Open Agenda

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 5 October 2011
6.30 pm
Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

Membership

Councillor Mark Williams (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Denise Capstick
Councillor Patrick Diamond
Councillor Norma Gibbes
Councillor Eliza Mann
Councillor the Right Revd Emmanuel Oyewole

Reserves

Councillor Poddy Clark
Councillor Neil Coyle
Councillor Mark Glover
Councillor Jonathan Mitchell
Councillor Helen Morrissey

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Contact Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

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Members of the committee are summoned to attend this meeting
Annie Shepperd
Chief Executive
Date: 27 September 2011

Southwark Council

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 5 October 2011
6.30 pm
Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

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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 open section of the meeting held on 29 June 2011.	1 - 15
5.	**CLINICAL COMMISSIONING** Documents attached detail Southwark NHS / Clinical commissioning's global spend on contracts, thier planed savings (QIPP) and polices on managing conflicts of interest.	16 - 49
6.	**PRESENTATION BY SOUTHWARK'S THREE ACUTE HOSPITAL TRUSTS.**	

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Date: 27 September 2011

HEALTH AND ADULT SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES of the Health and Adult Social Care Scrutiny Sub-Committee held on Wednesday 29 June 2011 at 7.00 pm at Town Hall, Peckham Road, London SE5 8UB

PRESENT:	Councillor Mark Williams (Chair) Councillor David Noakes Councillor Patrick Diamond Councillor Norma Gibbes Councillor Eliza Mann Councillor the Right Revd Emmanuel Oyewole Councillor Poddy Clark (reserve)
OTHER MEMBERS PRESENT:	
OFFICER & PARTNER SUPPORT:	Susanna White: Strategic Director of Health and Community Services. Andrew Bland: Managing Director of the Business Support Unit (BSU) Dr Amr Zeineldine: Chair of the Clinical Commissioning consortia Dr Ann Marie Connolly : Director of Public Health Julie Timbrell: Scrutiny project manager Shelly Burke: Head of Scrutiny Faz Hakim: Senior strategy officer Sarah Feasey: Senior legal officer

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Denise Capstick because she was in Germany on Territorial Army Camp. Cllr Poddy Clark attended as a reserve on her behalf.

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

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The chair requested that members from last administrative year's committee agree the minutes are an accurate record. They were agreed as an accurate record.

4.2 Cllr David Noakes asked if the follow up meeting about Equality Impact Assessments, referred to in the minutes, had taken place between last year's chair and officers. Shelly Burke, head of scrutiny, responded that it had not because of participants' availability.

5. PRESENTATION ON ADULT SOCIAL CARE

5.1 The Chair introduced Susanna White: Strategic Director of Health and Community Services. She went through the presentation tabled at the meeting.

5.2 The strategic director first outlined the national picture, and explained the budgetary pressures caused by the recent banking crisis. This has led to a large reduction in the council's overall budget and a hold on NHS spend. There is a national move to towards more choice and control. The U.K has an aging population and a rise dementia. This is an era of long term conditions and one of the challenges to redesigning the health and care system around this. Recently there have been to two big scandals in the care of older people and people with learning disabilities.

5.3 The strategic director than turned to the local context and explained that there are extreme pressures on the budget from young disabled people moving into adult services; there are about 40 people moving into the system each year adding about £2million to the budget. One way of providing better and cheaper care is to move towards more community care and less residential care but finding appropriate premises is a challenge in Southwark. Adult social care intends to put more emphasis on reenablement and this become a bigger service.

5.4 Southwark Council will need to make saving of around 25% of its budget, and is also set to lose significant grants. Adult social care is 30% of council spend. However NHS money is coming in to the council. There will be £4.5 million plus £900,000 for reenablement.

5.5 The strategic director commented that the overall reduction in spend will be mean it is impossible for this not to impact on care. The council will need to find savings of

£7.7 million this financial year (11/12). She reported that in the face of reduced budgets and increased demand the council need to provide more advice and support, rather than do so much. There will be cuts to day-care and lunch clubs. Delivering care within the council's budget, while maintaining quality, will be a challenge, and the strategic director welcomed advice from the committee.

5.6 The chair requested an update on Southwark's Southern Cross care homes, which are part of failing national chain own by private equity. The strategic director reported that Southern Cross operate three care homes in Southwark, and all have lease back arrangements with their respective landlords; which Southern Cross reports they can no longer afford. NHP, also a private equity vehicle, owns two of the homes. They are trying to renegotiate their arrangements with this landlord.

5.7 The strategic director explained that the council have contingencies if these care homes fail, however Southern Cross have an effective monopoly on nursing homes. The emphasis will be on people staying where they are and finding a way to run these homes. The other alternative is hospital. If the landlord was to ask them to go then we would work with health colleagues; however we hope it does not come to this.

5.8 A member of the committee asked if there had been a precedent to the £7.7 million reduction in the adult care budget. The strategic director responded that there had not been in her memory.

5.9 A member asked if the council had made a submission to the Dilnot Commission review. The strategic director undertook to find out and report back to the committee. Cllr Noakes reported that a submission had been made on the Big Care debate. [Following the meeting the Strategic Director reported that no submission to the Dilnot commission had been made by the council].

5.10 The strategic director was asked about progress on personalisation and the introduction of personal budgets. It was reported that the council is on target; a special project has been set up and all voluntary day centre users, who are eligible for care, will receive a budget. Some people are choosing self directed budgets rather than personal budgets as many older people prefer this arrangement.

5.11 A member asked about preserving quality and the strategic director commented that it is very difficult situation, sometimes there will be a decrease in quantity but they are aiming to not to reduce quality. A member voiced concerns about the impact on staff and that many people comment on the importance of the social aspect of care provision.

5.12 The strategic director was asked about her particular concerns and she responded that she is concerned about care in people's homes. The council has moved to having equity in payment to providers, and we now have only two providers. Recipients of care packages were given a choice of using their personal budgets to stay with their current providers. Quality of services in peoples' homes is a national issue. Southwark is trying to be fair and have equal relationships across providers, while monitoring care regularly. However there is not always a clear relationship between price and quality; substantial sums were spent on Winterbourne View.

5.13 A member asked about contracts and any steps that the council takes to ensue that care workers are not hard done by. The strategic director reported that the council does not take a role between the providers and their employees, as long as they are lawful. A further question was asked about contracting criteria that the council sets and the strategic director stated that the council looks at quality, but not the relationship with employees.

5.14 The strategic director was asked about day-care services for mental health service users and she explained that Southwark has 6 centres, while other boroughs have far fewer providers. This situation is being looked at as an opportunity to release money that can then go into personal budgets. The council has been working with SlaM to see how resources can be better shared.

5.15 A member asked if sheltered housing was being used by normal, younger people. The strategic director undertook to find out more and report back to the committee. [This paper is circulated with the minutes]

5.16 The chair spoke about the growing number of people with complex needs and asked the strategic director to elaborate on some of the challenges. She responded that her presentation had touched on the younger cohort of disabled people with complex needs entering the adult care system each year. This is a caused by a number of factors including the fact that more children are surviving as premature babies, and so is linked to improvements to in medical care. Alongside this many people with learning difficulties are living longer, fuller lives and need care as they grow older. Other conditions are also on the rise, including autism, and there has also been an increase in challenging behaviour. The adult care team has started a new programme working with 14 – 23 years, to prevent the adverse effects of what can be a funding fall off, and also in recognition that maturity can come at a later stage.

5.17 A member asked about performance of the Care Quality Commission (CQC). The strategic director commented that the committee needs to be aware that it is facing major cuts. There is an issue of risk management that the council needs to manage. Alongside that we are looking at a changing relationship between the council and citizen; people will need to take more control of their own lives. The council role is moving more towards providing advice and enabling.

5.18 A member asked about the role of the council in monitoring providers and the role of training. The strategic director responded that they are not monitoring training directly but they are involved in monitoring quality.

5.19 The strategic director ended by saying that there will be a change in what the council can deliver, given its reduced resources, and therefore the type of support the council gives will be altering. For example rather than day services the council is looking to release money for personal budgets. However the strategic director emphasised that this can't be an abrupt change of culture. The council is facilitating conversations with services users, staff and providers, but there are no simple answers.

RESOLVED

- Provide an update on any Southwark Council submission to the Dilnot Commission
- Provide information on the number of sheltered housing units for older people which are being used by able, younger people.
- The Chair informed the Strategic Director that he is recommending that the committee do a review on ageing of adults with complex needs, both at entry into Adult Social Care and emerging complex needs in later life.

6. PRESENTATION ON SOUTHWARK HEALTH COMMISSIONING CONSORTIUM

6.1 The Chair introduced Andrew Bland; Managing Director of the Business Support Unit (BSU) & Dr Amr Zeineldine, Chair of the Clinical Commissioning consortia.

6.2 The managing director commented that since they last came to the committee the essential elements remain; clinical commissioning and the savings that need to be made. As a result of the ‘pause’ it is likely that it will move to ‘clinical commissioning' rather than ‘G.P’ commissioning.

6.3 The managing director went through the presentation tabled at the meeting. The current arrangements involve all 47 practices and the area is co terminus with the London Borough of Southwark.

6.4 Southwark is a pathfinder. Dr Amir Zeineldine chair's the consortia committee; however the accountable body remains Southwark NHS. There will be increasing levels of delegated responsibility as accountability moves to the consortia.

6.5 The national commissioning body will be looking at the authorization process. As a result of the pause we will not be held to the April 2013 date, this is now more of a target than a deadline.

6.6 Dr Amr Zeineldine reported that they have clear views about how conflicts of interest are managed. If you look at the clinical leads (on the slide) it details the corporate governance role. He reported that patient and public involvement is a key area and they will be building on the existing patient groups.

6.7 It was reported that working on the ‘integration’ agenda is hugely important. They are working closely with the local authority and the Kings health partners; the three acute trusts. It is very important that they are co terminus with Southwark; but also very important that they work in partnership with Lambeth and Lewisham.

6.8 The chair asked if the enormous number of parliamentary amendment to the bill would fundamentally change the original plans. The managing director responded

that we have some constants; clinical commissioning and 0 % growth. We have been asked to make a further cut of £56 per head to bureaucracy – also known as administration and planning. Cuts will need to be made, however clinical commissioning will be leading. While there will be a change in the details, the fundamentals will remain.

6.9 A member asked what you the clinical commissioning consortia will be doing to preserve skills. Dr Amr Zeineldine responded that there is a corporate memory of setting up practice based commissioning and constant communication with the local authority; G.P.s would like to see this as a move forward.

6.10 A member asked if there have been cases where managers have been paid redundancy by Southwark NHS and then been reappointed by the BSU. The managing director responded that while there had been internal challenges about appointments, this had not happened here.

6.11 A member asked for the reason behind Southwark's decision to be a pathfinder. Dr Amr Zeineldine explained that as a first wave you get extra resources, this is the carrot. The stick is that you have to perform and do some real work, however there are toolkits. Also we considered that there was tremendous value in clinical led commissioning. The managing director commented that NHS London give 4 ½ months of extra resources and also it gave Southwark a chance to shape the process from the outset.

6.12 A member asked if clinical commissioning could lead to a more preventative agenda; keeping people well rather than rather than treating ill people. Dr Amr Zeineldine responded that they are looking to get to European levels in prevention, early detection and treatment of cancer.

6.13 A member commented that one of the issues of the old PCTs was the democratic deficit. He asked how the clinical commissioning consortia intend to ensure that you are will be accountable and transparent to the public and locally elected representatives. The managing director responded that meetings will held in public and papers published on the internet. They also have a strong engagement team who are concentrating on bottom up engagement and now 80% of practices have patient groups. Engagement is a priority for the pathfinder, but a good start has been made.

6.14 A question was asked about the size of patient practices; which can vary from 1,000 to 25,000 registered patients. The managing director commented that each practice has one of two patient representatives. Local issues are discussed, however they also want to promote discussion on the wider issues, for example the acute trusts.

6.15 A member asked if Southwark's monitory advantages in becoming a pathfinder could result in a two tier system. The managing director responded that the extra money was for pathfinders to lead the way, however while you do get extra resources there is an additional responsibility to share your practice as a pilot. Dr Amr Zeineldine emphasized that it was not a political decision to become a pathfinder; but based on a view that it would improve clinical decisions. A member commented that there is a shift in power, and Dr Amr Zeineldine agreed that there

is an increase influence; however he saw this as part of a modernization agenda that has been going on for sometime and delivering good outcomes.

6.16 A question was asked about contracting with private providers and conflicts of interest as some members of the consortia will have commercial interests. Clinical commissioning colleagues suggested that the committee review their conflicts of interest policy.

6.17 A member commented that there have been cases where health services have been commissioned from private providers; however this has led to a loss of control to the detriment of patients. For example cleaning contracts have driven down costs but lead to a poor standard of hygiene. The member went on to comment that the consortia will need to draw up robust contracts and many commercial companies have very good lawyers; he asked how will the clinical commissioning team how they will ensue they have the contractual skills.

6.18 Dr Amr Zeineldine commented that the G.Ps are clinical leaders, not bureaucrats. They will be procuring along clinical pathways, that is the principle and they will be avoiding commercial cherry picking. The robustness of the contracting process is for the BSU to ensure. The managing director commented that he and Southwark NHS strategic director of health service had cause to look at the out of hour doctors' service, due to concerns, but they are pleased with the progress. Their will be no relaxing of the procurement team. The managing director commented that he finds the lawyers of large acute trust are just as robust as commercial organizations. However he reported that we do recognize the need to ensure we have the right expertise, and commented that he was confident in the consortia's ability to contract with providers. The managing director went on to explain that GPs services are commissioned centrally.

6.19 A member asked about GP training around Drug and Alcohol services. Dr Amr Zeineldine commented that Southwark is a Beacon service. He said he did not think the picture was as bleak as it had been a few months back. The challenge we have is to look at incentives to encourage G.Ps to take up the training as they frequently have little time in the day.

