological therapies from 1st April 2011	£500,000
Total Reduction 2010 / 2012	**£3,700,000**

Current Community Structure and Commissioned Activity Levels 2010

No	Team	Type	Location	Actual Activity 2009 /10	Contracted Activity 2009/10
1	Lordship Lane Support and Recovery Team	Long term CPA care and support team for all mental health conditions	22 Lordship Lane SE22	1445 cases 1139 on CPA 52.7 wte care co-or average caseload is 21.6 to 27.4	1375 cases
2	St Giles 1 Support and Recovery Team	Long term CPA care and support team for all mental health conditions	St Giles House St Giles Road SE5		
3	St Giles 2 Support and Recovery Team	Long term CPA care and support team for all mental health conditions	St Giles House St Giles Road SE5		
4	North West Support and Recovery Team	Long term CPA care and support team for all mental health conditions	27 Camberwell Road SE5		
5	North East Support and Recovery Team	Long term CPA care and support team for all mental health conditions	Ann Moss Way SE16		
6	Lordship Lane Assessment and Brief Treatment Team	Access, assessment and short term care for all mental health conditions	22 Lordship Lane SE22	1193 cases av caseload 40.6	1100 cases
7	St Giles 1 Assessment and Brief Treatment Team	Access, assessment and short term care for all mental health conditions	St Giles House St Giles Road SE5		
8	St Giles 2 Assessment and Brief Treatment Team	Access, assessment and short term care for all mental health conditions	St Giles House St Giles Road SE5		
9	North West Assessment and Brief Treatment Team	Access, assessment and short term care for all mental health conditions	27 Camberwell Road SE5		
10	North East Assessment and Brief Treatment Team	Access, assessment and short term care for all mental health conditions	Ann Moss Way SE16		
11	SCOT Assertive Outreach Team	Assertive CPA care for people who find it difficult to engage with services	88 Camberwell Road SE5	314 cases	180 cases
12	SE START Homeless Team	Engagement, assessment and long term care for homeless people	88 Camberwell Road SE5		
13	SW START Homeless Team	Engagement, assessment and long term care for homeless people	88 Camberwell Road SE5		
14	Dual Diagnosis Team	Providing training and joint work with community teams for people with drug and /or alcohol issues	27 Camberwell Road SE5	Joint working cases	Joint working cases
15	North STEP Early Intervention for Psychosis Team	Comprehensive care for people under 35 with their first experience of psychosis	12 Windsor Walk SE5	180 cases	200 cases
16	South STEP Early Intervention Team	Comprehensive care for people under 35 with their first experience of psychosis	12 Windsor Walk SE5		
17	High Support Residential and Nursing Placements Team	Care, support and proactive move on for people in placements	113 Denmark Hill SE5	374 cases	370 cases
18	High Support Forensic Placements Team	Care, support and proactive move on for people in forensic placements	11 Denmark Hill SE5		
	Total No Clinical Teams 18			3427 cases	3125 cases

Following Disinvestment Future Community Structure and Commissioned Activity Levels 2010

