HEALTH AND ADULT SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES of the Health and Adult Social Care Scrutiny Sub-Committee held on Wednesday 5 October 2011 at 6.30 pm at Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Mark Williams (Chair) Councillor David Noakes Councillor Patrick Diamond Councillor Norma Gibbes Councillor Eliza Mann Councillor the Right Revd Emmanuel Oyewole
OTHER MEMBERS PRESENT:	
OFFICER SUPPORT:	Julie Timbrell , Scrutiny project manager Andrew Bland , MD , Bussiness Support Unit Richard Gibbs, Vice Chair, Southwark NHS Sarah Feasey , Legal officer

1. APOLOGIES

1.1 Apologies for absence were received from Councillors Denise Capstick. Councillor Poddy Clark was in attendance as a reserve.

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

2.1 The Chair agreed to accept additional documents in relation to item 4, Scrutiny Arrangements 2009/10, and item 5, Proposals for Scrutiny Reviews.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the meeting held on 29 June 2011 were agreed as a true and accurate record.

5. CLINICAL COMMISSIONING

5.1 Chief Finance Officer for the Clinical Commissioning Business Support Unit, Malcolm Hines, Richard Gibbs, Vice Chair of Southwark NHS and Andrew Bland, Managing Director of the Business Support Unit (BSU) introduced themselves.

5.2 The Chief Finance Officer gave an overview of expenditure. The highest spend by is in the secondary sector; £422, 954 000, and the biggest spend is in the General and Acute services; £230 909 000. The primary sector spends £ 106 366 000. The total spend is £529 320 000. He reported that Southwark NHS is receiving a similar amount this year, and while this is generous considering other areas, it still represents a big challenge.

5.3 He then went on to speak about the QIPP programme and explained that Southwark NHS has had this for some time as the health service has always had to make efficiency changes. This helps enable the services to invest in growth areas by making savings in areas that no longer justify continuing with the same rates of expenditure. Southwark NHS is looking at efficiency savings of about 4%, which is around 20 million. He reported that future allocations will similar, and under the rate of inflation, and there will be a requirement for greater efficiencies.

5.4 The Chief Finance Officer explained that because around 50% of Southwark NHS spend is on the acute services most of the efficiency savings are made to this area; this is also an area of growth. He explained that they are looking at areas of low take up and other areas that would be best delivered in the community. One focus is agreeing prices with providers which will make efficiencies. For example Southwark NHS negotiated a better tariff around sexual health services.

5.5 Significant efficiencies have also been delivered by limiting access to services of little clinical value; such as cosmetic procedures. There is an Urgent Care Centre redesign to reduce cost associated with unscheduled care that need not attend A & E. There has also been a Primary Care Productivity Programme which is related to general practice contracting.

5.6 The chair invited questions and a member asked if we are expecting to see an increase in primary care and a reduction in secondary care. Clinical Commissioning officer explained that in the past we have talked about moving more into primary care, now it is more about blurring the lines. This means we may have secondary services delivered in peoples' homes. However there has been a year on year increase in Acute spending and admissions. This has led to a bigger investment in urgent care to meet expanding need and to achieve efficiency savings. For example we are investing in a minor injuries unit that will have many benefits, not just financial. It is better that primary care doctors see certain patients

and A & E doctors deal with real emergencies. It is about the right practitioners seeing the right patients. QIPP is about innovation, not overall financial savings.

5.7 A member asked if Mental Health spending going to be preserved and the officer advised that Southwark NHS has quite high spend on both Mental and Sexual Health. There has been some modelling and sometimes there is 1% or less variation.

5.8 There was a question about any savings that can be made from proscribing drugs and it was explained that Southwark NHS is making savings by moving to generic drugs and being more efficient. The member asked a followe on question and enquired if a less effective drug would be used because it was cheaper. The members were assured that this did not happen.

5.9 A member asked if Southwark NHS invest in research and it was explained that Southwark NHS does not sponsor research, but there is a national programme that the Acute services bid for.

5.10 A member enquired more about efficiencies and it was explained that the process involves looking at productivity; whereby local performance is judged by national benchmarks, with a view to identify areas that need to improve.

5.11 A member asked about the renegotiation of contracts to improve performance and asked how Southwark NHS ensured that patient care did not fall when a lower price was agreed. The officer explained that Southwark NHS still ask for the same outcome and use Equality Impact Assessments, among a range of tolls, to ensure that care standards are maintained. The member pointed out that it is possible that the renegotiated contract and the savings made would have an adverse impact, and asked if there are ever unintended consequences. The officer explained that this is mitigated by good contract management, and explained that Clinical Commissioning is very active in scrutinising contracts and undertakes reviews.