6.20 The chair set out his intention to undertake a review of clinical commissioning and thanked the team for their presentation.

RESOLVED

The chair proposed a review of Clinical Commissioning including:

- impact of savings on patient care;
- transition arrangements
- conflicts of interest
- contract management

The commissioning consortia's 'conflicts of interest' policy will be considered

A short report on the impact of recent NHS savings on patient services will be requested.

7. PRESENTATION ON PUBLIC HEALTH

7.1 The Chair introduced Dr Ann Marie Connolly : Director of Public Health. She ran through a presentation on the 'Health of Southwark's Population' tabled at the meeting.

7.2 The director stated that there is still much uncertainty around Public Health and this is an area that the select committee is looking at during the 'pause'. However clarity may take some time. A new body is due to be set up but this could be delayed until 2013.

7.3 A member asked if Public Health responsibilities lie with the Southwark NHS. The director explained that at the moment Southwark NHS is responsible for delivering on health targets around mortality, obesity etc. However the other agency with responsibilities is the Health Protection Agency and this deals with disease outbreaks such as E.coli and toxins. In the future there is likely to be one national body and very local provision. There is London wide body overseeing the transition and attempting to design the future.

7.4 Many of the Public Health duties will transfer to local authorities; however there is uncertainty on how much money will come and with what responsibilities.

7.5 A member asked if there was uncertainty over sums that would be transferred from Southwark NHS to the council to deliver Public Health. The director reported that all Directors of Public Health had been asked to undertake a due diligence exercise this year to identify what is spent on a host of areas. When central government received these results there was a wide disparity across the country on spend, so local authorities have been asked to repeat this exercise and this time to get sign off by the local authorities' chief executive.

7.6 The director explained that Public Health spend covers a range of areas including smoking cessation, school nurses, substance misuse, sexual health etc. A range of providers are paid including G.Ps and pharmacies. There is an ongoing process to refine the financial data, and Public Health will need to do a few more rounds on this.

7.7 A question was asked about the 'health premium' and how this could affect the amount of money Southwark gets. The director was asked if the notion of payment on results could conflict with accessing money according to need. He said he understood that there was concern that better off areas might get more money. The director reported that significant concerns were raised over the health premium during the consultation. Many colleagues said that allocating money according to results can create distortions and that funding should be relate to need and deprivation.

7.8 A member asked how Southwark managed to have such high life expectancy for females. The director said this is partly because Southwark is becoming less deprived. Women are a good news story for Southwark, but we can still do better.

There are some wards that still have a high mortality, but women are doing better throughout all stages of their lives. This may be because women are better at taking up advice and healthy living. Smoking and alcohol abuse is more prevalent among men.

7.9 A member commented on the high mortality rates for cancer & cardio vascular disease and asked if we allocate resources according to need. The director explained that while we do spend our resources in relation to mortality , there are not always clear links . She reported that sometime the amounts spent on prevention are relatively low; the vast majority of our spend is on treatment. The chair requested a report on this and thanked the director for her presentation.

RESOLVED

A report was requested that identified the amount spent on preventative actions and the amount spent on treatment of different public health concerns, in order to see if there was a relationship in terms of the amount of resource allocated.

8. WORK PROGRAMME

8.1 The chair proposed reviews looking at clinical commissioning and the aging of adults with complex needs. He commented that there are national concerns over conflicts of interest and a recent Independent article had noted that three members of the local clinical commissioning board had commercial interests in secondary providers. These that could potentially create a conflict of interest. The chair went on to say that adults with complex needs, both entering the Adult care system and those growing older, were a growing group that the care system needs to provide for.

8.2 A member requested time to feedback on these proposals and it was agreed that the chair would email proposals around for comment. A member stated that clinical commissioning is a major change and he considered that it should be a major focus of the committees work.

8.3 A member commented that she is very interested in contracted providers and noted that earlier the committee was told the council could not do anything about employee terms as the contracts were already in place. She went on to say that in her view when contracts are drawn up by lawyers the council needs to ensure that there is protection for employees who look after our old and vulnerable. There was a request for more information about the amount of contracts in place.

8.4 It was noted that Southwark Town Hall will no longer be used for committee meetings in the future and the next committee meeting will be in a different venue. 160 Tooley Street is being fitted out to ensure that it is fit for the purpose of holding public meetings. Other potential venues were briefly discussed.

RESOLVED

The Chair asked members to comment by email on the following proposed reviews:

- Review A :Commissioning (impact of savings on patient care, transition arrangements, conflicts of interest & contract management)
- Review B : Ageing of Adults with Complex Needs (Entry into Adult Social Care and Later Life)

The committee requested that officers provide details of contracts that are up for renewal in the next 12-18 months.

The committee requested that options for future meeting venues are circulated to members.

Title Sheltered Housing – User Profile Briefing Paper	To Health and Adult Social Care scrutiny
From **Susanna White Strategic Director of Health and Community Services**	**Date 30.8.2011**

1. Foreword

- The current number of units of sheltered accommodation/alms housing funded through the Supporting People programme in Southwark is 1,151. This is made up of both Council and Registered Social Landlord schemes as set out below.

Table 1:

Total Sheltered units in borough

Provider	Number of units	Number of schemes
Southwark Council	626	20
RSL's and alms Houses	525	19
TOTAL	**1,151**	**39**

- All of these schemes receive funding (at varying levels) through the Supporting People program.
- A more detailed break down of these schemes is outlined in Appendix 1 of this report.

2. Allocation and age profile

The Council is currently undertaking a needs mapping exercise all residents in all Sheltered housing which will provide a greater understanding of their needs as well as up to date information in relation to age, gender, ethnicity etc. However from the current records the profile is as follows:

- **RSL Schemes :** All RSL schemes listed in appendix 1 have an age threshold of 60+, apart from one (Peabody Trust - Darwin Court Scheme) This unit was not designed as a typical sheltered block, but instead purposefully contains a mixture of people in their 50s as well as those who are 60+. However the Council does not pay or the support needs of those residents (numbered at 4 individual tenants) below 60 years of age in the scheme.

- **Council schemes:** Following a review of sheltered housing undertaken by the Supporting People program, the Council reduced the age threshold for in house sheltered schemes to 55 years +, as long as the applicant could demonstrate that they had a support as well as a housing need. The current age profile of Council sheltered tenants is set out below :

Table 2:
Age profile of Council sheltered tenants

Age range	% of tenants	No of units
55*to 74	32%	200
75- 84	47%	294
84+	21%	132
TOTAL	**100%**	**626**

*There are currently **11 sheltered tenants (2% of total)** aged between55 and 59

The sheltered service also currently has 200 older people on the sheltered housing register. The Council operates a choice based lettings scheme for sheltered housing As of August 2011 the average age of applicants on list is **72 years of age**. Further details are set out below

Table 3:
Age profile of Council sheltered housing applicants on the register.

Age range	% of applicants	No of applicants
55-59	4%	8
60-70	33%	66
71-80	47%	94
85-100	16%	32
TOTAL	**100%**	**200**

The support needs of the Council tenants do however tend to be higher than those living in RSL schemes, as highlighted through two previous surveys outlined below.

Table 4: Support needs of Council sheltered tenants

Support need	2008-9	Dec 2010
Require help with maintenance/housing management issues	53%	31%
Require help to access and monitor social care needs	23%	25%
Require help with income maximisation	24%	22%
Wheelchair dependent	9%	8%
Use walking frame or stick	40%	45%
Hearing impairment	15%	20%
Registered blind	2%	4%
Mental health issue and supported by CMHT	27%	8%
Other disability or impairment	13%	9%
Alcohol issues	5%	3%
Substance misuse issues	Less than 1%	Less than 1%
Learning disability	3%	8%

In receipt of personal or domiciliary support *	45%*	25%*
Telecare equipment installed	9%	9% (100% key safes)

3. Future action(s)

- Assessment of actual home care used by council sheltered tenants in November 2010, found that the number received personal care as a result of being assessed as eligible under Fair Access to Care Criteria had fallen to 17%, (117 tenants). This would in part be due to changes in eligibility criteria for these services and the successes of social care initiatives such as reablement, but may also be as a result of changes in age and support profile of those applying for council sheltered housing.

- The results from the needs survey undertaken over the summer of 2011, will provide a more robust analysis of the support needs of all sheltered tenants. After this has been processed it will be possible to assess whether lowering the age profile for the Council schemes has had a significant impact upon the tenants support needs.

- The Council is also currently consulting on a Older People's Action Plan of the Housing Strategy. This contains a number of proposals in relation to sheltered housing, one of which being restricting access to a number of identified schemes to those who not only demonstrate a housing need, but also eligible under Fare Access to Care Criteria and potentially pensionable age criteria.

- Following the completion of the consultation exercise, the Cabinet will consider a report at the end of the calendar year in relation to the Housing Action Plan. This will then set the strategic context in relation to the future offer of sheltered housing in the borough.

Lead officer	Report Author
Jonathon Lillistone **Head of Commissioning** **Health and Community Services**	**Andy Loxton** **Lead Commissioner Older People** **Health and Community Services**

Appendix 1 – current sheltered provision.

Provider	Scheme	Units	Cost p.a	Cost per week
Abbeyfield Rotherhithe Society Ltd.	Smith Close	16	£19,642	£23.54
AMICUS HORIZON	Arundel Court	40	£39,160	£18.78
AMICUS HORIZON	Barnards House	41	£40,295	£18.85
Anchor Almshouses	Hopton's	20	£5,726	£5.49
Anchor Trust	Clifton Court	30	£8,744	£5.59
Elim Housing Association	Plowright House	17	£18,234	£20.57
Elim Housing Association	Brewster House	23	£16,661	£13.89
Hanover Housing Association	Southwark Sheltered Housing	40	£9,093	£4.36
Hanover Housing Association	Helen Peele Memorial Houses	7	£469	£1.28
Housing 21	Ronald Buckingham Court	27	£5,910	£4.20
In Touch Support	Frank Whymark House	34	£25,972	£14.65
Orbit South Housing Association	Hindmans Road, Swan Road and Albion	40	£4,823	£2.31
Peabody Trust	Darwin Court	40	£69,186	£33.17
Peabody Trust	Lomond House	41	£40,502	£18.95
Riverside Group Limited	Carey Court	30	£18,689	£11.95
Riverside Group Limited	St James Cloister	18	£22,571	£24.05
Riverside Group Limited	Welton Court	32	£18,079	£10.84

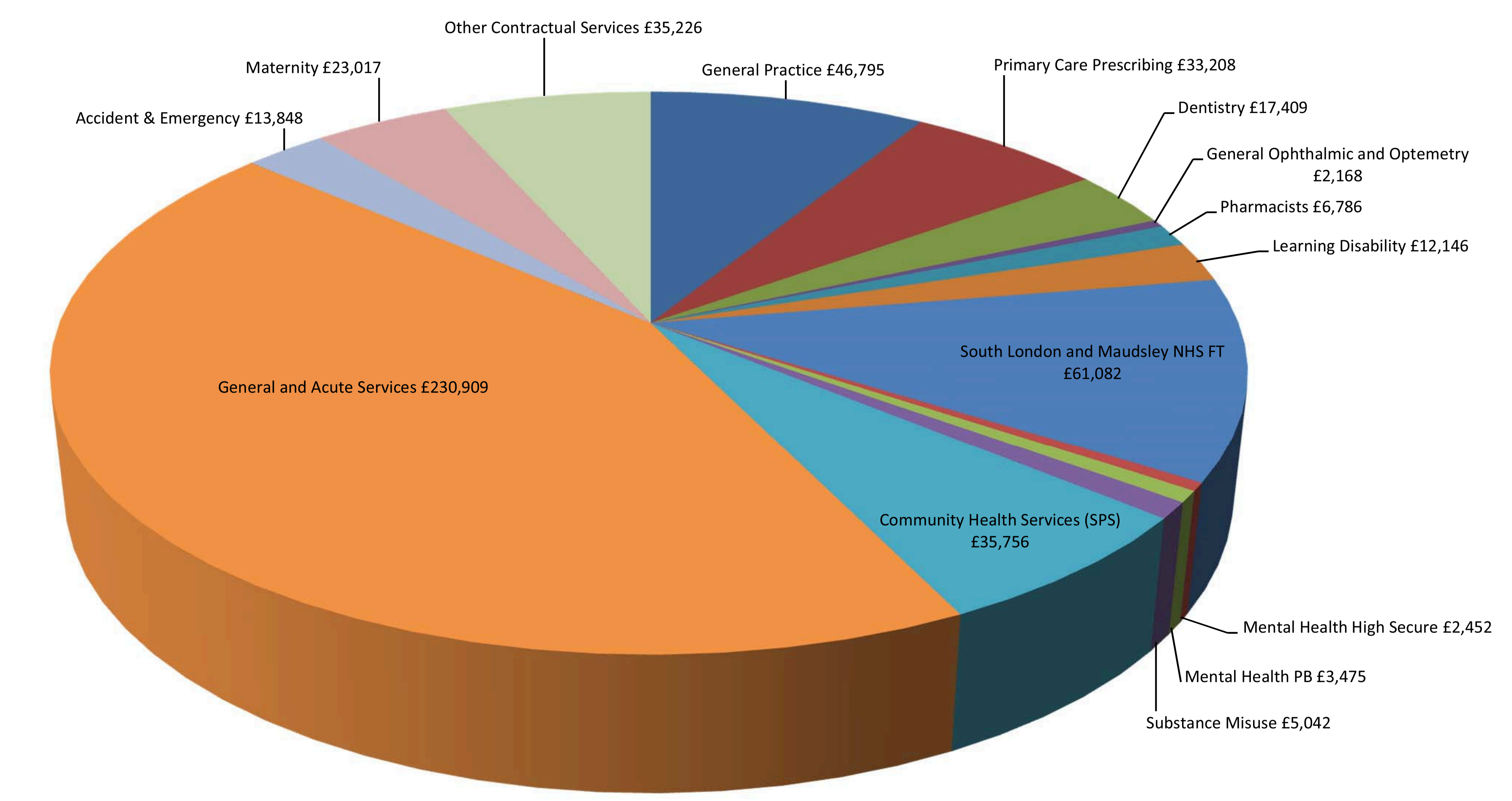
Riverside Group Limited	John Perry House	17	£7,757	£8.75
Wandle Housing Association	Anstey Road	12	£8,322	£13.30
		525		
Southwark Council	Sheltered	626	£850,917	£26.07

