Open Agenda

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 7 December 2011
7.00 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
Webpage:

Members of the committee are summoned to attend this meeting
Annie Shepperd
Chief Executive
Date: 29 November 2011

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Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 7 December 2011
7.00 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 5 October 2011	1 - 70
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10. WORK PROGRAMME

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

PART B - CLOSED BUSINESS

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

Date: 29 November 2011

Agenda Item 4 Open Agenda

HEALTH AND ADULT SOCIAL CARE SCRUTINY SUB-COMMITTEE

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

PRESENT: Councillor Mark Williams (Chair)
Councillor David Noakes
Councillor Patrick Diamond
Councillor Norma Gibbes
Councillor Eliza Mann
Councillor the Right Revd Emmanuel Oyewole

OTHER MEMBERS PRESENT:

OFFICER SUPPORT: Julie Timbrell , Scrutiny project manager
Andrew Bland , MD , Bussiness Support Unit
Richard Gibbs, Vice Chair, Southwark NHS
Sarah Feasey , Legal officer

1. APOLOGIES

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

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

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

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

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

5. CLINICAL COMMISSIONING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

policy available.

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

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

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

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

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

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

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

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

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

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

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

ACTION

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

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

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

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

6.2 The director explained the mission of King's Health Partners is to become the UK's leading AHSC. We will:

Drive the integration of research, education and training and clinical care, for the benefit of patients, through our new Clinical Academic Groups (CAGs).
•Consider all aspects of the health needs of our patients when they come to us for help.
•Improve health and well-being across our ethnically and socially diverse communities and work to reduce inequalities.
•Develop an AHSC that draws upon all academic expertise in medical

science and also in basic science, social science, law and humanities.
•Deliver a radical shift in healthcare by identifying 'at risk' groups, based on genotype and lifestyle, and helping them to avoid illness.
•Work innovatively with stakeholders in the redesign of care pathways, including the delivery of care closer to home.

6.3 The director explained that Kings Health Partners aims to be in the top 10 globally, both clinically and academically, in the fields of: Cardiovascular disease; transplantation, immunity and inflammation linked to disease & Mental Health and neurosciences. He explained that they will build our capacity to address diseases that have a particularly large impact on our local community, but also are important on a global scale, in the areas of: childhood diseases; diabetes and obesity & cancer. They will ensure academic expertise is applied to all clinical services to pursue a tripartite mission.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ACTION

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

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

7. SOUTHERN CROSS

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

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

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

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

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

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

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

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

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

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

ACTION

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

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

8. SCOPING DOCUMENTS

8.1 The chair requested members note the contents.

9. PUBLIC HEALTH - PREVENTION INVESTMENT

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

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

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

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

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

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

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

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

ACTION

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

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

10. CONTRACT INFORMATION

10.1 The chair asked members to note the contents.

11. WORK PROGRAMME

King's Health Partners Public Health Strategy

Theme D: Improving Public Health through Community Involvement

1. Purpose of Report

King's Health Partners wants to support Local Authorities in their new lead role in public health and wishes to join them as well as GP Consortia/PCTs, Directors of Public Health, third sector organisations, potential funders and the community in order to improve the health and wellbeing of local people in the most effective way. This paper covers theme D of KHP's Public Health Strategy.

2. Context

Despite significant progress in improving the health of the community, there remains a great deal still to do. KHP is working with other organisations to develop its overall Public Health Strategy around the following five themes (see appendix A):

A. Developing academic capacity to design interventions and contribute to delivery of the strategy
B. Developing the culture of Clinical Academic Groups
C. Delivering Public Health interventions to reduce risk and improve health and wellbeing
D. Community Involvement to improve Public Health *[This report sets out the more detailed plans - developed through the work of the Group March-April 2011]*
E. Public Health Collaborative for joint working

Regarding theme D, evidence highlights that individuals benefit more if they are actively involved in managing their health, as opposed to health improvement being imposed upon them. The Marmot review highlighted that effective local delivery requires effective participatory decision-making at local level which can only happen by empowering individuals and local communities (Marmot et al, 2010).

While Local Authorities already actively involve their communities in the work they do, the facilitation of greater community involvement in public health and wellbeing in partnership with a range of expertise in the field could result in further improvements across a broad range of public health outcomes as well as reduced inequality and enhanced social capital. Such work is coherent with the local priorities of health and wellbeing boards and also contributes to a more sustainable strategy which is particularly important in the current financial climate.