5.12 A member asked about the demands the health service is facing and how these will be met. Officers explained that population growth is about 2%, and inflation is about 4 %. The services are also constantly evolving pathways and treatments and this adds costs. There are pressures from an aging population and new drugs. This means that we need to be making at least 6 % efficiency savings each year to meet increased demand and inflation.

5.13 The Chief Finance Officer was asked about the shadow budget process whereby financial management moves from Southwark NHS to clinical commissioning. It was agreed that a paper would be circulated regarding this.

5.14 A member asked about change to Maternity services and officers explained that Maternity services have not been redesigned to save costs; but rather to improve quality.

5.15 A member noted that cosmetic procedures would be limited and sought assurances that people involved in major trauma would still be able to access these services. Practitioners assured members this was the case and there was a

policy available.

5.16 There was a question about drug and alcohol training for general practitioners and Clinical Commissioning officers agreed this was still an issues and it was acknowledged that there is a need to make training more attractive to G.P's and increase participation.

5.17 The chair invited the Vice Chair of Southwark NHS and Clinical Commissioning lead on Conflicts of Interest to present on Conflicts of Interest, with the assistance of the Managing Director of the BSU. They referred to the documents circulated, and explained that tomorrow there is an intention to sign up to the Nolan principles of public life at the Board meeting. The Vice Chair said that the Clinical Commissioning board intends to make conflicts of interest publically available. Declarations of Interest will be taken at the start of the meeting.

5.18 The Vice Chair explained that the policy states that they have a Non Executive Director (NED) as a champion, and this is his role. He went to explain this was a role suggested by the G.Ps, and is also now being rolled out nationally as a result of the 'listening' exercise. His role is to implement the guidance; this can be a judgment call.

5.19 A member asked the Vice Chair how a conflict of Interest is defined and he responded that one measure is by asking if participating in the decision about a provider could enrich the G.P. There is a system of alerts through the Declarations Of Interests procedure. The Vice Chair explained he sits on the Board and is aware of practitioners' business interests.

5.20 The Vice Chair went on to refer to the definition given in the papers supplied, this says:" Put simply, a conflict of interest can occur when an individual's ability to exercise judgment in one role is impaired by the existence of competing interests. In particular, a conflict of interest may occur when a member could be influenced by financial or other commitments or relationships and as a result could fail to adequately represent the views of his/her constituents (where representing others) or make impartial decisions. It can also arise when a member working for or having a link to a private company is involved in discussions at which information useful to the private company could be available"

5.21 The definition goes on the say: "For a clinical commissioner, a conflict of interest would exist when their judgment as a commissioner could be, or reasonably be perceived to be, influenced and impaired by their own concerns and obligations as a healthcare provider, as an owner, director of shareholder in an organisation doing business with the NHS, or as a member of a particular peer, professional or special interest group, or by those of close family members. "

5.22 A member asked the Vice Chair to define the role of G.Ps on the Board and how the Board relates to the wider governance structure. The Vice Chair responded that the Clinical Commissioning board has 8 G.Ps operating under the auspices of the Southwark NHS board, and the Department of Health. Eventually this responsibility will move to the National NHS commissioning board.

5.23 A member commented that this is an unusual set up whereby providers (G.P's) are

also commissioning services. The Vice Chair responded that social workers and head teachers are professionals with a similar role. There is a potential for GP led commissioning to lead to better integration with secondary care and better pathways.

5.24 A member commented that Declarations of Interest are noted in the minutes, but details are not given. While there are details on the piece of paper circulated it would be better practice if a Declaration of Interest was recorded in the minutes.

5.25 Members noted that the meeting of the Clinical Commissioning Board meet alternately in public and then in private; making it difficult to follow, particularly given that the same papers are used. The Vice Chair and BSU Managing Director undertook to get back to the committee on this.

ACTION

Members asked for more information on the shadow budget process, as the Clinical Commissioning consortium gradually takes control of the budget now spent by Southwark NHS.

Clinical Commissioning under took to get back to the committee about their meeting arrangements in response to members comment that the present arrangements, whereby one meeting is held on public and one in private, are confusing and can make following meetings difficult.