NHS
South East London

NHS Southwark Revenue Expenditure 2010/11 (£,000)

SOUTHWARK PCT 2010/11	
OVERALL PCT SUMMARY - Revenue Budgets	Expenditure
General Practice	46,795
Primary Care Prescribing	33,208
Dentistry	17,409
General Ophthalmic and Optemetry	2,168
Pharmacists	6,786
Total Primary Care	106,366
Learning Disability	12,146
South London and Maudsley NHS FT	61,082
Mental Health High Secure	2,452
Mental Health PB	3,475
Substance Misuse	5,042
Community Health Services (SPS)	35,756
General and Acute Services	230,909
Accident & Emergency	13,848
Maternity	23,017
Other Contractual Services	35,226
Total Secondary Care	422,954
Grand Total All PCT	529,320

NHS Southwark: Key Revenue Expenditure 2010/11 (£k)



South East London

Southwark Clinical Commissioning Committee & Southwark BSU

Quality, Innovation, Prevention & Productivity (QIPP) Programme 2011/12

Impact of the 2011/12 Southwark QIPP Programme

Southwark Council Overview & Scrutiny Committee

A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

1. The Southwark QIPP (Quality, Innovation, Productivity, Prevention) Programme is a suite of locally determined commissioning initiatives designed to support the delivery of quality care and to maximise the efficient use of resources. The gross value of the QIPP programme for 2011/12 is £20.2m, a 4% reduction of revenue expenditure. This is being delivered in addition to recurrent savings of £25m in 2010/11 and £15m in 2009/10

2. There are 31 QIPP initiatives across Acute, Community, Mental Health & Primary Care, with savings that vary from £2.2m large-scale productivity initiatives to £30k 'niche' projects (Annex 1)

3. GP Commissioners co-designed the QIPP programme with the PCT and will work with Southwark Business Support Unit (BSU) to deliver it. The Southwark Clinical Commissioning Committee (SCCC) of the PCT Board leads the local commissioning of QIPP. Designated BSU Officers and GP Leads manage the implementation of each of the QIPP programmes

4. Performance is reviewed in detail each month by the QIPP Delivery Group, a sub-group of the SCCC. The QIPP Group update the SCCC on progress against plan at their monthly meeting.

5. There are two over-arching methods of delivering QIPP initiatives. The first is to negotiate productivity targets with contracted providers and to secure quality improvements and savings, which are guaranteed in provider contracts/start budgets. The second category includes those QIPP initiatives delivered by implementing 'invest-to-save' programmes and/or service redesign which release efficiency savings. Risk for delivery of these programmes sits with the BSU or GP Commissioners

6. The BSU presented an overview of the QIPP programme to the Overview & Scrutiny Committee in March 2011. In light of this, this paper provides further detail on a number of key QIPP initiatives. In determining the initiatives on which further detail has been provided, we sought to reflect the following principles:

   a. The impact of the QIPP initiative on patients/Southwark residents
   b. The extent to which the QIPP initiative is about service change rather than provider 'efficiencies' that do not impact on patients
   c. The level of risk associated with successful delivery of the QIPP initiative
   d. Total financial value of the initiative
   e. Initiative being in an area/with a provider where the Local Authority also commissions services

7. The second part of this document (page 5 -12) provides a statement on the following for each of the key QIPP areas: a) description and rationale; b) savings target; c) impact of initiative on the four aspects of 'QIPP'; d) engagement completed and e) impact on patients. The below QIPP initiatives have been selected as they are of significant financial value, are programmes of redesign that will impact patients' experience of services and are initiatives led by the BSU/GP Commissioners who absorb the full risk for non-delivery:

   1. Outpatient redesign
   2. Emergency admissions/reablement programme
   3. PoLCE
   4. Urgent Care Centre
   5. SLaM Provider Efficiencies
   6. Support Service Contracts (Southside Home & Dry and Newpin)
   7. Primary Care Productivity

8. Further to the seven key initiatives above there are a further number of initiatives that were felt not to merit a detailed exposition in light of the principles set out in point 6. The below four tables that set out a summary description of groups of these other QIPP initiatives. The tables include a brief rationale as to why these initiatives were not considered to meet the above principles

Name of Group	**Contractually Secured Provider Productivity (Acute)**	
Summary description of Group of QIPP Initiatives	This group of QIPP initiatives are each associated with securing improvements in productivity with our key hospital trust providers Guy's & St Thomas' and King's College Hospital. The basis of these programmes is to target efficiency improvements in areas where local trusts' performance is outside of the London lower quartile. In these areas savings reflect the change required to move within the lower quartile benchmark. These efficiency programmes are delivered by each trust undertaking projects locally to enhance the productivity of their staff. This could take the form of the Medical Director working with service leads to reduce the number of follow-ups where patients could be returned to the care of their GP. It could also be the trust's chief pharmacist working with clinical teams in the trust to prescribe cost-effectively. In either instance the efficiency is generated from local changes in working practices. As such the risk for delivery for all the below initiatives sits with the hospital trusts and the trusts' start contracts secure savings for the commissioner.	
	QIPP Initiatives Included	Savings Target (£,000)
	Reduction in Outpatient Follow-Ups	£1,548
	Consultant-to-Consultant Referrals	£201
	Emergency Admissions (A&E Conversion Rates)	£690
	Excess Bed Days per Spell	£304
	30 Day Readmissions	£3,389
	Acute Prescribing & Medicines Management	£442
	Other Productivity & Efficiency Measures	£255
	Clinical Haematology (Paediatrics)	£228
	Other Guaranteed QIPP Savings	£1,258
Rationale for not presenting detail to OSC	Although significant in terms of financial benefit, the above initiatives are secured with associated savings 'in the bank' as of 1st April 2011. As contracted efficiencies, patients will not, in the main, notice any difference in the way services are provided. There will be work led by the trusts to support a repatriation of some patients to the care of their GP where this is appropriate, with other work seeking to reduce bed days where patients are awaiting discharge or an operation for example.	

Name of Group	**Provider Service Redesign (Acute)**	
Summary description of Group of QIPP Initiatives	The two small QIPP initiatives again refer to projects led by the acute trust agreed with commissioners across Lambeth, Southwark and Lewisham. The maternity project is associated with improving the coding of activity related to admissions for maternity episodes, thus not affecting the operational function of the service The plan to release £27k in Southwark as a result of the redesign of the Vasectomy and Termination of Pregnancy pathway will be achieved by shifting the proportion of both interventions completed at the hospitals, with more activity channelled to independent and voluntary sector providers where these providers are shown to provide the same quality of care to patients	
	QIPP Initiatives Included	Savings Target (£,000)
	Redesign of Maternity Pathway	£56
	Sexual Health (ToPs & Vasectomy)	£27
Rationale for not presenting detail to OSC	These initiatives have been secured in 2011/12 contracts with acute services. The ToPs and Vasectomy QIPP will see a greater use of existing non-acute providers delivering high-quality care under the NHS Contract at a lower tariff. The maternity initiative is associated with clinical coding rather than any change in pathway or provision. Initiatives are low value and relate to relative low activity levels. Equality Impact Assessment has been completed for Sexual Health QIPP initiatives	

Name of Group	**Non-Acute Services Contract Renegotiation**	
Summary description of Group of QIPP Initiatives	Each of the below initiatives have been achieved as commissioners renegotiated contracts with providers at a lower unit cost than 2010/11. For example, the SH & HIV Voluntary Sector QIPP has been delivered by negotiating a reduction in the tariff paid to a range of SH providers relative to 2010/11 contract values both within SEL and pan-London. Primary Care Prescribing achieves a benefit by the switching from branded to generic drugs as they come off patent along with other similar productivity measures. And funding to support GSF refers to the freezing of investment in end of lifer care at 2010/11 levels	
	QIPP Initiatives Included	Savings Target (£,000)
	Sexual Health (Voluntary Sector)	£162
	Substance Misuse	£50
	Community Services Efficiencies	£250
	Primary Care Prescribing	£1,063
	Funding to Support GSF in Nursing Homes & Primary Care	£200
	Mental Health Support Services Retendering	£123
Rationale for not presenting detail to OSC	The impact of tariff renegotiations on service received by patients is small. Commissioners assess and agree with providers the approach they will take to make efficiency savings and in this robustly seek assurances (enforced under contract monitoring) that performance and quality is maintained. The QIPP programmes are secured at the beginning of the financial year	

Name of Group	**Other Operational Efficiencies**	
Summary description of Group of QIPP Initiatives	These QIPP savings relate to efficiencies generated within Southwark BSU corporate expenditure. Management cost savings targets were issued for NHS commissioning organisations nationally with an organisational restructure completed ahead of April 2011. Estates savings will be made from the reduction in costs associated with maintaining two properties in the borough, both of which have not been in use for some time	
	QIPP Initiatives Included	Savings Target (£,000)
	Management Costs - Commissioner	£1,341
	Management Costs - Provider	£850
	Estates	£705
Rationale for not presenting detail to OSC	Management Cost Savings proposals have been presented to the Overview and Scrutiny Committee on a previous occasion. Estates costs relate to the net benefit of the disposal of St Giles and St Olave's community sites, which are currently unused	

1	Name of QIPP Initiative:	**GP-initiated 1st Outpatient Referrals (shift & decommissioning)**			
	Description of Initiative	There are two key parts to this QIPP initiative: the implementation of referral management for GP-initiated electronic referrals, and the commissioning of up to ten redesigned outpatient services delivered in settings closer to patients' homes A Choose and Book **Referral Management Service (RMS)** system is being established across both Lambeth and Southwark in collaboration with KCH and GSTT. This service will quality assure referrals initiated by Southwark GPs, directing non-urgent referrals to the most appropriate local service whilst not delaying referrals to secondary care We have invested on a spend-to-save basis to commission **outpatient services in a range of community settings**. In addition, support and training is being delivered locally to increase the ability of primary care providers to manage long term conditions in the community without referral to hospital. **Dissemination of clinical protocols** support the above referral pathways and GP Locality Leads work with practices to improve the quality of referrals to specialist care			
	Savings Target	£2,156k			
	'QIPP' Domains Supported	Quality	Innovation	Productivity	Prevention
		☑	☑	☑	
	How does this initiative support the above noted QIPP domains?	The initiative enhances the quality of clinical care available in General Practice by **investing in local education and training**, quality assuring referrals to ensure patients are seen in the most appropriate setting of care, and establishes community outpatients service in the community with significantly shorter waits than local hospital trusts RMS is an innovative approach to delivering the quality assurance of GP-initiated referrals as the BSU is working in partnership with Lambeth and King's Health Partners to deliver a **local solution** to the NHS-wide problem of variation in referral quality			
	What communication and engagement with patients has been completed?	The *Transforming Southwark's NHS* consultation was conducted in 2009. One of the areas of focus was planned care where local patients' indicated support for increasing the capacity of planned care available 'closer to home' (i.e. in a non-acute community or primary care setting). Following *Transforming Southwark* a workshop was established in each of the four Southwark localities to test these ideas and give local people an opportunity to shape the PCT's plans. Workshop output at http://www.southwarkpct.nhs.uk/about_us/transforming_southwarks_nhs Patients remain engaged with this QIPP area in the new engagement structure. Patient Participation Groups (PPGs) have been established at practice level, are represented at locality level and feed into commissioning decisions made at borough level via a Engagement & Patient Experience Group. This group is one of three sub-groups of the Southwark Clinical Commissioning Committee. This approach to engagement is designed to be a 'bottom-up' approach to garnering patient involvement, which also reflects GP Commissioner's engagement structure with constituent practices Communications with patients for new community outpatient services has been led by the BSU with patient information leaflets produced by the providers on a specialty basis. These leaflets have been made available to all practices and are sent to patients with their appointment confirmation. In addition, all contracts with community outpatient providers include a requirement for an annual patient experience survey to be completed			
	Impact of this initiative on patients	Once referred, patients will be contacted either by the trust or community outpatient service to arrange an appointment. In community services they will be able to **choose the location**, which best suits them (e.g. dermatology at Aylesbury, Elm Lodge (North Dulwich/Herne Hill); Dun Cow Surgery (Old Kent Rd); or Lister Health Centre (Peckham Rd). **Waiting times** in community services are typically 30% of waits in hospital (weeks not months)			

<table>
<tr><td>2</td><td>Name of QIPP Initiative:</td><td colspan="4">Emergency Admissions / Reablement</td></tr>
<tr><td></td><td>Description of Initiative</td><td colspan="4">This QIPP programme is being undertaken as a pilot in Q3 & Q4 2011/12. The approach is to invest in services which prevent admission to hospital and provide alternative mechanisms for effective management in the community of patients at risk of admission. The proposals have been generated by Lambeth and Southwark BSUs with the input of clinical commissioners, Social Services, KCH, GST Community Health Services, and the KHP Integrated Care Pilot.

Southwark has particularly high levels of admissions including high levels of admissions for ambulatory care sensitive conditions including:

• Congestive Heart Failure
• COPD
• Diabetes with complications
• Hypertension
• Pyelonephritis

The main components of the QIPP programme are:

Piloting of the Virtual Ward model in partnership with the Community Provider. There are two main elements to this service development: 1) Enhanced Rapid Response services, accessible both directly from GPs, community and via A&E/acute hospital referral. This service would involve the development of strengthened multi-disciplinary teams including social workers, physiotherapists and rehabilitation support workers as well as nurses, to provide a rapid response to patients who are assessed as needing a timely intervention to prevent admission including out-of-hours provision. 2) Virtual Ward - Risk stratification and early intervention - a multi-disciplinary team model, led by community matrons using risk stratification tools to identify patients at high risk of admission, and providing timely interventions to prevent admission.