With regards to theme D, in order to achieve the largest impact on the health and wellbeing of the local population, King's Health Partners wishes to contribute to enhancing community involvement by:

- Working with the Local Authority, GP Consortia/PCT, Directors of Public Health, specific local third sector organisations and potential funders to

involve and engage the wider community about their health and wellbeing and the most effective ways to improve it
- Following the involvement exercise, to work with the community and partners to implement agreed interventions in the most effective way
- Working with the community and partners to facilitate evaluation of the impact of increased community involvement as well as a range of interventions together with the internationally recognised research expertise at KHP
- Working together to support the securing of funding

Such a collaborative approach also requires cultural change among some medical experts and institutions. This proposal therefore sets out some suggested methodologies to secure such a co-productive approach with communities in defining the issues and solutions to improve their health and wellbeing. It also highlights a number of existing local initiatives.

3. Some background on the Public Health White Paper and King's Health Partners Commitment to Action

The White Paper on Public Health 'Healthy Lives, Health People: our strategy for public health in England' (DH, 2010) defines Public Health as "The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society". It aims to build people's self-esteem, confidence and resilience right from infancy. The White Paper is proposing a radical new approach to reach across and reach out to address the root causes of poor health and wellbeing. The approach has four components [responsive; resourced; rigorous and resilient] with responsive defined as owned by communities and shaped by their needs.

King's Health Partners Strategic Framework 2010-2014 states that it wishes to work with others to:

- *Improve the health and wellbeing across our ethnically and socially diverse communities and working to reduce inequalities*
- *Deliver a radical shift in healthcare by identifying 'at risk' groups, based on genotyping and lifestyle, and helping them avoid illness*
- *Transform the nature of healthcare: by moving from treatment towards population screening and disease prevention*
- *Be inclusive: by designing systems and procedures so that everyone is actively encouraged to become involved and has the opportunity to do so.*

King's Health Partners commitment to local people and communities is described in the following terms:

We need to address the inequalities illustrated in the heat map by using our resources to maximum effect. We will
- *Strive to enhance healthy lifestyles by working with key stakeholders to address public health issues*

- *Continue to use our infrastructure to have a positive impact on the social, environmental and economic context in which local people live, and develop and deliver a challenging environmental sustainability strategy which is vitally important for the health and wellbeing of the population*
- *Work to eliminate the barriers to accessing our services, employment and education opportunities because we know that our population is diverse and within it there are vulnerable and disadvantaged groups*
- *Promote fairness and equality for all.*

A core element of our values and guiding principles is inclusivity and working in partnership with others to achieve our aims.

Taken together these are a powerful statement of what makes King's Health Partners unique amongst Academic Health Sciences Centres and we now wish to build a system-wide collaboration to move from vision and commitment to action.

This report was developed through collaborative working with a time-limited group which identified a number of important issues:

- *A definition of wellbeing should encompasses aspirations, the right to a sense of purpose and the ability to lead a meaningful life*
- *Public health is not a commodity to be managed and dispensed from one group to another, but is the collective responsibility of all members of the community.*
- *The core principles for good public health are already well established and researched. The responsibility of KHP and local authorities is to ensure that, whatever activity is undertaken, it complies with the agreed principles and ensures strong accountability for the quality of delivery and outcomes*

King's Health Partners is committed to pioneering better health and wellbeing, locally as well as globally. It wishes to contribute to the development of the evidence based of 'what works' in collaboration with local players across Lambeth, Lewisham and Southwark (in this piece of work) and eventually Bexley, Bromley, Croydon and Greenwich – since all seven boroughs comprise the KHP footprint.

4. Public health interventions, community involvement and social capital

The Public health White Paper highlighted that health is not just about the absence of disease or illness (be that physical or mental), but also about how well people are (DH, 2010). Improvements in public health and wellbeing can occur as a result of a variety of interventions. The Public Health White Paper also highlighted how key attributes of wellbeing including self-esteem and resilience have important impacts on health behaviour. Certain behaviour change is associated with improved outcomes; for instance, eating less and doing more exercise reduces weight and the associated risk of diabetes, cancer and heart attacks. However, getting people to change health-related behaviour so that they take responsibility for their own health and wellbeing is more difficult.

Improving the wellbeing of individuals and their communities is associated with a range of reduced health risk behaviour and physical illness. Such interventions thereby reduce health inequality particularly in groups at higher risk.