6. PRESENTATION BY SOUTHWARK'S THREE ACUTE HOSPITAL TRUSTS.

6.1 The chair invited John Moxham of Director of Clinical Strategy to give a presentation on Kings Health Partners. The director gave an overview by explaining that. Kings Health Partners is an Academic Health Sciences System (AHSS). This was set up nationally because the UK Health care system was underperforming. There are severe inequalities and poor outcomes. The NHS was not well placed to meet new challenges; such as ageing populations, obesity and diabetes. The development of new treatments was slow and costly and adoption of best practice patchy. There was an imbalance between basic and translational research. Others do better and internationally some AHSCs (combining a critical mass of academic and clinical activity) perform strongly.

6.2 The director explained the mission of King's Health Partners is to 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.

6.3 The director explained that Kings Health Partners aims to 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. He explained that they 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. They will ensure academic expertise is applied to all clinical services to pursue a tripartite mission.

6.4 They have a number of strategic objectives and these include:

• 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

6.5 The director spoke about 'the whole patient pathway'. Developing an excellent clinical pathway needs engagement and commitment from all healthcare/social care professionals involved in an individuals care. He explained this calls for a shift in the mindset of staff, to focus on the performance of the system, rather than an institution. Pathways have public health goals which help control of costs and enable effective commissioning. Available evidence suggests that healthcare systems must cover, in an integrated way, the whole patient pathway if we are to achieve significant savings and better outcomes. 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.

6.6 Angela Dawe, Director Operations Community Services, presented on the Integrated Care Pilot. This started in 1st April 2011. There is now one community management team across Lambeth and Southwark with two clinical directorates. They are building the new teams, bedding down systems and processes and working on culture and values.

6.7 The services include :Adult community services; Community nursing and inpatient units ; Rehabilitation and therapies; Health inclusion teams (Health promotion and

sexual health) ; Children's community services ; Universal (health visiting & school nursing) and Specialist services (children with disabilities and special needs)

6.8 This enables admission avoidance and is a “virtual hospital” for Kings Health Partners. They are improving discharge arrangements for both adults and children. They are delivering new model of health visiting which provides opportunities for service integration on musculoskeletal triage, stop smoking, sexual health and leg ulcers.

6.9 Next there was a presentation on a pilot Integrated Care project initiated by King’s Health Partners working with older people. The pilot is a significant strategic objective for King’s Health Partners and provides exciting opportunities for innovation, improvement and efficiency on a number of fronts. The development of new approaches to integration reinforces KHP’s commitment to the health and health outcomes of its local population in Lambeth and Southwark.

6.10 Clinical staff spoke about the older people views that they had gathered from local interviews and the reference group. Older people supported the pilot’s aims are ‘excellent’–but there is scepticism about whether it will happen. People don’t want to go to hospital or into a care home. Older people are concerned and sometimes frightened about being admitted to hospital as they feel vulnerable and are worried about cleanliness, infections and dignity. They want better support when they’re discharged from hospital and more communication and support after discharge including more time to talk. They value continuity of care with the same professionals and people who know them.

6.11 Zoe Reed , Executive Director , Strategy and Business development at South London and Maudsely presented on the trust work. She explained they support around 39,000 in the community and mental health trust are used to thinking of themselves as part of a system of care – rather than just seeing themselves as a hospital based institution.

6.12 The executive director went on the explaining that there challenges include a disinvestment / cost improvement programme of £61m over the next 3 years. She explained that at the same time the trust needs to maintain and improve standards. The CQC will be visiting the Maudsley Hospital any time now.

6.13 The trust is focusing on Clinical Academic Groups (CAGs) and Care pathways. She reported that aim is to ensure that the trust always offer the right treatment at right time. A particular issue for the trust is the needs of BME residents given the pattern of much greater proportion of the BME populations presenting with Psychosis compared with white ethnic groups. She went on to explain this maybe partially be accounted for because the population statistics fail to account for the impact of differential population growth in minority groups as evidenced in Southwark schools. So for example the proportion of young people from BME backgrounds (2010) presenting with non affective psychosis matches their representation in the 2001 school population. She went on to say the trust continue to be concerned to ensure there is equality of access and outcome.

6.14 The executive director said that the Pathway development work will included

spreading good practice across the whole CAG e.g. Lambeth OAISIS evidence is that the duration of untreated psychosis/Prodromal Stage has been reduced from 52 weeks to 7 days and we are developing an early intervention proposed to encompass all boroughs for discussion with commissioners. They will be monitoring the ethnicity of discharged from community teams including those that access the Staying Well Team and Peer Support. Currently very few have been discharged. She stated that the trust will continue also to support BME specific services such as the BME Volunteer project and the Peckham Befrienders as well as the mental health promotion BME specific work.