Specialist respiratory nursing support to provide a hospital at home approach and support the management of COPD exacerbations at home

Social work resource to reflect the need to assess clients rapidly before admission rather than as part of discharge planning, social care staff aligned to A&E and to the admission avoidance services have been included

Equipment availability and rapid delivery service where rapid delivery of equipment on a same day basis will prevent an admission

Clinical Discharge co-ordination within acute providers to give improved case finding and discharge planning administration for patients after an unplanned admission

Night Owl Service with generic workers to respond to basic health, social or domestic needs overnight which would prevent patients requiring a health-care response or a possible A&E presentation</td></tr>
<tr><td></td><td>Savings Target</td><td>£711k</td><td colspan="3"></td></tr>
<tr><td></td><td rowspan="2">‘QIPP’ Domains Supported</td><td>Quality</td><td>Innovation</td><td>Productivity</td><td>Prevention</td></tr>
<tr><td></td><td>☑</td><td>☑</td><td>☑</td><td>☑</td></tr>
<tr><td></td><td>How does this initiative support the above noted QIPP domains?</td><td colspan="4">Reductions in incidents of admissions where possible for significantly better for patients. High quality and increasingly specialist care will be made available in community settings both in and out of hours. The service is built around the early identification and management of ambulatory care patients to support prevention of exacerbations and admissions</td></tr>
<tr><td></td><td>What communication and engagement with patients has been completed?</td><td colspan="4">The Transforming Southwark’s NHS consultation was conducted in 2009. One of the areas of focus was unscheduled care where local patients’ indicated support for the provision of increasing resources to prevent hospital admissions. Following Transforming Southwark a workshop was established in each of the four Southwark localities to test these ideas and give local people an opportunity to shape the PCT’s plans. Further details of the consultation and associated workshops http://www.southwarkpct.nhs.uk/about_us/transforming_southwarks_nhs</td></tr>
<tr><td></td><td>Impact of this initiative on patients</td><td colspan="4">The key impact is planned to be improved outcomes for patients using the admissions avoidance service. Improvement in patients’ ability to self–manage and meet their health care requirements in their home or within a community setting in a range of LTCs including diabetes and COPD. The evidence on the above mentioned schemes show improved patient outcomes in both the short and longer term</td></tr>
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3	Name of QIPP Initiative:	**Procedures of Limited Clinical Effectiveness (PoLCE)**			
	Description of Initiative	Commissioning Support for London (CSL) worked with Dr Foster to identify procedures carried out in hospitals that may have **limited clinical effectiveness**. They concluded that 41 potentially ineffective procedures were identified, falling into four distinct groups: 1. Relatively **ineffective procedures** 2. Potentially **cosmetic interventions** 3. Effective interventions with a **close benefit/risk balance** in mild cases 4. Effective interventions where **cost effective alternatives** should be tried first For many years Southwark has used the long established South East London Treatment Access Policy. This policy defines procedures where there is limited evidence of effectiveness or the conditions under which their use might be appropriate for patients. This was reviewed in the light of the PoLCE work done by London and the policy has now been revised to include the further procedures with criteria for access. The updated policy has been approved by Southwark GP Clinical Leads and the PCT Board This initiative has been secured in acute contracts with GST and KCH to reflect those procedures where restrictions apply under the SEL Treatment Access Policy. Although these savings have been contractually secured, commissioners are responsible for reviewing activity and managing variation from the agreed policy and contract			
	Savings Target	£452k			
	'QIPP' Domains Supported	Quality	Innovation	Productivity	Prevention
				☑	☑
	How does this initiative support the above noted QIPP domains?	The initiative recognises that expenditure must be focussed only on procedures where a **robust evidence base exists** to demonstrate the clinical benefits of a procedure. Where this evidence base does not support intervention. Where this evidence base does not support intervention, the procedure should not be funded, or it will only be funded for certain categories of patients. This may **support improving clinical practice** across the local area			
	What communication and engagement with patients has been completed?	In October 2009 a stakeholder workshop was conducted to review the Southwark Prioritisation Policy. This policy included criteria for access to some procedures of limited clinical effectiveness, which reflected the South East London Treatment Access Policy. This stakeholder engagement included **input from public and patient groups** LiNK and Community Action Southwark, with the policy signed-off by the PCT Board in January 2010			
	Impact of this initiative on patients	Implementing the expanded SEL Treatment Access Policy means that patients will not undergo surgical procedures which bring little or no clinical benefit to that individual. The policy defines which types of patients can have access and the criteria that apply for payment for procedures. It also specifies where prior approval is sought for procedures and where hospital can notify the NHS after the procedure has taken place. There is a panel that assesses applications for patients who fall outside these criteria, to assess whether they can be funded as an exception. There is also an appeals process.			

4	Name of QIPP Initiative:	**Urgent Care Centre – redesign of A&E Front-end**			
	Description of Initiative	Annual increases in A&E attendance exert significant financial and operational pressures on departments in London. Evidence shows that a significant number of A&E attendees could receive treatment delivered by clinicians in other more appropriate settings of care. The aim of this initiative is to ensure that where patients have a need for unscheduled care, they are seen by the right clinician in the right place Southwark is leading on the procurement of three Urgent Care Centres at Guy's Minor Injuries Unit and the front ends of and at Kings and St Thomas' A&E. The latter is a joint programmes of work with Lambeth BSU Procurement of UCCs is reflected in the SEL Cluster Integrated Plan and is a key component of our commissioning intentions for unscheduled care. It has strong support from our lead GPs and is scheduled to give a significant financial benefit to commissioners, whilst **meeting a demand for unscheduled care that need not attend A&E** The UCC developments will be overseen by the Lambeth and Southwark Unscheduled Care Programme Board, chaired by the Managing Director of Lambeth BSU on behalf of both boroughs. That Board reports to the Local Clinical Commissioning Committees of both boroughs, as formal committees of the PCT Boards.			
	Savings Target	£38k			
	'QIPP' Domains Supported	Quality	Innovation	Productivity	Prevention
				☑	☑
	How does this initiative support the above noted QIPP domains?	Urgent Care Centre **tariff is significantly cheaper** than charges incurred in A&E departments. Expanding UCC provision will also reduce pressure on main A&E departments, supporting trusts to **reduce waiting times for attendees** and in the achievement of national performance targets In addition to providing urgent primary care within the UCC to patients that require same day attention, the UCC will be responsible for active and **supported redirection of patients** back to the community for primary care needs. This is to ensure that long term primary care needs are supported in the most clinically appropriate and also cost effective manner. In **supporting patients to contact/register with local GPs**, commissioners hope to gather feedback on the accessibility of general practice and use this information as a further driver for **improving Primary Care performance**, access and quality of care for patients			
	What communication and engagement with patients has been completed?	An audit of primary care attendances at A&E and a subsequent patient survey was completed in North Southwark in 2008 – providing commissioners with an insight into the reasons that patients attend A&E with primary care needs. The A&E audit also includes a patient experience survey, the results of which will be used inform the contract requirements for the planned UCCs			
	Impact of this initiative on patients	Improved patient streaming and response to patient's needs so that patients can be seen by the right health professional. Patients with minor conditions will be treated by primary care professionals in a timely manner and will be given advice, information and support to access appropriate services for future needs. UCCs will also work closely with Southwark practices to support patients to register with a GP and to use their services. Streaming of minor patients to the UCC will **reduce pressure on A&E specialist resources**. Patients with conditions requiring A&E care should thus be seen with less wait manner.			

5	Name of QIPP Initiative:	**Primary Care Productivity Programme**			
	Description of Initiative	This area of saving is in large part derived from the changes in general practice contracts and payments, some of which are nationally determined and some that are more local The vast majority (£1m) of the savings associated with this QIPP area have been achieved through a programme of **decommissioning of previously established enhanced services and projects that had attracted additional funding and are now delivered as part of core work in general practice. Commissioners and the representative committee for the profession locally have also been able to negotiate reduced levels of payment for specific areas of work. These areas were agreed prior to the start of the financial year and have been included in contracts and start budgets.** A smaller but significant proportion of savings (circ £200k) is associated with the likely outcome of contract reviews and tendering for five specific practices in Southwark. Three of these practice contracts end in-year and will be re-tendered with a clear expectation of achieving a higher value for money in new contracts. The other two contracts are subject to performance reviews that are likely to result in the termination of the contracts and re-tendering, again with a view to achieve a higher value for money.			
	Savings Target	£1,200k			
	'QIPP' Domains Supported	Quality	Innovation	Productivity	Prevention
		☑		☑	
	How does this initiative support the above noted QIPP domains?	As the BSU and SEL Sector focuses on **commissioning only the most effective enhanced s**ervices, we expect practices to achieve positive outcomes in these areas, whilst delivering commissioning efficiencies. The quality of primary care providers will be improved in the re-tendering exercise.			
	What communication and engagement with patients has been completed?	Engagement has not occurred around the routine alternation of national or local elements of contracting as the changes do not relate to a change in service but rather the level of incentivisation or remuneration associated with it. As practices are re-tendered across the year a very clear engagement plan will be implemented within those local communities that are impacted upon.			
	Impact of this initiative on patients	This QIPP initiative relates primarily to the agreement between Southwark BSU and the Local Medical Committee on a programme of efficiencies in Primary Care. Southwark patients will **benefit from improvements in the quality of Primary Care** established at the conclusion of the re-tendering exercise			

<table>
<tr><td>6</td><td>Name of QIPP Initiative:</td><td colspan="4">SLaM Provider Efficiencies & CAMHS/Mental Health</td></tr>
<tr><td></td><td>Description of Initiative</td><td colspan="4">NHS Southwark/Southwark BSU and SLaM have agreed to jointly manage a two-year programme of change to deliver £2.26m of annual savings across services within Adult Mental Health (AMH), Specialist, Mental Health of Older Adults (MHOA), Mental Health in Learning Disability (MHLD) and Child and Adolescent Mental Health Services (CAMHS). The programme of change focuses on delivering quality interventions as part of improved and cost-effective patient pathways, achieved by service redesign, synergy of provision, reduction of activity by enhancing the provision of effective recovery services, delivering care out of hospital and specialist settings and de-commissioning clinically unnecessary activity. The following sections identify the key areas of proposed savings in greater detail:

Redesigning Community Mental Health Team (CMHT): SLaM clinical teams to work with patients in order to change the care arrangements for those patients for which it is clinically suitable to do so. The focus on this work is to deliver services with an enhanced focus on support and recovery, allowing more people to live increasingly independently. The outcome of this will be that fewer people will be retained long-term on CMHT caseloads.

Community Mental Health Team facility on Walworth Road, which is in a poor condition. Reduction in this estate and re-investment in other mental health services.

Rationalising Intake and Assertive Outreach, which involves changing the provision of 'assertive outreach', which is currently delivered by a designated team in SLaM across a range of commissioned areas. Work will be undertaken to review this team's caseload with a schedule to transfer management of outreach to the specialist support and recovery teams. These teams will incorporate outreach as part of their ongoing duties and in this will be in a position to provide specialist input to outreach work

Reducing Length of Stay (LoS) with a programme to deliver a greater proportion of care in primary care and decommission the work from SLaM. The work encompasses demand management; reduces duplication and delivers the rationalisation of the care pathway for mental health patients from primary care into secondary care. The over-arching approach is to develop, in collaboration with GPs, an episodic model of care with patients referred back to the care of their GP and managed out of hospital. SLaM specialists will remain centrally involved in patients' care through their ongoing support to GPs and other professionals managing patients in the community

Rationalising Counselling to invest in the national priority Improving Access to Psychological Therapies (IAPT) programme. There is a strong evidence base for IAPT delivering better outcomes for patients and in commissioning an extension of IAPT in place of other counselling services, the BSU is able to enhance quality and reduce investments in less effective provision

Out-of-area provision for CAMHS placements of adolescents admitted with an emerging personality disorder with the proposal to deliver care to this patient cohort using Dialectic Behavioural Therapy (DBT) that SLaM are now able to deliver in the community. DBT has had great success in the USA in preventing these sort of admissions for adolescents with emerging personality disorders and, when admission has proved necessary, in substantially reducing lengths of stay. SLaM aim be able to profile the saving opportunity that can be delivered to the PCT next year now this service is up and running.</td></tr>
<tr><td></td><td>Savings Target</td><td>£1,561k + £700k</td><td colspan="3"></td></tr>
<tr><td></td><td rowspan="2">'QIPP' Domains Supported</td><td>Quality</td><td>Innovation</td><td>Productivity</td><td>Prevention</td></tr>
<tr><td></td><td>☑</td><td>☑</td><td>☑</td><td>☑</td></tr>
<tr><td></td><td>How does this initiative support the above noted QIPP domains?</td><td colspan="4">Improvement in patient outcomes with lower length of stay wherever possible and increasing management of clients in a community or primary care setting, supported by enhanced clinical skill-mix.</td></tr>
<tr><td></td><td>What communication and engagement with patients has been completed?</td><td colspan="4">Southwark ran a stakeholder event on the above areas of redesign in August 2010. This workshop was followed by a specific user event held in 19 October 2010. The purpose of the day was to inform users and carers of how and how services are changing, to listen to their views, to learn about the role of the GP in mental health care and answer questions. Mental Health Commissioners continue to engage with patients at monthly MIND User Council meetings and through the Mental Health Partnership Board, which include user representation. Engagement work has continued this year, with a stakeholder engagement workshop in July 2011 run to engage groups, including service users, to shape priorities and 12/13 QIPP plans</td></tr>
<tr><td></td><td>Impact of this initiative on patients</td><td colspan="4">The Mental Health QIPP has been designed in partnership with SLaM to achieve financial savings by enhancing the quality of care received by patients. With SLaM clinicians working closely with GPs and community teams, patients are increasingly able to access quality care outside of SLaM facilities. Enhanced IAPT provision increases the quality of service in this area with the evidence suggesting improved outcomes to patients in this programme. To support the work on reducing length of stay and in CAMHS placements, we have shifted investment to models of care that support recovery, which focus more intently of improving the quality of service users' lives</td></tr>
</table>