Social capital and mortality
A meta-analytic review including 148 studies and 308,849 participants found that loneliness and social isolation has a higher risk on mortality than lifelong smoking (Holt-Lunstad et al, 2010). A meta-analysis of social networks and cancer mortality found that high levels of perceived social support or larger social network was associated with decreases in relative risk for cancer mortality of 25% and 20% respectively (Pinquart and Duberstein, 2010).

Social capital and mental ill-health
Low involvement and poor quality social support are associated with both the onset and persistence of childhood mental disorders (Parry-Langdon et al, 2008). Severe lack of social support is associated with a more than two fold increased risk of mental illness (Melzer et al, 2004). Regarding effects on dementia, a longitudinal cohort study of social networks, level of Alzheimer's disease pathology and level of cognitive function found that cognitive function was higher for those with larger network sizes (Bennett et al, 2006). Participation in leisure activities is also associated with reduced risk of dementia (Verghese, 2003) while other studies suggest that mentally or socially oriented stimulating activity may protect against dementia (Fratiglioni et al, 2007, 2004; Wang et al, 2002).

Social assets approach to health
The WHO European Office for Investment for Health Development uses the term "health assets" to mean the resources that individuals and communities have at their disposal which protect against negative health outcomes and/or promote health status. These assets can be social, financial, physical, environmental or human resources; for instance education, employment skills, supportive social networks, natural resources, etc. (Harrison et al., 2004). An asset-based approach can also respond to health inequalities (Morgan and Ziglio, 2007). Assets based approaches complement the deficit model by:

- Identifying the range of protective and health promoting factors that act together to support health and wellbeing and the policy options required to build and sustain these factors.
- Promoting the population as a co-producer of health rather than simply a consumer of health care services, thus reducing the demand on scarce resources.
- Strengthening the capacity of individuals and communities to realise their potential for contributing to health development.
- Contributing to more equitable and sustainable social and economic development and hence the goals of other sectors.

Community engagement can be distinguished from community development. The former primarily involves a *top-down* effort to involve people in a given agenda while community development is the *bottom-up* stimulus and facilitation for people to become involved through their own priorities e.g. on a housing estate. Community organising is another approach where community leaders build capacity and share skills and tools as they facilitate identification of issues and commitment to action. Community organising occurs within an on-going organisation that has structure, leaders and members who pay dues – where there are already strong relationships between the members.

Evidence for impact of community engagement

An important result of community involvement is the building of social networks or social capital which can also promote health and reduce inequality. NICE (2008) examined how community engagement can increase involvement in decisions that affect them including the planning, design, delivery and governance of services as well as activities which aim to improve health and reduce inequalities. It highlighted several approaches and that several factors prevent them being implemented effectively.

Regarding health promotion activities and initiatives to address wider social determinants of health, NICE (2008) found that:

- Community engagement approaches mainly based on working with individual citizens as opposed to civic institutions, may have a marginal impact on health although may improve appropriateness, accessibility and uptake of services.
- Community engagement approaches can improve health literacy.
- Approaches that help communities to work as equal partners or which delegate some power to them may lead to more positive health outcomes.
- Such co-production may also improve other aspects of people's lives such as improving their sense of belonging to a community (social capital) empowering them or otherwise improving their sense of wellbeing). This is achieved because these approaches
  - utilise local people's experiential knowledge to design or improve services, leading to more appropriate, effective, cost-effective and sustainable services
  - empower people by giving them the opportunity to co-produce services and an increased sense of control

- build more trust in government bodies by encouraging accountability and democratic renewal
- contributing to developing and sustaining social capital
- encourage health-enhancing attitudes and behaviour.

The guidance highlights that effectiveness depends upon the approach used and process used to implement it. Learning how to ask communities what they have to offer in terms of their existing skills and knowledge leads to opportunities for them to work with professionals for mutual benefit. The guidance includes twelve recommendations for most effective community engagement which covers four interlocking themes:

1. Long term investment
2. Organisational and cultural change
3. Level of engagement and power
4. Mutual trust and respect

Infrastructure

5. Training and resources
6. Partnership working

Approaches

7. Area-based interventions
8. Community members as agents of change
9. Community workshops
10. Resident consultancy
11. Evaluation

The Marmot review highlighted that significant health benefits can occur for individuals actively involved in community empowerment or engagement initiatives including improvements in physical and mental health, health related behaviour and quality of life (Piachaud, 2009). Evidence from seven studies suggests that community engagement may have a positive impact on social capital and social cohesion (NICE, 2008).