6.15 She spoke about new ways of working on with dementia, and referenced the Lambeth Living Well Collaborative. She explained that recent innovations include an Alzheimer's test: we have developed an advanced computer programme to detect Alzheimer's from a routine brain scan. The scan can return an 85% accurate results within 24 hours. This early diagnosis enables people to plan their care and get access to treatment – rather than waiting until they reach crisis point. She reported that the test is now being used within our memory service in Southwark

6.16 The executive director went on to talk about Empowering Parents and Empowering Communities (EPEC): and explained the trust has launched a new scheme in Southwark to train parents to teach effective parenting and the scheme is up in front of the HSJ award judging panel today! The project has been initiated because inner city areas have twice the national rate of severe childhood mental health problem. There is an EPEC: a project in Southwark with 40 parent groups over 2 years with 350 parents. The results show significant improvement in child behaviour rates and over 70% of parents gave Being a Parent course the highest satisfaction rating

6.17 The executive director spoke about the Early onset services for people with psychosis and stated the early intervention unit at Lambeth Hospital for young people with psychosis is now accessible to Southwark residents. She explained One of the potential benefits of Clinical Academic Groups is about bringing a greater consistency of quality to all of the communities we serve. With the support of Lambeth commissioners, we have built up specialist clinical expertise in the field of early intervention for psychosis. In the last year, we extended accessibility to our early intervention unit Lambeth Hospital to Southwark residents as well as Lewisham and Croydon)

6.18 Lastly the executive director spoke about the take-home heroin antidote study: researchers at the trust National Addiction Centre at the Maudsley Hospital have led the way in developing new treatments. One example is the largest intervention study within the UK prison population: involving 56,000 people in 20 prisons. She reported that the trusts aim is to reduce mortality from heroin overdose by a third by giving prisoners a supply of take-home Naloxone. She explained that at the moment 1 in 200 prisoners with a history of heroin abuse will be dead from an overdose within 4 weeks of being released.

6.19 The chair invited members to ask questions. A member asked why we have a women's CAG and not a men's CAG , and it was explained that this is primarily because women have babies; this is about the provision of maternity services.

6.20 There was a question about the choices of specialities and the Director of clinical strategy explained that there is a focus on obesity, HIV and diabetes because these are local problems . He explained that they have been testing pregnant women for HIV since 2004.

6.21 A member reported that she had spoken to someone in Dulwich who had to wait for three hours for transport home; even though she lives very close. Hospital staff responded that they are trying to improve services.

6.22 A member spoke about the tension between integration and competition . The Director of Clinical Strategy said that he did not think they are completely incompatible. Commissioner does not have to go down the competition route in all cases.

6.23 A member asked the director if a shift to outcome based targets is a good thing and he responded that if you want to effect outcomes like disablement from a stroke you have to have process targets; that measure things like blood pressure monitoring to reduce risk; time taken to give treatment if a stoke has happened and rehabilitation. However he advised that if a health system wants to make a significant difference to outcomes the focus should not just be on wonderful high tech Acute services, as these are very expensive. He explained that the best way to impact on outcomes is to focus more on prevention. This is about a Public Health prevention agenda and he advised the committee to really focus on this.

6.24 Members asked how Southwark Council could work in partnership with Kings Health Partners on this and the Director of Clinical strategy spoke about a recent paper that had been developed in partnership with the council and Public Health. It was agreed that this will be distributed. He explained that public health systems that drove down costs and kept value really focused on this. Conditions like lung cancer are linked directly to smoking and this is much more prevalent in deprived communities. The same is true of diabetes and obesity; two linked conditions that people living in poverty are much more at risk of. He stated that a massive investment in public health is needed to tackle these problems.

6.25 Members asked about recent discussion about a more formal merger of Kings Health Partners and the Director of Clinical Strategy reported that there was a recent review of the partnership and the benefits of merging. He reported that they are not committed to it , but we are debating it. He referred to a paper that was circulated by email.

6.26 There was a question on older people and access to beds if they are crisis. Member requested that the executive director of Maudsley provide a paper on this.

6.27 A member spoke of her enthusiasm for the older people's integrated project and asked how this would work. It was explained that the Southwark project is very all encompassing and will look at prevention, early discharge and risk management of older people with long term conditions.

ACTION

Circulate a public health paper produced by King's Health Partners on Improving Public Health through Community Involvement. This had been developed in collaboration with Southwark Council's corporate strategy unit.

Produce a briefing paper describing services and beds available for older people in mental health crisis.

7. SOUTHERN CROSS

7.1 Jonathan Lillistone, Head of Commissioning Adult Social Care introduced the report on Southern Cross circulated with the papers. He explained we have quite considerable exposure, including some residents placed outside of the Borough. He reported that Southern Cross is now being wound up and new organisations are being formed.