	Team	Type	Location	Contracted Activity 2010 /11
1	North Assessment and Liaison Team	Liaison and assessment service for primary care and other stakeholder providers	27 Camberwell Road SE5 and Ann Moss Way SE16	320 cases
2	South Assessment and Liaison Team	Liaison and assessment service for primary care and other stakeholder providers	22 Lordship Lane SE22	
3	North Support and Recovery for Mood Disorders Team	Care and support for people with anxiety, depression, trauma and personality disorders	27 Camberwell Road SE5 and Ann Moss Way SE16	520 cases
4	South Support and Recovery for Mood Disorders Team	Care and support for people with anxiety, depression, trauma and personality disorders	22 Lordship Lane SE22	
5	Staying Well Team	Providing support to people to develop their own care plans to live independently in the community	St Giles House St Giles Road SE5	1100 cases
6	St Giles 1 Support and Recovery for Psychosis Team	Care and support for people with psychosis	St Giles House St Giles Road SE5	
7	St Giles 2 Support and Recovery for Psychosis Team	Care and support for people with psychosis	St Giles House St Giles Road SE5	
8	St Giles 3 Support and Recovery for Psychosis Team	Care and support for people with psychosis	St Giles House St Giles Road SE5	
9	North East Support and Recovery for Psychosis Team	Care and support for people with psychosis	Ann Moss Way SE16	
10	Supporting People Team	Care, support and proactive move on for NRPF people and people in Supporting people accommodation	88 Camberwell Road SE5	
11	3 Borough START Homeless Team	Engagement and assessment for homeless people	88 Camberwell Road SE5	120 cases
12	High Support Residential and Nursing Placements Team	Care, support and proactive move on for people in placements	113 Denmark Hill SE5	360 cases
13	High Support Forensic Placements Team	Care, support and proactive move on for people in forensic placements	11 Denmark Hill SE5	
14	North STEP Early Intervention for Psychosis Team	Comprehensive 2-3 year care programme for people under 35 with their first experience of psychosis	12 Windsor Walk SE5	180 cases
15	South STEP Early Intervention Team	Comprehensive 2-3 year care programme for people under 35 with their first experience of psychosis	12 Windsor Walk SE5	
	Total no Clinical Teams 15			2600 cases

Jk 26/7/10

Agenda Item 7

Southwark NHS
Primary Care Trust

Summary of the White Paper *Equity and Excellence: Liberating the NHS*

The White Paper sets out the Government's vision for the future direction of the NHS.

The key elements of the vision are that:

- The NHS will remain free at the point of use and based on clinical need not the ability to pay

- The Government will increase spending in real terms in each year of the current Parliament.

- Patient choice is at the heart of the NHS, with patients having increased information about quality and outcomes and increased control over their care records.

- The NHS will be held to account against evidenced-based outcome measures not process targets.

- Any provider meeting national quality standards and accepting national tariffs will be able to offer NHS funded services, and GP consortia will be able to buy in support.

- Providers will be paid according to their performance, with payment reflecting outcomes and quality goals not just activity.

- Power and responsibility for commissioning hospital and community health services will be devolved to GPs working in consortia. GP consortia will have a duty to work in partnership with local authorities. Primary medical care will be commissioned centrally. PCTs will divest their provider service functions by April 2011, in line with the existing policy direction. PCTs will be abolished from April 2013.

- The Government will not be determining the geographical extent of the GP consortia, that will be down to GPs themselves. However, certain principles have been set out in the White Paper such as that GP consortia must cover a contiguous geographical area and should be able to commission services jointly with local authorities, as well as that they should be of sufficient size to manage financial risk.

- A new NHS Commissioning Board will allocate resources to GP consortia and be accountable for delivery of outcomes and the use of NHS resources. The NHS Commissioning Board will have an explicit duty to promote equality and tackle inequalities in access to healthcare. It will

hold GP consortia to account. Strategic Health Authorities (such as NHS London) will be abolished during 2012/13.

- A further White Paper on public health will be published later in the year. Health protection functions from various bodies will move into a new national Public Health Service and PCT public health responsibilities will transfer to local authorities, who will employ the Director of Public Health (jointly appointed with the Public Health Service), with a ring-fenced budget with funds allocated according to relative population health need, from April 2012.

- The role of the Care Quality Commission as an effective quality inspectorate will be strengthened across health and social care. CQC and Monitor will jointly license health providers and CQC will inspect providers against the essential levels of safety and quality.

- Local authorities will promote the joining up of local NHS services, social care and health improvement. Through new statutory arrangements local authorities will establish health and well-being boards or through existing LSPs will promote integration across health and adult social care, children's services including safeguarding and the wider local authority agenda. These functions would replace the current statutory functions of Health Overview and Scrutiny Committees.

- The Government will establish a commission on the funding of long-term care and support, to report within a year. The commission will consider options including a voluntary insurance scheme and a partnership scheme. The Government will also reform and consolidate the law underpinning adult social care. The overall vision will be brought into a White Paper in 2011.

- The Government will seek to break down barriers between health and social care funding to encourage preventative action.