Marmot suggests that the state can intervene to create and deepen social networks and capital. Ideally, intervention needs to be local activity in a national context Marmot et al, 2010).

Social Return on Investment (SROI)

NICE (2008) highlighted that conventional cost effectiveness analysis can rarely be carried out on community engagement work: the effects of such approaches are often diffuse, occur far into the future and are not easily measured and a range of other factors also hinder the process. However, doing a Social Return on Investment can assist organisations appreciate and manage the social, environmental, and economic value that they create. The approach combines, cost-benefit analysis and social auditing, taking into account the social benefits to all stakeholders. There are often different outcomes for different stakeholders.

5. Improving Public Health through Community Involvement (KHP Public Health Strategy – theme D)

Process and timetable for theme D

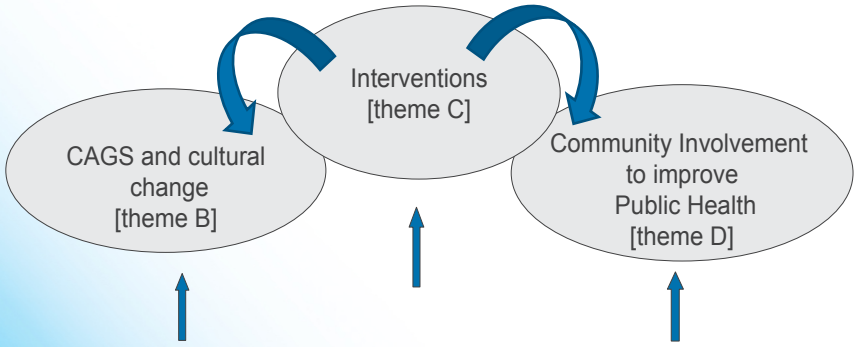
It is possible to conceive of a Five-phase programme to take forward this work but this would obviously be dependant on local circumstances and decision-making

- **Phase 1** - Spring 2011: Time-limited group invited to help shape this theme as part of KHP Public Health Strategy
- **Phase 2** – Spring to Summer 2011; Establishing Borough-based coordination and leadership
- **Phase 3** - Autumn 2011 to Autumn 2012: Working with the Local Authority, GP Consortia/PCT, Director of Public Health, specific local third sector organisations and potential funders to involve and engage the wider community about their health and wellbeing and the most effective interventions to improve it. The effectiveness of methods of engagement would be evaluated together with the internationally recognised research expertise at KHP.
- **Phase 4** - Autumn 2012 to Autumn 2013:
    - Following the involvement exercise, to work with the community to implement agreed interventions in the most effective way
    - Working with the community to evaluate effectiveness of a range of interventions together with the internationally recognised research expertise at KHP
- **Phase 5** – Autumn 2012 onwards: in parallel with Phase Four making changes to services, systems and resource allocations as a result of the evaluation

This Report is the product of Phase 1 work and sets out the advice and recommendations of the time-limited Group to local authorities in taking this work forward. It is an offer from King's Health Partners to support the active engagement of local civic institutions in a process of co-creating the public health agenda. The proposal is that community organising principles are applied and that KHP academic resources are used to evaluate the process and output.

Theme D relates to the four other strands of the public health strategy as highlighted in figure 1 below.

Public Health Collaborative [theme E]



Academic capacity and funding [theme A]

Phase 1 - Spring 2011: Time-limited group invited to help shape this theme as part of KHP Public Health Strategy

The second half of this report records the work of a time-limited group which met four times during March and April 2011 and shared their individual and collective wisdom and advice to KHP and helped to shape one of five Themes in the KHP Public Health Strategy.

A number of individuals representing a cross section of statutory and voluntary organisations were invited to become a time-limited Group to help shape the work for the KHP Public Health Strategy Theme called "Improving Public Health through Community Involvement".