7.2 The chair explained that the committee intend to write a report on this and the focus will be how the council can learn and become more resilient. He asked the officer if it is possible to ascertain the financial health of a provider. The officer explained this is never very easy. He explained that Adult Social Care officers' focus has been on quality, and he stated that there have been some concerns, as the report outlines.

7.3 A member noted that the new organisation being formed in Southwark; Health Care One will reform the homes and care provision into one package; this was the original business model of Southern Cross. However, could these again be asset striped? The officer explained that as a local authority we have little leverage over that threat, other than taking our business elsewhere. However that could potentially leave the council open to be challenged on why we did not send people to local homes.

7.4 The chair refereed to the CQC report which raises concerns about medicine management. The officer explained that they are doing ongoing work with the home. The committee requested to be kept informed on any embargo on homes.

7.5 Officers were asked about the arrangements for existing staff in the homes and if they would keep their jobs when the new organisations took over control. The officer reported that he understood that from Care Manager and below staff would keep their positions, however the new organisation may well change more senior management. Staff will be protected by TUPE. Members asked to see relevant briefing papers produced at national level.

7.6 A member noted that Southern Cross provide 73% of nursing beds in the borough and commented that the committee should consider how can we promote a diversity of providers so we do not put all our eggs into one basket. The officer responded that the council is seeking to reduce the use of care homes though focusing more on integrated care in people's homes.

7.7 A member asked how residents at Southern Cross had been communicated with and the officer reported that Southern Cross is leading on this and all families have

been written too. Alongside this social workers and front line staff are clear about what they can say. The focus has been on reassurance and continuity of care. The member responded that it would have been good if the council had also written to the residents setting out our position and what we are doing.

7.8 The officer said that this has been a challenging process, and they are now building relationships wit the new providers so that they can help us meet our aspirations to improve care.

7.9 A member asked about sheltered housing and asked for clarification on the age criteria. The officer explained that older people are eligible from 65 plus, and for specialised service for disabled people from 55 plus.

ACTION

Officers undertook to keep the committee informed on any embargo on Southern Cross homes.

Officers will update members on relevant Health and Social Care briefings provided by Southern Cross and central government.

8. SCOPING DOCUMENTS

8.1 The chair requested members note the contents.

9. PUBLIC HEALTH - PREVENTION INVESTMENT

9.1 Jin Lin, Public Health consultant , presented the report on investment to prevent health conditions occurring This looked at what Public Health are spending on investment and what is are spent on treatment.

9.2 He reported that they have identified some areas where they have been spending upstream; principally smoking cessation, Early Detection and obesity prevention and treatment. He explained that they have a range of practitioners working in Children's Centres, schools and in doctor's surgeries. He explained that there is a national health check for people over 40 and this looks for diabetes, high blood pressure and other indicators. Doctors then give patients advice on how to reduce their risk.

9.3 There is work on Mental Health prevention to raise awareness and help people deal with issues effectively. Alongside this there is access to CBT therapy. There is some work on alcohol prevention and early detection, and substance misuse early detection and harm reduction.

9.4 The officer reported that prevention work can be hard to cost as it takes place in many universal services, such as health visitors and GP's and seeks to prevent a number of related conditions.

9.5 A member commented that working with community groups would help the prevention agenda. The officer agreed and indicted this was happening. Members asked about the effectiveness of the Bowel screening programme and links with Diabetes UK.

9.6 A member mentioned social impact bonds and commented that it may be worth investigating these, given the present budget pressures.

9.7 The officer was asked about the Shadow Budget process, whereby the budget now spent by Southwark NHS is identified and gradually turned over to the council. Officers reported that there had been intensive work on this and a shadow budget will be in place by Christmas. The council will assume more control of this in 2012 and by April 2013 the council will receive the cash directly.

9.8 Members asked if it is anticipated that the council will receive the same amount of money. The officers responded that they are unsure; however the suggestion is that the council will not. Officer commented that statistics show that for every £1 spent on prevention, £11 is saved in treatment. A Member commented that Public Health does need to be incentivised.

ACTION

Public Health officers undertook to get back to the committee on:

- The effectiveness and results of the Bowel screening programme
- Linking up with the Diabetes UK to promote early testing and prevention.
- The results of the shadow budgeting process for Public Health budgets, as this function moves from Southwark NHS to Southwark Council.

10. CONTRACT INFORMATION

10.1 The chair asked members to note the contents.

11. WORK PROGRAMME