7	Name of QIPP Initiative:	**Southside Home & Dry and Newpin Family Welfare Association**			
	Description of Initiative	This is joint programme of work to deliver efficiencies from contracts with providers in mental health. This includes the cancellation of two contracts for support: Southside Home & Dry (£0.08m) and Newpin (£0.06m). These initiatives are been delivered for April 2011 in full as services have been decommissioned ahead of the beginning of this financial year.			
	Savings Target	£143k			
	'QIPP' Domains Supported	Quality	Innovation	Productivity	Prevention
				☑	
	How does this initiative support the above noted QIPP domains?	**Termination of non-statutory ser**vices, where BSU officers have assurances that some alternative provision is available where services are being withdrawn. Part of the decision to decommission these services was the lack of quantitative evidence that provision consistently offered enhanced patient outcomes			
	What communication and engagement with patients has been completed?	Notice was served via providers to terminate contracts			
	Impact of this initiative on patients	Alternative provision available			

Annex 1. Southwark QIPP Programme 2011/12

Southwark BSU QIPP Initiatives	2011/12 (£)	Lead Director	Lead GP
Reduction in outpatient follow ups	1,548,000	Tamsin Hooton	Dr Zeineldine
New OP referrals (GP) - decommissioning	608,180	Tamsin Hooton	Dr Zeineldine
New OP referrals (GP) - shift	1,546,325	Tamsin Hooton	Dr Zeineldine
Consultant-to-Consultant referrals	201,000	Tamsin Hooton	Dr Zeineldine
Reduce A&E attendance	99,000	Tamsin Hooton	Dr Holden
Emergency admissions / re-ablement	711,000	Tamsin Hooton	Dr Holden
Emergency admissions (A&E conversion rates)	690,000	Tamsin Hooton	Dr Holden
Excess bed days per spell	304,000	Tamsin Hooton	Dr Zeineldine
30 day re-admissions	3,388,541	Tamsin Hooton	Dr Holden
PoLCE	452,000	Tamsin Hooton	Dr Zeineldine
Acute prescribing and medicines management	442,000	Tamsin Hooton	Dr Ashworth
Other productivity & efficiency measures	255,000	Tamsin Hooton	Dr Zeineldine
Redesign of maternity pathway	56,000	Tamsin Hooton	Dr Cliffe
Sexual health - voluntary sector budget	162,474	Tamsin Hooton	Dr Heaversedge
Sexual health - ToPS & vascetomies	27,000	Tamsin Hooton	Dr Heaversedge
Urgent Care Centre – redesign of A&E front end	38,000	Tamsin Hooton	Dr Holden
Clinical Haematology (Paediatrics)	228,000	Tamsin Hooton	Dr Zeineldine
QIPP shortfall covered from acute budgets	1,258,000	Malcolm Hines	Dr Fradd
Acute QIPP Initiatives Total	**12,014,520**		
Primary Care Productivity Programme	1,200,000	Andrew Bland	N/A
Funding to support GSF in care Homes & primary Care	200,000	Malcolm Hines	Dr Bradford
SLaM provider efficiencies	1,561,000	Gwen Kennedy	Dr Durston
CAMHS/Mental health	700,000	Gwen Kennedy	Dr Durston
Mental health community support service retendering	123,000	Gwen Kennedy	Dr Durston
Cancel Southside Home & Dry Contract	84,000	Gwen Kennedy	Dr Durston
Newpin (Family Welfare Association)	62,908	Gwen Kennedy	Dr Durston
Substance misuse	50,000	Gwen Kennedy	Dr Durston
Primary Care Prescribing Programme	1,063,000	Tamsin Hooton	Dr Ashworth
Estates Optimisation Programme	705,465	Malcolm Hines	Dr Fradd
Community Services savings	250,000	Tamsin Hooton	Dr Heaversedge
Management cost savings - commissioner	1,341,000	Malcolm Hines	Dr Fradd
Management cost savings - provider	850,000	Malcolm Hines	Dr Fradd
Non-Acute QIPP Initiatives Total	**8,190,373**		
QIPP Initiatives (gross)	**20,204,893**		

South East London

Southwark Clinical Commissioning Committee & Southwark BSU

Conflicts of Interest Approach for Clinical Commissioning Pathfinders

Southwark Council Overview & Scrutiny Committee

A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

Context

1. As they develop and move from 'leadership of' to 'accountability for' commissioning activities Clinical Commissioning Groups (CCGs) will need clear and robust mechanisms for managing conflicts of interest. This briefing and the attached papers seek to provide an update on the approach and guidance developed for this area in South East London and for Southwark in particular. The documentation provided here seeks to describe arrangements for the transition period ahead of any formal authorisation of CCGs in the future, pending legislation. As part of that authorisation we expect further national guidance on the management of this critical area.

2. In December 2010 Southwark Health Commissioning (SHC), a consortium (now referred to as CCG) of all Southwark practices was awarded first wave Pathfinder status for clinically led commissioning. The establishment of Pathfinders across the country was an arrangement that sought to provide groups of clinicians with the opportunity to test new ways of working as outlined by the White Paper published early that year.

3. As a Pathfinder SHC have worked with the Southwark Business Support Unit (BSU) to lead the commissioning process and to develop a Pathfinder Delivery Plan which outlines the points at which, during the transition period running to April 2013, local clinicians would take on delegated responsibility for commissioning areas prior to receiving any accountability for that commissioning. As a Pathfinder, SHC worked with commissioners and provided clinical leadership to the process. As Pathfinders with 'Delegated Responsibility' from the PCT Board they would be responsible for commissioning budgets. Once they are authorised they would become accountable to the NHS Commissioning Board for these areas.

4. The SHC Pathfinder Delivery Plan was submitted for consideration in June 2011 and the outcome of that application will be known in September 2011. SHC has already received the recommendation of the PCT Board to proceed with its plan but final approval is required from NHS London, the Strategic Health Authority. Any delegation would be managed and governed through the Southwark Clinical Commissioning Committee (SCCC), a committee of the PCT Board that has been established formally since May 2011 (but has met in Shadow form for some time). The terms of reference for the committee are attached as **Appendix B**, this is a clinically led group with BSU Executive and Non-Executive membership in addition to Southwark LINk representation. Clinicians have the majority voting rights and the committee is chaired by a GP, Dr Amr Zeineldine.

5. SHC's plan, when approved would transfer responsibility to the Pathfinder in three phases (previously reported to the OSC) each being approximately equivalent to one third of the overall PCT budget. The first phase would be in September 2011, the second in November / December 2011 and the third in January 2012. This will provide SHC will more than 12 months opportunity to hold delegated responsibility, supported by the BSU, before seeking formal authorisation. It is for this period specifically, and in reality since April 2011, that the current conflicts of interest guidance is applicable.

Managing Conflicts of Interest

6. Two documents are appended to this briefing. The first (**Appendix A**) is the NHS South East London Pathfinder / LCCC Conflict of Interest Guidance (due to be adopted formally in September 2011) and the second (**Appendix B**) is the terms of reference for the Southwark Clinical Commissioning Committee.

7. **Appendix A** provides details of the full guidance that will be followed in the six boroughs that make up NHS South East London. Although this document is yet to be formally adopted SHC have ensured that all requirements in the document have been established for the SCCC since its formal establishment in May 2011. Specifically the SCCC, as a committee of the Board, has adopted the Nolan Principles of Public Life; a register

of members' interests has been created and is publically available; declarations of interest a standing agenda item for all meetings and they, along with the register are minuted and accepted by each meeting.

8. The SCCC has two PCT Non Executive Director members and one of those members, Richard Gibbs, has been formally identified as the Southwark Champion or Guardian for Conflicts of Interest and their management and he specifically advises the committee in its management of this area.

9. **Appendix B** provides the terms of reference for the SCCC. These are aligned to the NHS South East London guidance and describe the specific Southwark arrangements. In particular, Appendix C of that document provides the SCCC's approach to conflicts of interest.

South East London

Pathfinder / LCCC Conflict of Interest Guidance

1. Introduction

1.1 As they develop, Clinical Commissioning Groups (CCGs) will need clear and robust mechanisms for managing real and perceived conflicts of interest. If they are not managed effectively, confidence in the probity of commissioning decisions and the integrity of the clinicians involved could be seriously undermined, but with good planning and sound governance clinical commissioners should be able to avoid these risks.

1.2 The requirements outlined in this paper apply to, but are not limited to, all Pathfinder Board members (and therefore by extension the Local Clinical Commissioning Committees' membership operating as committees of NHS SEL Boards) and any working groups or Pathfinder staff members (jointly referred to as "members" in this document).

2. Guiding Principles

2.1 Conflicts of Interest

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.

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.

2.2 Standing orders

The policy for the declaration and management of conflicts of interest is

as set out in the NHS South East London Standing Orders/Standing Financial Instructions/Scheme of Delegation (excerpts set out in 'what to declare' section).

This document summarises the arrangements regarding declaration and management of conflicts of interest in the context of the establishment of GP Pathfinders and of Committees of the Joint Boards for the purpose of delegation of commissioning functions to Pathfinders (or their successor bodies). However, for the avoidance of doubt, and in the case of any query or matter of detail, the NHS South East London Standing Orders take precedence.

Members must also comply with the Standards of Business Conduct for NHS Staff, the NHS Code of Conduct for NHS Managers 2002 and the ABPI Code of Professional Conduct relating hospitality/gifts from pharmaceutical/external industry and should also take account of the GPC Guidance and The Principles of GP Commissioning. The NHS SEL Boards have also adopted the Nolan Principles of Public Life which describe the values and behaviours transcending such codes, policies and principles may be applicable. The Boards commend these principles to the emergent pathfinders.

3. Implementing the Principles

3.1 Register of Interests

Members are required to declare interests which are relevant and material to the Committee/s of which they are a member. All existing members should declare such interests; any members appointed subsequently should do so on appointment. Any new interests or changes to interests arising during the year should be declared as and when they arise.

Each Clinical Commissioning Committee will establish a Register of Interests, which will be held by the Committee and reported to the NHS South East London governance team to form part of the overall NHS SEL Register of Interests which will be available publically. This register will be accepted and minuted at a meeting of the Pathfinder Clinical Commissioning Committee. The register will be updated as required during the year and reviewed in full annually. The register of interests will be published in the respective Care Trust or PCT's annual report and be available on the website. (An indicative pro forma is attached as Appendix 1)

3.2 Declarations of Interest at Meetings

Committee members will be expected to declare any relevant interests at the start of each meeting or for agenda items as they arise (indicative pro forma is attached as appendix 2). Depending on the nature of the

interest they may present their views on the subject but not be part of any vote, or where appropriate in line with Standing Orders will play no part in the discussion or decision or absent themselves from the meeting for that item (by leaving the room for the discussion and decision, for example). The overriding principle guiding such considerations should be to ensure that both the affected individual's conduct and any decisions taken by the committee are beyond reproach.

Where appropriate, due to the nature of the conflict of interest, agenda items or related papers in draft or final form will not be shared with the Committee member. Decisions regarding this will generally be taken by the Chair of the Committee in consultation with the Business Support Unit (BSU) Managing Director, or where it concerns the Chair of the Committee or BSU Managing Director, by a Non-Executive member of the Committee in consultation with the Chair/BSU Managing Director or another member of the committee who does not have a conflict of interest.

Note: Standing orders should be referred to regarding the very specific conditions for application by the Chair of the waiver in relation to the disability to participate in respect of healthcare professionals.

Where the withdrawal of the member has the effect of making the meeting inquorate, the Chair will decide whether to adjourn the meeting to permit the attendance of other members at another date or whether to proceed with the discussion in order to make a recommendation subject to ratification at a future quorate meeting, or at the Joint Boards.

4. Procurement and areas of significant conflict of interest

4.1 All procurement and contracting must comply with EU law and best practice across NHS South East London, which includes obligations in respect of openness, transparency, equality and non-discrimination.

4.2 NHS South East London is considering the establishment of a procurement panel to oversee all decisions on procurement routes for contracts in excess of £50k and approve the administrative arrangements for the procurement, where a significant proportion of clinical commissioners have a conflict of interest.

4.3 Where a significant proportion of the Committee members have a specific conflict of interest in a particular proposal or contract, the Committee would remit any related process (e.g. tendering) to this group albeit that the matter is within the Committee's delegated responsibility.

4.4 In all circumstances where a 'procurement' is being discussed any member with a conflict of interest will be required to absent themselves from the meeting.

5. Monitoring and Review

5.1 Pathfinders and BSU Managing Directors will establish local proportionate arrangements for monitoring declarations of interest (advising the SEL central governance team of any updates / amendments) and audit of the arrangements will overseen by the South East London Director of Finance.

5.2 NHS South East London may also request internal auditors undertake a review of declarations of interest including members of Local Clinical Commissioning Committees and GP Pathfinder Boards.

6. What to declare

6.1 Members are required to declare any relevant and material personal or business interests or positions of influence for themselves and any relevant and material personal or business interests or positions of influence of people connected with them which may influence or be perceived to influence their judgment.

6.2 These are listed within the NHS SEL Standing Orders as interests which are relevant and material:

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management (and any relevant company included in this fund that has a potential relationship with a PCT/Care Trust must be declared.)

h) Practice Based Commissioning

(ii) Any Member of the Joint Boards, or individual PCT/Care Trust Board or Local Commissioning Committee who comes to know that a PCT/Care Trust or Local Commissioning Committee has entered into or proposes to enter into a contract in which he or any person connected with him (as defined in Standing Order 8.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member or Local Commissioning Committee member shall declare his/her interest by giving notice in writing of such fact to the Director of Corporate Affairs as soon as practicable.