Participants that accepted the invitation were drawn from across Lambeth, Southwark and Lewisham from:

- Local Action - representation from the following organisations participated
  - Citizens UK and local organisations (see Appendix 3A)
  - DIY Happiness (see Appendix 3B)
  - Health Education Centre and John Donne School (see Appendix 3C)
  - Health Empowerment Leverage Project (see Appendix 3D)
  - Mental wellbeing impact assessment (see Appendix 3E)
  - MindApples (see Appendix 3F)
  - Mindfulness and Mental Health Foundation (see Appendix 3G)
  - Oxford Muse in Lewisham (see Appendix 3H)
  - Time banking UK and local organisations (see Appendix 3I)
- Local Authorities – e.g. Directors of Policy, Chief Executive's Office
- Public Health/PCTs – e.g. Public Health Managers [nb Directors of Public Health Strategy Coordinating Group]
- GP Consortia – e.g. Community Engagement leads
- KHP/KCL – Expertise on community organising and research/evaluation with capacity to translate ideas into proposals including visiting professors with expertise in community organising and conversation
- GSTT Charity – representation

Participants were invited to help develop two distinct phases of the "Improving Public Health through Community Involvement" theme in KHP's Public Health Strategy and a slide-set in the invitation pack set this out:

(i) Setting the agenda with the community by working:
- To create an agenda that has been authentically developed through very many face to face conversations and small group meetings, and
- An organised body of people who have ownership of that agenda and are willing to act and to persevere in order to see it carried out.

Citizens UK had particular expertise to offer for this first phase of the work because they used an approach called community organising to build commitment to action with demonstrable achievements (see appendix 3A). London Citizens membership now stands at 240 civil society

institutions representing around 250,000 people which they would offer as part of a hub for this public health work and could train and spread the methodology to other institutions which took part in the public health agenda-setting phase. Time banking UK similarly had a network of organisations across the local area (see Appendix 3I). These had a specific commitment to improving the health and wellbeing which could be harnessed as part of this first phase. Some local time banks are also operating as adjuncts to health institutions e.g. GP Surgeries and mental health trust which gave them an added expertise and focus on the public health and wellbeing agenda.

(ii) Defining and implementing the interventions to scale together with appropriate evaluation.

At the first meeting, Zoe Reed (Executive Director, Strategy and Business Development, South London and Maudsley NHS Foundation Trust and lead for KHP on community involvement) presented the slide pack which had been sent out with the invitation email. She emphasised how grateful KHP was that people were willing to give of their time and expertise to help them create the KHP Public Health Strategy. However, she highlighted that involvement would not necessarily lead to their initiative being taken forward by local authorities.

The time-limited group contributed to identifying ways of working with communities which would:

- be effective in creating an agenda which has been authentically developed through very many face-to-face conversations and small group meetings, from
- An organised body of people who have ownership of that agenda and are willing to act and to persevere in order to see it carried out.
- support effective community involvement regarding their health and wellbeing and the most effective interventions to improve this
- facilitate effective community involvement in helping to ensure maximum impact of implemented interventions and best ways of delivering interventions

Participating representatives of each particular Local Action intervention/ organisation were asked to send a one-page summary setting out a description of the intervention, its use in the local area and evidence for effectiveness including any evaluation of cost effectiveness. [Attached]

Individuals from the time-limited group attended four workshops/meetings through March and April 2011. The group workshops are summarised in the following sections:

- Why is community involvement important
- Purpose and goals of proposed projects
- Key audiences
- Community involvement building on current work
- Issues relevant to effective community engagement
- Consulting the Local Authority
- Key qualities of partner organisations
- Important implementation issues

- Interventions to be taken to scale
- Practical steps

Why is community involvement important?
Despite progress, large amounts of poor health and inequality remain. Furthermore, the majority of the community are not engaged with health improvement.

Increased community engagement can support, complement and build on existing work to improve public health, reduce health inequalities and build social capital which also has significant impact on health outcomes. Increased community involvement can also facilitate effective partnership development and joint working across organisations

Purpose and goals of proposed project
- Listen to concerns and priorities of communities
- Agree priorities with community and partners building on current priorities
- Agree evidence based interventions with community and partners to be locally implemented within resource availability
- Co-implement effective interventions to scale
- Co-evaluate impact of community involvement approach
- Co-evaluate impact of interventions including cost benefit analysis

Key audiences
As well as the community, key audiences include:
- Local Authorities including CEO/Strategy as well as elected councillors and health and wellbeing lead within that group.
- Health and Wellbeing Boards comprising Local Authority and Health and Voluntary Sector.
- Directors of Public Health (DsPH's)
- GST charity
- KHP
- GP consortia/Clinical Commissioners

Community involvement builds on current work
The Group acknowledged the importance of taking account of the large amount of work which has already been done and the need to link with range of stakeholders including DsPH's as well as audiences highlighted above. The current project is seen as part of wider public health strategy within KHP to increase effectiveness of interventions.