- A strategy for social care reform (covering personalisation, prevention and reablement) will be published in November 2010.

- The Health Bill will contain provisions to create HealthWatch England, a new independent consumer champion. LINks will become the local HealthWatch, to be funded by and accountable to local authorities, and will promote choice (e.g. helping people choose which GP practice to register with) and complaints advocacy. Local HealthWatch will have powers to recommend that poor services are investigated.

Summary of Supplementary Consultation Documents

Following publication of the White Paper the Government has published five consultation documents seeking comments on a series of questions relating

to the development of various aspects of policy. The five consultation documents are:

- Local democratic legitimacy in health
- Commissioning for patients
- Transparency in outcomes – a framework for the NHS
- Regulating healthcare providers
- Review of arms-length bodies

The following is a brief summary of each of the first four of these documents (the review of arms-length bodies has less impact on local services, decision-making and governance).

Local Democratic Legitimacy in Health

The document defines localism as one of the defining principles of Government policy and proposes local democratic accountability by which councillors and councils will have a new role in ensuring the NHS is answerable to local communities. The aim is that patients who need the help of both health and social care services can expect to get much more coherent, effective support. In this new role councils will have greater responsibility in four areas:

- assessing local needs by leading joint strategic needs assessments (JSNA) to ensure coherent and coordinated commissioning strategies
- supporting local voice, and the exercise of patient choice
- promoting more joined up commissioning of local NHS services, social care and health improvement
- leading on local health improvement and prevention activity.

The main specific proposals are that:

- Local Involvement Networks (LINks) will become the local HealthWatch, which will be given additional functions and funding to provide a signposting function to the range of organisations locally, an NHS complaints advocacy service, supporting individuals to exercise choice such as choosing a GP practice. Local authorities will fund HealthWatch and contract for their services and hold them to account for discharging these duties and ensuring the focus of local HealthWatch activities is representative of the local community. Local HealthWatch will be part of the Care Quality Commission (CQC) and will be able to report concerns about local health or social care services directly to HealthWatch England, within CQC.

- The Government prefers to specify a statutory role for local authorities to support joint working on health and well-being. A statutory partnership board – a health and well-being board – within the local authority would

provide a focal point through which joint working could happen. The four main functions of health and well-being boards proposed are:

- To assess the needs of the local population and lead the JSNA
- To promote integration and partnership including through joined-up commissioning across the NHS, social care and public health
- To support joint commissioning and pooled budget arrangements where all parties agree
- To undertake a scrutiny role in relation to major service redesign

It is proposed that the statutory functions of the OSC would transfer to the health and well-being board. Local authorities would need to ensure that a process was in place to scrutinise the functioning of the health and well-being board and health improvement policy decisions.

- When PCTs cease to exist responsibility and funding for local health improvement activity will transfer to local authorities (e.g. in relation to smoking, alcohol, diet and physical activity). A national Public Health Service will integrate and streamline health improvement and health protection functions. Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service, with direct accountability to both. They will have a ring-fenced health improvement budget allocated by the Public Health Service.

Commissioning for Patients

Most commissioning decisions will now be made by consortia of GP practices, held to account for the outcomes they achieve by the NHS Commissioning Board. It will be a requirement that every GP practice to be part of a consortium and to contribute to its goals. It is proposed that a proportion of GP practice income is linked to the outcomes that practices achieve through commissioning consortia and the effectiveness with which they manage NHS resources. Consortia will be able to employ staff or buy-in support from external organisations. Consortia will determine which aspects of commissioning require collaboration across several consortia.
The NHS Commissioning Board will be responsible for commissioning primary medical services, and also dentistry, community pharmacy, primary ophthalmic services and national and regional specialised services and maternity services.

The Secretary of State will set the NHS Commissioning Board an annual mandate, based on a multi-year planning cycle, covering the totality of what the Government expects from the Board. The Board will in term hold consortia to account for their performance.

Consortia will have a duty to promote equalities and to work in partnership with local authorities. Consortia will have a duty of public and patient involvement.