7. Related Parties

7.1 For this purpose, a person connected may include the following and other persons where the connection could be deemed to be such as to influence a decision or an individual:

- Spouse (including civil partner);
- Cohabitee;
- Child;
- Parent;
- Sibling.

7.2 For professional members of the Committees a relevant and material interest may include such interests relating to members of their Practice Partnership. Interests that should be deemed to be relevant and material include:

- Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- Partnership or employment in a professional partnership (whether salaried or profit sharing);
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
- A position of authority (eg employee or trustee) in a charity or voluntary or social enterprise organisation in the field of health and social care;
- Any connection with a voluntary or other organisation contracting for NHS services;
- Research funding/grants that may be received by an individual or their department or by their Pathfinder (CCG), or by their Practice;
- Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with any of the PCTs must be declared);
- Any interests that arise from any joint working arrangements, or similar, such as with the local authority;

- Any interest that they (if they are registered with the General Medical Council) would be required to declare in accordance with paragraph 55 of the GMC's publication Management for Doctors or any successor guidance;
- Any interest that they (if they are registered with the Nursing and Midwifery Council) would be required to declare in accordance with paragraph 7 of the NMC's publication Code of Professional Conduct or any successor code.

8. Failure to Declare

8.1 An unwitting failure to declare a relevant and material interest or position of influence and/or to record a relevant and material interest or position of influence that has been declared may, but will not necessarily, render void any decision made by the Board or its properly constituted sub committees.

8.2 The PCT Board will reserve the right to declare such a contract void. In any event the Committee member or employee affected will be required to declare any benefit he or she or person connected with them received under the contract in the Register of Interests.

8.3 Any conscious or deliberate failure to declare a relevant or material interest or position of influence will be addressed through the relevant performance or disciplinary routes.

Appendix one

DECLARATION OF PERSONAL AND FINANCIAL INTERESTS – BOARD MEMBER / DIRECTOR / LCCC MEMBER

1 I wish to declare that I, or a close relative or associate, hold the following directorships, appointments, and/or significant and financial interests in the business, companies, public sector organisations, other NHS bodies and/or voluntary organisations which may contract with the business of NHS South East London

i Company/Organisation ……………………………

Personal interest (give details)

Position held ………………………………………

Shareholding (if any) …………………………….

Is remuneration paid? ……………………………

ii Company/Organisation ……………………………

Personal interest (give details)

Position held ………………………………………

Shareholding (if any) …………………………….

Is remuneration paid? ……………………………

iii Company/Organisation ……………………………

Personal interest (give details)

Position held ………………………………………

Shareholding (if any) …………………………….

Is remuneration paid? ……………………………

[Enter “Nil” if appropriate. Continue on a separate sheet if necessary]

PLEASE TURN OVER

2 I wish to declare the following directorships and/or other significant interests not covered above:

3 I wish to declare that I have received the following gifts, hospitality and sponsorships (excluding items of low intrinsic value):

Signed ………………………………………………….. Date ………………………

(Please sign here in all cases, including nil returns)

Name (Block Capitals please) ……………………………….

Appendix two

NHS xxxxx PATHFINDER BOARD
E.g. Xday XXth XXmonthXX 2012, 3.00pm-6.00pm, at the XXXXX

BOARD MEMBERS ONLY
ATTENDANCE/DECLARATION OF INTERESTS* SHEET

NAME	DECLARATION	SIGNATURE

*All Board members and senior employees of NHS SEL have the legal obligation to act in the best interests of each of the SEL PCTs and Care Trusts in line with their delegations. Public service values matter in the NHS and those working in it have a duty to conduct NHS business with probity. All Board members and senior employees are therefore expected to declare any personal or business interest which may influence, or may be perceived to influence, their judgement. This should include as a minimum, personal, direct or indirect financial interests

TERMS OF REFERENCE
Southwark Clinical Commissioning Committee

1. Introduction / Purpose / Constitution

1.1 In South East London the statutory functions of the six current PCT/ Care Trust Boards will be fulfilled by the six boards operating jointly. Within these arrangements each Board will establish borough based Local Clinical Commissioning Committees (LCCCs) as formal sub-committees that have delegated responsibility for local commissioning budgets. In Southwark this LCCC will be known as the Southwark Clinical Commissioning Committee (SCCC).

1.2 The SCCC will establish with the Joint Boards (hereafter referred to as the PCT Board, as the NHS Southwark Board remains the legal entity of the transition period) the areas that it will be commissioning for and will have formal agreement of the commissioning resource envelope for which it is responsible. This commissioning envelope will be based upon the areas that GP Commissioners are awarded 'Delegated Responsibility' for in advance of GP Commissioning Consortia becoming statutory bodies in April 2013. As such, this commissioning envelope will increase over time as local GP Commissioners move closer to fulfilling the requirements of full GP Consortia status.

1.3 Over the transition period it is essential that local decision making should support ownership, understanding and engagement of local clinicians and that as much business as possible should be delegated to the LCCCs.

1.4 Appendix A (below) outlines those areas that can be delegated by PCT/ Care Trust Boards to LCCCs and an agreed scheme of delegation will outline how many of these functions are delegated to the SCCC and within what timeframe.

1.5 Appendix B (below) details those areas that cannot be delegated by PCT/ Care Trust Boards[1].

2. Duties/ Roles and Responsibilities

2.1 In December 2010 Southwark Health was established as a GP Commissioning Consortium and was awarded First Wave Pathfinder

[1] Whilst it is not anticipated that these areas would be delegated, LCCC's would be expected to undertake the significant majority of the planning, monitoring and assurance gathering that will enable PCT Board to undertake these functions.

Status within the NHS London development programme. This consortium is currently co-terminus with the current PCT boundaries and comprises all general practice in Southwark. At the same time the PCT Board delegated commissioning responsibility for a limited number of areas to the then Clinical Commissioning Board.

2.2 Southwark Health will seek to achieve ‘Delegated Responsibility’, under the new NHS London arrangements for this area, for 30% of the current PCT commissioning budget in quarter one of 2011/12 and will seek to agree a trajectory of increasing ‘Delegated Responsibility’ across the transition period with the PCT Board.

2.3 The terms of reference outlined below describe the remit and functions of this PCT Board committee and assumes that ‘Delegated Responsibility’ will be granted and increased over time.

2.4 The SCCC will undertake the following roles:

- To develop and ensure the implementation of local commissioning plans, aligned to the Sector strategy, ensuring value for money services are commissioned that best meet the needs of local people
- Ensure that local commissioning follows a clear policy framework that incorporates national guidance and takes account of local priorities
- Review, assess and make recommendations on commissioning and provider proposals for service delivery in the locality
- Provide guidance on clinical governance requirements to GP practices and other organisations that develop business cases as an alternative provider of services
- Assume the duty to consult local Overview & Scrutiny Committees on proposals for substantial developments or variations in local health service and carry out responsibilities to consult and engage patients as outlined in the Local Government and Public Involvement Act 2007 and other legislation in force.

2.5 The Committee is a decision-making body of the PCT Board and will be delegated responsibility for commissioning services within Southwark to ensure that:

- Through strategic leadership, NHS Southwark delivers on its statutory duty to secure the best possible services for the local population within the allocated budget.
- Services commissioned take account of the needs of the local population and aim to improve the health and well-being of local people, reduce health inequalities and provide choice.
- The annual Operating/Business Plan reflects the strategic objectives of the Commissioning Strategy Plan.
- Services commissioned deliver quality and value for money

- Commissioning and joint commissioning are developed, to enable the GP consortium to take on the commissioning responsibilities in accordance with any changes effected through legislation.
- Pathways are redesigned to deliver services closer to home, in line with clinical governance guidelines and delivered by a range of providers.
- Southwark contributes to Cluster Commissioning arrangements.
- There is active engagement with Southwark Local Involvement Network and other patient and user groups.

3. Accountability

3.1 The committee will be responsible for the day-to-day commissioning of the Trust and will operate within a scheme of delegation, accountable to the PCT Board for an agreed commissioning budget. Significantly the committee will perform the statutory functions of the PCT's Professional Executive Committee (PEC) and will be responsible for developing and recommending a commissioning plan that meets the health needs of local people to the PCT Board annually.

3.2 The remit of the SCCC is as follows:

- To be responsible for developing local commissioning strategies and plans, maximising health gain for the resources spent and delivery and performance against plans
- To oversee and direct the operation of the Southwark borough based Business Support Unit (BSU)
- To be accountable for the delivery of strategic and operational delivery within those areas of 'Delegated Responsibility' to the GP Commissioning Consortium, Southwark Health
- To undertake the significant majority of the planning, monitoring and assurance gathering that will enable PCT Board to undertake those commissioning functions that are not delegated to the SCCC.
- To hold those South East London Sector functional areas, managed by shared business services lines, to account for the delivery commissioning support to the consortium and local BSU commissioners.

4. Committee Membership

4.1 Membership of the committee will comprise the Southwark Health's eight mandated GP Commissioning leads, executives of the Southwark BSU, non-executive directors of the PCT Board, the Southwark Director of Public Health and a Southwark LINk representative.

4.2 The SCCC will be chaired by the Chair of the Southwark Health GP Commissioning Consortium (and PEC Chair) and the specific membership is outlined below:

Members with voting rights:

- Eight GP Clinical Commissioning leads (including a Chair)
- Two Non-Executive Director of the PCT Board[2]
- One Nurse
- Managing Director, Southwark BSU
- Director of Finance and Business, Southwark BSU
- Southwark Director of Public Health (and Health & Well Being Board representative)

4.3 Non voting members:

- Director of Joint Commissioning and Partnership, Southwark BSU
- Director of Acute and Community Commissioning, Southwark BSU
- Southwark LINk representative (Speaking rights only)
- Southwark Local Medical Committee Chair (Speaking rights only)
- Additional local authority representation may be identified

4.4 Other BSU senior managers will be expected to attend meetings in accordance with the annual programme of work and in line with reporting requirements of the defined business cycle. The Committee may co-opt further persons with relevant experience and expertise where it considers this necessary.

4.5 The SCCC Chair, the Non Executive Director of the PCT and the Managing Director of the BSU are all members of the PCT Board.

5. Reporting Arrangements and supporting structures

5.1 The SCCC will report to the PCT Board. The minutes of Committee meetings and committee decisions shall be formally recorded and submitted to that body. These documents will be made available on the PCT's public website.

5.2 The business cycle for the SCCC will be fully aligned with the business cycle of the PCT Boards.

The SCCC will undertake its functions through a series of local sub-committees and groups. The following sub-groups are proposed:

- Integrated Governance Group
- QIPP Delivery Group
- Engagement and Patient Experience Group

[2] Will share a vote

The membership of each sub-committee will include a GP Commissioning lead and the relevant members of the Southwark BSU and South East London Cluster functional directorates.

6. Quorum rules

A Quorum shall be one BSU Executive Director, four GP Clinical Commissioning Leads and either one of the NEDs or the Director of Public Health.

Decision making;

The SCCC will seek to make decision by consensus and agreement of its membership. Where decisions can not be made by consensus the SCCC will take decisions by vote and will approve decisions by majority of those members with voting rights. In the event of a ‘tie’ the Chair will hold the casting vote.

GP Clinical Commissioning leads have been selected / elected by constituent practices across the borough. The nurse member will also be appointed by the same process. Decision making of the SCCC will take full account of the locality engagement of practices when taking decisions. There maybe those decisions that are considered so important that further consultation with general practices in there localities would be required.

Local approach to managing conflict of interest is set out in appendix 3

7. Frequency of Meetings

The SCCC will meet on a monthly basis. Alternate meetings will be held in public and meetings will provide opportunity for a public ‘open session’ at the beginning of those meetings where members of the public may submit questions in advance or make representations to the SCCC.

8. Monitoring adherence to the Terms of Reference / Review

These terms of reference shall be reviewed initially after six months, and then annually.

Appendix A

Issues which could be delegated to local borough-based committees (Clinical Commissioning Committees)

- delivery of the Borough aspects of the QIPP and integrated delivery plan;
- delivery of the PCTs financial obligations at a borough level;
- ensuring best use of resources and QIPP delivery at a borough level;
- development of and support to GP commissioning development at a borough level;
- inform the development of the CSP and Integrated Delivery Plan with partners, based on an agreed JSNA;
- making optimal linkages to health and well being boards and GP commissioning operating arrangements;
- development of joint commissioning at a borough level;
- oversight and performance management of operating framework deliverables at a borough level;
- delivering service and quality improvement at a local level;
- ensuring borough based statutory deliverables e.g. safeguarding are achieved;
- assurance mechanisms for ensuring Quality of Primary Care.

Appendix B

Issues which only the Joint Boards can deal with

- overseeing the delivery of the single SE London QIPP and Operating Plan;
- decision-making on change programmes that have an impact across the cluster (e.g. potential reconfiguration or SE London wide models of care);
- achieving financial balance across SEL;
- oversight of planning for 2011-14;
- oversight and management of strategic risks;
- whole system performance management;
- market management / FT pipeline;
- tracking the delivery of SEL wide QIPP and change programmes;
- leadership to the organisational development and change implementation in preparation for the new commissioning system;
- adherence and delivery of the statutory PCT responsibilities;
- decisions on further delegation.

Appendix C

SCCC approach to Conflicts of Interest

1.1. A register of interests of members of the SCCC will be systematically maintained and will be made publically available. These details will be published in the PCT Annual Report. Members will also be asked to declare any interests at the start of each SCCC meeting.

1.2. To ensure that no commercial advantage could be gained, a GP lead who declares an interest in an area cannot be involved in it. If after being involved, any bids received from the lead's practice would not be accepted.

1.3. Where the business of the committee requires a decision upon an area where one GP holds a significant conflict of interest, the Chair will ensure that the individual takes no part in the discussion or subsequent decision making.