Effective involvement of the community
The first stage to involving the community in any project requires much prior engagement. However, it was suggested that a more formal listening process which included identifying capacity and building the conversation with the public sector as well as discovering what the community considered the priorities and interventions to address these, was an important step in initiating ongoing involvement and co-production.

Key issues relevant to effective community engagement were identified as:

- Recognition of and engagement with the broad structure of community needs to take account of the fact that within any particular geographical area numerous parallel communities exist across any 24 hour period with often little interaction between different groups.
- Often high turnover within communities
- Majority of residents do not usually get involved and the process to facilitate wider engagement is important
- Councils now have significantly less resource to do work which they previously covered. Most community engagement teams have been significantly reduced so processes which rely on citizen capacity as opposed to profession capacity are important.
- That there were a range of different methods of community engagement include surveys, community organising, community development and training.
- That there was often lack of clarity about the purpose of community engagement as well as lack of clear methodology.

Local examples of third sector organisations with an extensive network of organisations within the community are Time Banking UK and London Citizens.

What do Local Authorities need to assist them
The time-limited group suggested that Local Authorities (LAs) required intellectual rigour to assist with what they are already doing. The group identified that important elements of interventions included that they were sustainable, scalable, drivers of wellbeing and could be evaluated. It was also suggested that they were linked to JSNAs.

Groups also identified that this collaborative approach could be supported through KHP expertise and charity money which also enhanced credibility with other potential funders.

Further group work then examined possible frameworks for identifying partner organisations and interventions.

Key qualities of partner organisations
The qualities of ideal partner organisations able to lead in setting the agenda and seeing it through included:
- Existing links with local community-based organisations and particularly popular and permanent institutions such as schools
- Capacity to carry out interventions including a trained workforce
- Ability to deliver evidence based interventions with measurable outcomes or which looks very promising
- Operating from a method which enables joint community/health/LA etc. development of community led interventions/ actions
- Collaborative involvement of research and evaluation expertise in design and evaluation of project

Important implementation issues
During one group meeting, individuals were asked to join one of three groups in order to gain important differences in perspective. Members of

the group from LAs, PCTs, Public Health and GP consortia highlighted the importance of:

- Learning from the past 10 years of experience of various local initiatives
- Taking account of existing practices in relation to community engagement
- Local realities needing to influence interventions
- Demonstrating the effectiveness of interventions and added value
- Reducing silo working and encourage whole system focus
- Good discipline regarding methodology of implementation
- Linking to JSNA, existing programmes and interventions
- Capacity for KHP to work in areas of high inequalities to address these

Members from the KHP academic group highlighted the importance of:

- Institutions responding to needs of local communities
- Institutional and culture change
- Credentializing civic agency approach through research
- Recovering public dimensions of teaching and medical vocation as contributing to public life

Discussion occurred resulting in the following suggestions:

- Link to theory of change
- Power analysis to determine who the key players are, resources and potential obstruction.
- Mapping resources to enable maximum impact
- Identifying key organisations which could put interventions into practice
- Piloting of case studies of interventions

Interventions to be taken to scale

The group suggested that a variety of interventions would be required which work at individual, family and wider community level. National and local policy will influence KHP's ability to take some interventions to scale and therefore these levels should also be considered. Important criteria for choosing interventions to take to scale included:

- **Evidence based:** Conventional wisdom was that all intervention to be taken to scale must have an evidence base. Although there are different levels of evidence, in some cases we might want to take an intervention that has a lower level of evidence but would benefit from rigorous testing and research.
- **Control and self-determination:** Recognised as having a key impact on wellbeing and therefore should be a central theme. Interventions that co-produce health and encourage ownership rather than "do to" people.
- **Assets based approach:** A key principle is working from an asset model rather than a deficit one, whether individual assets or community assets.
- **Enhanced social connections:** Social connections, social support, a sense of belonging and community are key components for wellbeing.
- **Sustainable:** designed to build in sustainability within civil society

- **Measurable:** There should be robust measures including ability to demonstrate cost effectiveness and where those savings are accrue (e.g. a health intervention may have benefits for criminal justice).
- **Reduce inequality:** Interventions should contribute to decreasing health inequalities.