The economic regulator and the NHS Commissioning Board will ensure transparency and fairness in spending decisions and promote competition, including by ensuring that wherever possible any willing provider has an equal opportunity to provide services.

The NHS Commissioning Board will have a significant role in managing financial risk, including through oversight of risk pooling within and between consortia. The principles for managing overspends and underspends will be agreed between the NHS Commissioning Board, the Department of Health and HM Treasury.

The aim is that GP consortia will take on their new responsibilities as rapidly as possible. The timetable is:

2010/11	GP consortia begin to come together in shadow form
2011/12	A comprehensive system of shadow consortia in place, and the NHS Commissioning Board established in shadow form from April 2011
2012/13	Formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board established
2013/14	GP consortia to be fully operational with real budgets and holding contracts with providers

Transparency in Outcomes – a Framework for the NHS

The Secretary of State will hold the NHS Commissioning Board to account through the NHS Outcomes Framework, which is concerned with how the performance of the NHS across the system will be judged at a national level. It will be made up of a set of national outcome goals that will provide an indication of the overall performance of the NHS.

The NHS Commissioning Board will in due course develop a commissioning outcomes framework that measures the health outcomes and quality of care achieved by GP consortia. It will develop a set of indicators to operationalise the national outcome goals set by the Secretary of State.

There will be separate frameworks for the NHS, public health and for social care. The NHS Outcomes Framework will therefore focus on the outcomes that the NHS can deliver through the provision of treatment and healthcare.

The consultation on the national NHS Outcomes Framework asks for views on:

- The principles that should underpin the framework

- A proposed structure and approach that could be used to develop the framework
- How the proposed framework can support equality across all groups and help reduce health inequalities
- How the proposed framework can support the necessary partnership working between public health and social care services
- Potential outcome indicators, including methods for selection, that could be presented in the framework.

The proposal is to structure the NHS Outcomes Framework around a set of five outcome domains that attempt to capture what the NHS should be delivering for patients:

Domain 1: preventing people from dying prematurely
Domain 2: enhancing quality of life for people with long-term conditions
Domain 3: helping people to recover from episodes of ill-health or following injury
Domain 4: ensuring people have a positive experience of care
Domain 5: treating and caring for people in a safe environment

There are specific proposals for outcome indicators for each of the domains and some very detailed issues on which comments are being sought.

Regulating healthcare providers

This consultation document seeks to accelerate progress towards all NHS provision being provided by NHS Foundation Trusts (FTs), considers potential additional freedoms for foundation trusts and proposes to establish an independent economic regulator for health and social care.

The core purpose of Monitor will change to take on the role of economic regulator, responsible for regulating prices, promoting competition and supporting service continuity. Monitor will carry out a range of regulatory functions currently delivered wholly or in part by the Department of Health. Monitor's principal duty will be to protect the interests of patients and the public in relation to health and adult social care by promoting competition where appropriate and through regulation where necessary.

It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust.

The Government's intention is that FTs will be regulated in the same way as any other provider in the private or voluntary sector.

Foundation trusts freedoms will be extended:

- The cap on the proportion of earnings from private income will be repealed
- The Government is considering whether to retain Monitor's power to limit the amount FTs can borrow from banks and other lenders

- FTs will be able to amend their own constitutions with the consent of their boards of governors
- There will be greater freedom for FTs to acquire another organisation or to de-merge (subject to merger controls to protect competition)

Monitor will be responsible for establishing funding arrangements to finance the continued provision of services in the event of special administration (to be triggered to protect additionally regulated services before the start of any insolvency process). It is likely that it will establish a funding risk pool raised from levies on providers.

NHS Southwark Response to the Consultation

The consultation on all four documents runs until 11 October. NHS Southwark will be making a response and is liaising with Southwark Council to discuss where our views may align. A draft of the response is not available at the time of writing but the content of the draft will be discussed at the Scrutiny Committee meeting by which time a draft will have been written.