1.4. Where more than two GP leads holds a significant conflict of interest the committee will require consideration of the proposal / issue to be made by a separate evaluation panel. The evaluation panel would evaluate the proposal for quality and cost-effectiveness and if satisfied it would then make a recommendation to the Clinical Commissioning Committee, excluding the interested GP members, for decision.

1.5. The Evaluation Panel, when called upon, will provide neutrality in the evaluation process and will have the following membership:

- One Non-Executive Director of the PCT Board
- Managing Director, Southwark BSU
- Southwark Director of Public Health (and Health & Well Being Board representative)
- Co-Opted clinical expertise if necessary at discretion of the MD

1.6. In the rare occasion where the Clinical Commissioning Committee is unable to reach a decision under these circumstances the decision maybe referred to the PCT Board.

Conflict of Interest Guardian

1. The approach of Southwark Clinical Commissioning Committee (SCCC) to managing Conflicts of Interest (CoI) of GP commissioners is set out in Appendix C of SCCC's terms of reference. This includes the role of a Non Executive Director (NED) of the PCT Board on a separate evaluation panel.

2. In addition SCCC has agreed that one of the PCT NEDs should act as a CoI "guardian". The role of the CoI guardian is to advise the SCCC on CoI issues and, where necessary, adjudicate.

3. There is a considerable amount of guidance from the Department of Health (DH) on handling CoI issues and also a guidance document from the SE London cluster. These provide clear statements of the principles of what constitutes CoI and how it should be dealt with. However sometimes the interpretation of these principles and their application to the details of a specific case is not completely clear-cut (the "devil in the detail") and there is therefore room for differing personal judgements. The purpose of the CoI guardian is to provide independent and authoritative judgement in such cases.

4. The scope of the CoI guardian's work is twofold:

    a. to judge whether there is a risk of a material CoI arising

    b. to advise how this risk should be eliminated

5. The CoI guardian operates in two modes:

    a. Reactively, when the SCCC as a whole or individual GP members seek his advice on a specific issue

    b. Proactively, when he himself identifies a potential CoI risk and acts on it. The CoI guardian is a voting member of the SCCC (as well as the PCT Board) and is familiar with the work of the SCCC and the roles of the GP leads. He is therefore in an informed position to identify such risks when they arise.

6. In either mode the CoI guardian discusses the issue with the GPs involved and any other relevant party and then issues written advice or judgment for the SCCC board.

7. The members of the SCCC, including all GP members, have agreed that they will accept the advice or judgement of the CoI guardian in such cases.

Agenda Item 7

Title **Southern Cross Care Homes Briefing Paper**	To **Health and Adult Social Care scrutiny**
From **Susanna White** **Strategic Director of Health and Community Services**	**Date 23 September 2011**

1. FOREWARD

Southern Cross run three care homes in Southwark, out of a total of 16 in Greater London and 753 nationally. The 3 Southwark homes contain a mix of residential and nursing beds, as summarised below.

Southern Cross Placements by the Council.
(1 August 2011)

Southern Cross Placements	Total	Residential Permanent	Residential Respite	Residential Temporary	Nursing Permanent	Nursing Respite	Nursing Temporary
Tower Bridge	56	24	1	2	29	0	0
Camberwell Green	27	3	0	0	23	1	0
Burgess Park	23	0	0	0	22	0	1
Other Southern Cross Homes	3	2	0	0	1	0	0
Total	**109**	**29**	**1**	**2**	**75**	**1**	**1**

Southern Cross currently provide **74%** (181) of all the **243** available nursing bed spaces in the borough and **21** (**6.5%)** of the total of 290 beds residential care beds available for Southwark to use in the borough.

Southwark is the primary referring authority to these homes, although there are clients from other boroughs also placed. (Primarily Lambeth PCT and Lewisham, Greenwich and Westminster Council's) with a small number of self funders who have paid for their placement independently. All three homes carry voids at an average rate of **38%** (approx 92 beds)

2. UTILISATION BY SOUTHWARK RESIDENTS

Southwark Council currently purchase a total of **109 beds**. All but three of these beds are in the 3 homes situated in borough. There are a further 12 Southwark residents who have been placed by the PCT (Business Support Unit) in Southern Cross Homes. Virtually all of the placements are older people.

- **Nursing Beds:** Southwark has **77** service users placed in nursing care beds in the three homes. This equates to approximately **33%** of the Council's total placements of nursing care for older people.

- **Residential Care:** The Council currently has 32 older people placed in Southern Cross residential care beds**,** which constitutes approximately 9% of the boroughs residential placements of older people.

The Council is projecting to spend approximately **£3.6 m** on these placements in 2011-12. (Just under £2 m of which on the Tower Bridge Care home) All the placements have been on a spot contracting arrangement. The Council has never held a block contract with Southern Cross.

The Council has operated embargos against the local homes over the last year, due to concerns regarding the quality of care. These embargos had been lifted earlier this year for Tower Bridge and Camberwell Green, although the embargo continues at Burgess Park for all but very exceptional placements that are being requested by the family. The quality standards in the homes continue to be closely monitored to ensure that the organisational problems do not impact upon the care being delivered on the ground.

3. CURRENT RISK TO SOUTHWARK HOMES

Some years ago Southern Cross devised an operating model whereby it sold the properties in which it run its homes and leased back the buildings. The properties were sold to private equity 'vehicles' largely set up specifically for the purpose. Rental agreements were set with an upward trajectory of rents. With the downturn in the economy, and Council policies of using less institutional care, Southern Cross ran into difficulties in paying its rents. This year it tried to get agreement from its landlords for rent to be withheld over the summer. Ultimately the landlords did not agree and Southern Cross notified the Council formally on 14 July 2011, that it would cease operating, whilst also giving assurances that the three homes in Southwark would continue to operate after their cessation of trading.

Since then, the Council has continued to work with Southern Cross directly, and through the Association of Directors of Adult Social Care (ADASS) in relation to transfer of the local homes. There is a landlord committee working to devise a way forward for all homes. The landlords have said they will bring in new operating companies. There are a few major landlords, and a number of smaller ones. NHP, the biggest single landlord, is working with Court Cavendish, an established provider, to set up a new operating company.

The web of parent and subsidiary companies involved in Southern Cross is wide and complex. It can make tracing ownership and liabilities difficult.

The current situation is as follows:

Tower Bridge and Camberwell Green

The Council has now received notification from Court Cavendish and NHP, that they will be forming a new registered care provider that will be operating under the name of "HC-One" . A provisional date for this arrangement has been set for 1st November 2011. From the information provided it would appear that the intention is

that this new company will take on the ownership of the homes, rather than there being a landlord/care provider relationship that existed previously. The situation remains under close review and officers will be pleased to further update the Scrutiny Meeting as these issues are finalised.

Burgess Park

The Council has been informed formally by Southern Cross that Four Seasons will be taking over the Burgess Park Care Home. The Council has also received confirmation of this through separate and independent initial discussions with Four Seasons. It is understood that the timelines are likely to again be in early November, although as yet no final date has been set. They are now undertaking a period of due diligence in relation to TUPE requirements etc. The situation remains under close review and officers will be pleased to further update the Scrutiny Meeting as these issues are finalised.

4. RISKS FOR THE COUNCIL

The risks to the Council of cessation of operations locally can be summarised as being twofold:

Risk 1 - Service delivery

The greatest risk the Council would face would be in the in the provision of Nursing Care beds as Southern Cross is the major local supplier and has responsibility for 77 residents (23 of which are in Burgess Park).

The risk in relation to residential care placements would be less acute, as there is likely to be capacity in other homes within the borough (Primarily Anchor)

The impact upon the health and well being of the residents if any home were to close would be considerable. There are no very local nursing home alternatives.

Risk 2 - Cost pressures

The second significant risk for the Council would be in relation to increased costs of alternative placements. The average weekly placement fee for Southern Cross Homes paid by Southwark is **£488** p.w. This is less than the fee charged by most other spot nursing care providers, where average unit costs are between **£500** and **£600** per week. The fees under the Anchor contract for residential care are again higher than those charged by Southern Cross, and vary from **£516** per bed per week to **£623** per bed per week.

These rates again do not account for market pressures pushing up costs if Southern Cross withdrew from other boroughs concurrently. The competition for beds between boroughs is likely to result in an upward inflationary pressure on bed prices.

4. CONTINGENCY PLANS

Since the problems with Southern Cross were first known, the Council has been undertaking extensive contingency planning measures. These have followed the

principals of engagement issued to Local Authorities by ADASS in May 2011. The contingency plans are updated and reviewed regularly by senior officers of the Council. The priority would be to support Southern Cross in keeping the homes operating, given the lack of alternatives. The specific areas addressed through these plans include:

- Working with neighbouring boroughs, to jointly manage risk and ensure the continuity of service for the Council's out of borough placements. The most affected boroughs being Lewisham, Greenwich and Bexley)
- Undertaking an assessment of the needs of the current Southwark residents in the three homes, to establish appropriate contingency plans for each resident.
- Work with Southern Cross in relation to ensuring that timely and accessible information is made available to family and other stakeholders.
- Enhancing monitoring of the homes to ensure that quality standards do not slip below acceptable levels as a result of the organisational uncertainty.
- The Council's brokerage service is identifying and monitoring bed availability in alternative homes.

23 September 2011

Agenda Item 8

Scrutiny review proposal

1 What is the review?

Review into the establishment, transition to and operation of a Clinical Commissioning Consortia in Southwark following changes to the NHS brought about by the government's Health & Adult Social Care Bill which is currently before Parliament.

The review will focus on: i) Transition to the Consortia; ii) Impact of Cost Savings on Patient Care; iii) Conflicts of Interest and iv) Contract Management

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

This review seeks to influence Southwark Council, the Southwark Clinical Commissioning Consortia, the SE London PCT Cluster, the (to be created) Health & Wellbeing Board, NHS London and central Government.

Achievable outcomes: influence Consortia's internal procedures; influence the transition to/setting of Consortia policies; draw attention to potential risks so that these can be mitigated by the council and consortia.

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

Carried out immediately and completed by Jan/Feb 2012

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

Investigation

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

i) Transition to the Consortia; ii) Impact of Cost Savings on Patient Care; iii) Conflicts of Interest and iv) Contract Management

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

Southwark Council, Southwark Clinical Commissioning Consortia, Acute Trusts, SEL PCT Cluster, Southwark LiNK

7 Any suggestions for background information? Are you aware of any best practice on this topic?

HASC Bill, NHS Future Forum Report, Govt's Response to NHS FF Report, Guidance/draft policies drafted by SEL PCT Cluster/Consortia.

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?

e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Verbal and written submissions, site visits and meeting with stakeholders.

Scrutiny review proposal

1 What is the review?

Review into the Ageing of Adults with Complex Needs, in particular the increasing numbers of Southwark residents who are moving from Children's Services into Adult Social Care (c40 per year) and those adults with complex needs who are now living into old age.

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

This review seeks to influence Southwark Council Adult Social Care and also providers of adult social services.

Outcomes: pick up best practice to inform Southwark Council's planning around this area and better prepare for a future where increasing numbers of individuals with complex needs survive into adulthood and old age.

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

Carried out immediately and completed by Jan/Feb 2012

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

Investigation

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

Care provision. Financial challenges faced by the council, impact of Dilnott recommendation and govt's position.

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

Southwark Council Adult Social Care, Adult Social Care providers, Clinical Commissioning Consortia, adults with complex needs, their families and carers.

7 Any suggestions for background information? Are you aware of any best practice on this topic?

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?

e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Verbal and written submissions, site visits and meeting with stakeholders.

Scrutiny review proposal

1 What is the review?

Lessons that can be learnt from the financial collapse of Southern Cross and its impact on providing Health and Adult Social Care services to Southwark residents

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

Southwark Council Adult Social Care.

The Business Support Unit (BSU) for the PCT & Clinical commissioning consortia.

Regional and national government or bodies with a responsibility for financial/economic regulation of residential care homes.

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

October 2011

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

Investigation

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

The background to the financial collapse of Southern Cross

The impact on residents; including how the Council and BSU have communicated with residents and families. Are there any recommendations for improvement?

What measures did Southwark Council take to measure the financial health of Southern Cross and were they adequate? Could these be improved to better manage the risk of financial collapse. Whether relevant government agencies should take an active interest in the financial health of care providers.

What role, if any, did other bodies have in alerting public commissions to financial risks in private providers? Were they sufficient?

Are there any issues around competition and diversity that the Council and the BSU need to consider when commissioning Health and Adult Social Care services in the future to better deal with market failure and promote market resilience?

What steps the council/govt is putting in place to monitor the viability and standards of care of the new organisations who will take over the operation of the 3 Southern Cross care homes in the borough.

How the new organisations will ensure clinical governance and continuity of care.

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

Southwark Council & BSU

Residents and their families

7 Any suggestions for background information? Are you aware of any best practice on this topic?

Any good practice guidance on :

- measuring financial health when commissioning (including 'spot contract' commissioning)
- managing risk and promoting market resilience

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?
e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Reports from Southwark Council – including requests for detailed information on commissioning practices

Gather evidence from residents and families – this could be via a letter or a visit to one or more of the homes.

Agenda Item 9

Southwark Council
Health and Adult Social Care Scrutiny
5th October 2011

Public Health interventions – the Case for Prevention

1. Summary

1.1 Health & Adult Social Care Scrutiny Committee requested a report identifying the amount spent on preventative actions and the amount spent on related treatment, in order to consider if there is a relationship in terms of the proportion of resources allocated.

2. Recommendations for discussion

2.1 Prevention is a complex subject. This overview paper begins to outline some of the key areas for public health and should be viewed as a starting point for potential further discussion. More detailed information can be provided on specific topics if required by Scrutiny Committee.

2.2 The Southwark Health and Well Being Board is in the process of being (re)established. This senior level Board will be Member led and include key partners across the Council and NHS.

The Board will be developing the Joint Health & Well Being Strategy for Southwark. This will be a high level strategic framework setting out the direction for health and well being. Scrutiny may wish to request that the H&WB Board:

- Ensure that prevention is one of the priorities in the HWB Strategy
- Recognizes that inequalities in prevention, service use and health outcomes exist and that the JHWB Strategy must clearly address the health inequalities in Southwark.
- Consider that mental wellbeing is integral to health and to encourage the promotion of mental wellbeing in the JHWB Strategy.

2.3 Individuals and communities must take more responsibility for their own health. Scrutiny may wish to also consider advocating for an asset based approach to prevention in the JHWB strategy which may help identify and unlock the resources in the communities.

3. Background

3.1 The term ‘prevention’ refers to interventions that prevent rather than cure or treat disease. For the purposes of this report, we can consider prevention as:

- primary prevention
- secondary prevention

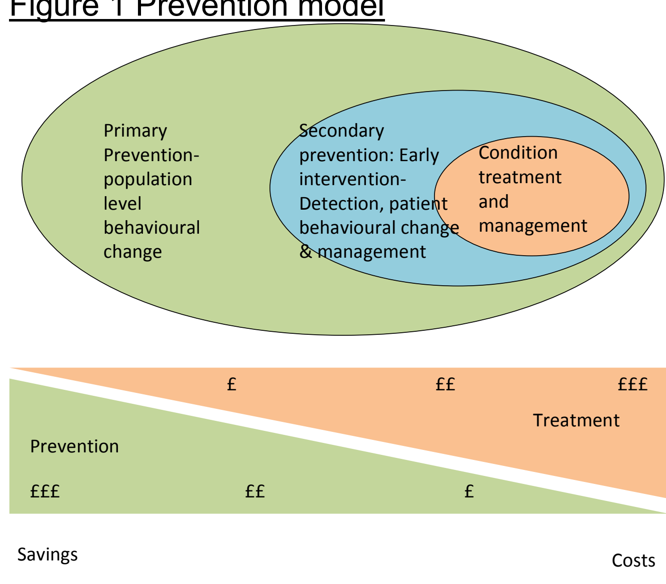
3.2 Primary prevention aims to prevent disease. Most health promotion and behavioural change interventions fall within this category eg

healthy eating, physical activity, smoking cessation and other tobacco use, alcohol, safer sex, drug misuse and safer sun. It is important to recognize that mental wellbeing underpins much of effective or unsuccessful behavioural change and indeed can be a driver for 'unhealthy behaviors' for eg alcohol misuse, over eating and other 'stress related behaviours'.[1]

3.3 Secondary prevention, also referred to as 'earlier intervention', aims to diagnose and treat an existing disease in its early stages before it results in significant morbidity. Earlier diagnosis and treatment potentially improve outcomes through treating disease earlier and ensure greater treatment options are available. Examples include breast, cervical and bowel screening, cancer symptom awareness for a range of conditions (eg testicular, prostate), 'case finding' through development of GP chronic disease registers (eg diabetes, hypertension, chronic obstructive pulmonary disease - COPD) and earlier detection of HIV. In addition to the management of a condition with medication or clinical interventions, a good treatment plan will include health promotion and behavioural change. For example, a healthy diet and physical activity alongside appropriate medication, will play a major part in effectively managing and slowing the progress of diseases such as diabetes and hypertension and similarly, smoking cessation and exercise can be important aspects of managing chronic obstructive pulmonary disease (COPD). For communicable diseases, such as HIV, diagnosis and treatment will also reduce transmission.

Figure 1 below illustrates the model for prevention, savings and costs. There is no agreed formula for how much should be spent on prevention relative to costs of treating ill health, although many prevention activities are considered cost-effective. Some of this evidence is summarized in Table 1.

Figure 1 Prevention model



[1] Department of Health (2011) No health without mental health

4. Case for prevention

4.1 There is a very strong case for primary prevention. Table 1 below summarises the Southwark investment for some of the key areas for prevention. Some of the related evidence for effectiveness and cost effectiveness is included in the table.

Table 1 Southwark investment in prevention

Area	Programme / activity	£ ,000	Effectiveness & cost effectiveness
Screening	Breast	501	• Reduction in breast cancer mortality of about 35% in women who are regularly screened • Assuming 75% of invited women of 50–70 years of age are screened, estimated 1400 lives saved in England[2]
	Cervical	369	• Cervical screening in women 20–24 years of age has little or no effect on rates of invasive cervical cancer up to the age of 30 years. • Screening older women is very effective and leads to a large reduction in incidence and mortality from cervical cancer[3].
	Bowel	433	• Cancer mortality was reduced by 16% in populations offered screening compared with populations not offered screening.[4]
Smoking	Smoking cessation service	200	• Smoking causes 317 deaths in Southwark[5]

[2] NHS Clinical Knowledge Summaries http://www.cks.nhs.uk/breast_screening/evidence

[3] NHS Clinical Knowledge Summaries http://www.cks.nhs.uk/cervical_screening/evidence/supporting_evidence/screening_related_to_age

[4] Cochrane review 2007 Hewitson, P., Glasziou, P.P., Irwig, L. et al. (2007) *Screening for colorectal cancer using the faecal occult blood test*

[5] Source: 'Health profile 2011: Southwark'. APHO 2011

cessation			• Every pound spent, saves £4[6] • Each smoker giving up gains 3.6 life years; giving up at 30, you gain 10 years[7]
Obesity	Health promotion and community nutritionists Weight mgmt (Health Checks) MEND family intervention	215	• Estimated costs in Southwark of treating diseases related to overweight and obesity £86.1 million in 2010 and £92.1 million in 2015[8].
	Health Promotion Exercise on Referral + cardiac rehab phase 4 (condition management and secondary prevention)	165	• Supporting inactive adults (approx 47% of adult pop) to achieve recommended 30mins x 5 days physical activity could generate upto £10m in savings for Southwark[9]
Health checks	NHS Health Checks • Including physical activity, motivational interview hub, glucose intolerance	232 100	• For every £1 spent on NHS Health Checks, £11 saved. Savings arise from costs of treating heart disease, stroke, diabetes and kidney disease [10]
Mental health	Mental health promotion BME mental health promotion Psychological therapies (management of conditions as well as secondary prevention)	45 70 3.5M	• Mental illness during childhood and adolescence results in UK costs of £11,030 to £59,130 annually per child[11] • Suicide training for GPs saves £44 for every pound while

[6] Bernstein H, Cosford P and Williams A. 'Enabling effective delivery of health and wellbeing – an independent report' Dept of Health 2010

[7] HM Government. 'A smoke free future – a comprehensive tobacco control strategy for England' DH 2010.

[8] Department of Health 2008 Healthy weight, healthy lives: Toolkit for developing local strategies

[9] Department of Health 2009 Be Active, Be Healthy: A Plan for Getting the Nation Moving

[10] Department of Health 2008 Putting prevention first: Vascular checks risk assessment and management - impact assessment

[11] Suhrcke M, Pillas D, Selai C (2008) Economic aspects of mental health in children and adolescents. In Social cohesion for mental well-being among adolescents. Copenhagen: WHO Regional Office for Europe

			bridge safety barriers save £54. • For every pound invested in workplace health promotion programmes nearly £10 is saved (reduced costs of stress and sick days)[12]
Sexual health	Chlamydia	100	• Frequency of chlamydia infection highest in under 25s; RCTs show reductions in the risk of pelvic inflammatory disease of women screened[13]
	Sexual health promotion training	132	• Focus of SH training is on supporting roll out and promotion of HIV testing in primary care and SRH clinics. Southwark's prevalence is 7x higher than UK; half of newly diagnoses cases are diagnosed late and quarter very late.
	HIV incl condom & pan London prevention	419	
Alcohol	Brief interventions in primary care (DES & LES)	TBC 2	• Screening and brief intervention in primary care for alcohol misuse saves nearly £12 for every pound invested
Substance misuse	Mostly secondary prevention (eg needle exchange & reoffending)	1.4M	• For every £1 spent on prevention, £3 is saved to health and crime services[14]

5. Realising savings

5.1 Although there is a very clear case for investing in prevention and evidence based models for estimating the associated costs of

[12] Knapp, Martin and McDaid, David and Parsonage, Michael (2011) Mental health promotion and mental illness prevention: the economic case. 15972. Department of Health, London, UK
[13] http://www.chlamydiascreening.nhs.uk/ps/evidence/index.html
[14] National Treatment Agency Value for Money Toolkit

treatment and care for preventable diseases, the realisation of savings specific to interventions is problematic. Intervention at a population level poses a number of issues which makes the realization of direct savings difficult. For example,

- the population itself is not stable ie people move in and out of Southwark, thus the 'subject' of intervention changes.
- at an 'individual' level – personal differences will impact on the effectiveness of behavioural change (eg different values, different cultural beliefs, peer influence, changing circumstances eg unemployment)
- the quality of the delivery of interventions themselves will impact on effectiveness eg quality of training, quality of administrative systems eg call and recall

5.2 Recently, Social Impact Bonds have been suggested as a means to potentially realize savings for investment in early intervention or prevention. This is currently being trailed in some boroughs[15],[16]. It is still too early to assess the effectiveness of SIBs.

6. Cost of ill health

6.1 Table 2 below shows the estimated financial costs of treating disease by Programme Budgeting categories (a Department of Health approach to categorizing disease spends). It is important to note that not all health conditions can be attributed to preventable risk factors, for example, some heart conditions can be congenital and family history increases the risk for some cancers.

6.2 More importantly, the financial costs must be considered alongside the human cost of 'early deaths' (ie deaths under 75 years). In Southwark, in 2009 there were 205 early deaths due to cancers (35%) and 133 (23%) due to circulatory diseases[17]. Lung is the largest category of cancer deaths (about a quarter of total cancer deaths in Southwark). Smoking and unhealthy weight are key amendable factors for cancers and circulatory diseases. Smoking is estimated to cause about 80% of lung cancer deaths, 18% of coronary heart disease deaths, and 11% of stroke deaths. It is a major risk factor for other cancers (eg mouth, throat, liver, pancreas, bladder, cervix and bowel – they account for about a third of Southwark cancer deaths)[18]. Unhealthy weight is a key risk factor for hypertension and type 2 diabetes, both of which are risks for circulatory diseases. Weight itself, independent of co-morbidities (eg diabetes and hypertension), is now considered to be an independent risk factor in fatal heart disease[19].

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[15] http://www.socialfinance.org.uk/
[16] Hammersmith & Fulham, Westminster and in Birmingham and Leicestershire http://www.guardian.co.uk/society/2011/aug/26/big-society-social-impact-bond
[17] Southwark Annual Pubic Health Report 2010
[18] ibid
[19] http://heart.bmj.com/content/early/2011/01/24/hrt.2010.211201.abstract

Table 2 Costs of treating disease

Some associated health behaviours [1]	**Programme budgeting category (09/10)** From DH Programme Budgeting PCT benchmarking Toolkit 09/10 v1	
Smoking, other tobacco, some foods, sedentary behaviours	Cancers & tumors [1]	£27.7 M
Obesity, healthy eating, sedentary behaviour, smoking	Circulatory disease [1]	£32.2 M
Smoking, seasonal flu	Respiratory disease [1]	£24.6 M
	Mental health [1]	£93.0 M
Safer sex	Genito urinary [1]	£36.2 M

Note [1] Not all disease is preventable through change in health behaviour.

Agenda Item 11

Health and Adult Social Care Scrutiny
Work programme 2011/12

Meeting 1 Wednesday 29 June 2011

Introductory presentations on:

- Adult Social Care – Susanna White
- Public Health – Dr Ann Marie Connolly
- Commissioning – Andrew Bland & Dr Amr Zeineldine

Particular issues of concern: Safeguarding & Southern Cross
Impact on services of recent NHS savings – a short report will be requested on impact on patient care

Work programme

Indentify and confirm work programme and reviews

Potential reviews are:

- Review A :Commissioning (impact of savings on patient care, transition arrangements, conflicts of interest & contract management)
- Review B : Ageing of Adults with Complex Needs (Entry into Adult Social Care and Later Life)

Interim work

Agree and scope reviews

Visit Southwark three acute trusts during August and the first week of September:

- King's College Hospital NHS Foundation Trust (KCH)
- Guy's and St Thomas' NHS Foundation Trust (GSTT)
- South London and Maudsley NHS Foundation Trust (SLaM)

Meeting 2 Wednesday 5 October 2011

Presentation by Acute Trusts (x3)

Review A: Clinical commissioning

Review scoping documents
Commissioning – presentation by Andrew Bland & Dr Amr Zeineldine and possibly portfolio holder transition lead. Issues to be explored are:

- Impact of saving on services (reflecting on report requested)
- Transition to full delegation
- Conflicts of interest

- Contract Management

Review B : Ageing of Adults with complex needs

Review scoping of adults with complex needs – initial identification of demographic issues and preliminary consideration given to impact on health & social care services. Decide what evidence is needed to further review

Receive information on Southern Cross and related issues – decide if the further information is needed to make recommendations

Receive information on Public Health prevention investment

Receive information on contracts

Meeting 3 Wednesday 7 December 2011

Cabinet member interview – consideration given to expanding interview panel

HIV consultation

Review A: Clinical commissioning - receive interim report

Review B : Ageing of Adults with complex needs – Review evidence and pursue further lines of enquiry

Review of Southern cross and related issues – produce short report

Meeting 4 Wednesday 1 February 2012

Review B: Ageing of Adults with complex needs – Review evidence and pursue further lines of enquiry

Review A: Clinical commissioning – work on finalising report

Safeguarding – review and receive Annual report from Safeguarding Board and Chair

Health and Wellbeing Board draft strategy

Meeting 5 Wednesday 14 March 2012

Review B: Ageing of Adults with complex needs – Finalise report

Meeting 6 Wednesday 2 May 2012

Quality Accounts
Consider broader evidence base – e.g Healthwatch, GP patient practice groups, service users advocacy groups (Older people, disabled people, mental health etc)

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