Agenda Item 9

Trigger template for standard variations to health services

NHS Trust & lead officer contacts:	
Alastair Gourlay – Programme Director – Estates Strategy **Paul Tiernan – Programme Manager – Cancer Programme** **Deirdre Conn – Project Manager – Cancer Treatment Centre**	020 7188 5371 020 7188 9564 020 7188 4487

Trigger	**Please comment as applicable**
Reasons for the change	
What change is being proposed?	Currently, patients requiring outpatient radiotherapy and chemotherapy for cancer treatment receive this care in a variety of locations across Guy's & St Thomas' sites. It is proposed to build a new Cancer Treatment Centre at Guy's Hospital which will bring together all outpatient radiotherapy chemotherapy and supportive care services across the two hospitals into one location. Radiotherapy is provided using Linear Accelerators (Linacs). Currently the Trust treats approximately 3000 pts /year on 6 Linacs.
Why is this being proposed?	This change will improve the patients experience by providing services in purpose built facilities in one location. The facilities will accommodate up to date equipment to provide the best care. It will also increase capacity to meet the increasing demand for cancer treatment. The future requirement is for 4000 pts to be treated which requires an increase to 11 Linacs.
What stage is the proposal at and what is the planned timescale for the change(s)?	The proposal is at the Outline Business Case stage and if approved in September ,a Full Business Case will then be developed. If approved the plan is to open the building in 2014.
Are you planning to consult on this?	Patients and the public are being involved in the design process. Models and pictures of the proposed building (part of a RIBA run competition) will be displayed in strategic areas around the Trust site and community locations including Southwark council offices. People are being asked for their comments on these designs. There will be a patient and public engagement plan developed as part of the Full Business Case process in 2011.
Are changes proposed to the accessibility to services?	**Briefly describe**
Changes in opening times for a service	The aim is to open the building from 0800-2000 which will increase the number of patients that can be treated .
Withdrawal of in-patient, out-patient, day patient or diagnostic facilities for one or more speciality from the same location	None
Relocating an existing service	Radiotherapy and outpatients will relocate from 4 different departments across Guy's & St Thomas' to one department in the proposed cancer treatment centre.
Changing methods of accessing a service such as the appointment system etc.	Most patients requiring Radiotherapy and outpatient care will receive this in one location at Guy's hospital rather than a variety of locations which will be less confusing.
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.	There is an unmet need for Radiotherapy in the community affecting many groups of patients, particularly older people. The CTC will provide an increase in the availability of Radiotherapy and improve access.

What patients will be affected?	**Briefly describe:**
Changes that affect a local or the whole population, or a particular area in the borough.	All patient across Lambeth and Southwark and Kent requiring outpatient care and radiotherapy for cancer will equally benefit from this proposed change.
Changes that affect a group of patients accessing a specialised service	The co-location of services within the CTC will mean that patients will not have to move around between departments on the Guys site or move between Guy's and St Thomas' site as much as they do now.
Changes that affect particular communities or groups	as above
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	n/a
Delivering care using new technology	n/a
Reorganising services at a strategic level	n/a
What impact is foreseeable on the wider community?	**Briefly describe:**
Impact on other services (e.g. children's / adult social care)	There is no foreseeable impact on the wider community.

Health and Adult Social Care Scrutiny Sub-Committee:

Work Programme Outline 2010/11 – working draft

Meeting date	Agenda item
Wednesday 30 June 2010	- Introductory briefings - Proposed variation: vascular surgery services (KHP) - Albany Midwives deputation - Restructure of drug and alcohol services - Marina House - Work programme
Wednesday 6 October 2010	1. Restructure of drug and alcohol services - Marina House 2. SLAM disinvestment 3. Policy summaries: i) Health White Paper, ii) Public sector equality duty consultation 4. Key review - EIAs 5. Proposed service variations: Cancer treatment centre (GSTT)
Monday 29 November 2010	- Cabinet member interview - Continue key review(s) - Proposed service variations
Wednesday 2 February 2011	- Continue key review(s) - Proposed service variations
Wednesday 23 March 2011	- Quality Accounts? - Continue key review(s) - Proposed service variations
Wednesday 4 May 2011	- Final report(s)

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