Participating representatives from the Local Action Groups/Initiatives were asked to send a one page summary description of the intervention, its use in the local area and evidence for effectiveness including any evaluation of cost effectiveness. [Attached]

Practical next steps

Important issues around people and organisations included:

- Identification of partners from LA's, health, third sector groups and communities
- Engagement and coordination with leadership including DsPH's and Chief Executives
- Engagement with existing programmes and those already working in this area: a stakeholder map could highlight who is interested and why as well as potential resources. Wellbeing network of 700 people highlighted.
- Clarification needed regarding which forum owns the project and who this is next taken to.
- Need to take account of changes currently going in LA's, PH and GP commissioning as well as reduced funding

Important issues around steps in the process include:

- Simple and understandable project plan: A clear one page summary is required for each audience highlighting what this is asking them to do and the resulting improved outcomes
- Clarification of desired outcomes for different populations and geographical areas
- Clarification of what needs to change to make it happen
- Effective engagement across the wider community which involves both listening and education.
- A good communication strategy including use of high profile figures can also highlight the work and further promote engagement.
- Bring resources to build on existing capacity
- Clarifying the process to scope a number of implementable interventions and then agree which ones
- Ensure that interventions effectively cover all groups to prevent widening of inequality
- Develop and build capacity for implementation of interventions through partnership working
- Quality assure interventions
- Evaluation of impact of interventions
- Effective early collaboration with range of research expertise
- Clarification of time scale

Phase 2 – Spring to Summer 2011; Establishing Borough-based coordination and leadership

- Working with Lambeth, Southwark and Lewisham Local Authorities to individually coordinate with their Director of Public Health, GP Consortium/PCT, specific third sector organisations and potential funding organisations to join with KHP and create the programmes which we collectively decide to run.

Recommended Criteria for Local Authorities to propose for their public health improvement system

- Each participating organisation to encourage their operational teams and services to identify community groups they are in contact with
- Each participating organisation to identify existing public health initiatives they would like to see more widely implemented and evaluated
- Each participating organisation to commit to doing whatever is necessary within their areas of responsibility in response to the ideas and solutions generated through the agenda-setting part of the programme and action research projects
- Secure funding for Phase 3 below

Phase 3 - Autumn 2011 to Autumn 2012: Engaging with the community about public health priorities and interventions

- Working with the Local Authority, GP Consortia/PCT, Director of Public Health, KHP and specific local third sector organisations to engage and listen to the wider community about their health and wellbeing and their views regarding the most effective ways to improve it
- Analyse effectiveness of engagement with the community in creating an organised body of people prepared to take action on the intervention they have co-created and in identifying sustainable interventions to support measurable improvements in public health.
- Develop and agree a framework for decision making and prioritisation of the interventions and changes to be undertaken to support the implementation of the learning across communities.
- Secure funding for Phase 4.

Outputs required from all initiatives run through Phase 3

- An agenda that has been authentically developed through very many face to face conversations and small group meetings and
- An organised body of people who have ownership of that agenda and are willing to act and to persevere in order to see it carried out.

Methodologies for large scale Community Involvement in setting the public health agenda

The proposal is that each borough council provide the hub of a collaboration of local organisations that will provide the infrastructure to develop and test a particular type of community involvement in setting the public health agenda.

Citizens South London and Time banking are already established in local boroughs and are ideally placed to provide the Borough-based anchor and platform for this approach. In addition, other local civil society institutions and public organisations such as schools might well be keen to participate.

Identification of which interventions to implement

- The local action initiatives and organisations which participated in the time-limited group to develop this offer are examples of important work in this area. No doubt, however, as part of Phase 2 and 3, others will be identified and crucially local citizens and citizen-based organisations involved in the development work will have their opinion regarding the most effective interventions to facilitate public health improvement in their areas.
- Information will be provided regarding different interventions
- Decisions will need to be taken on which initiatives to take on scale and evaluate.
- Communities and other partners (GP Consortia/PCTs, Directors of Public Health, KHP, third sector organisations) to co-design the support and interventions required to improve the health and wellbeing of local people
- Develop and agree the outcomes and outputs to be delivered through the agreed supported change programmes [mindful that many changes will be implemented by communities without recourse to any public funding so won't come within this Framework]

Phase 4 - Autumn 2012 to Autumn 2013: Work with the community to implement agreed interventions in the most effective way

Following the large scale community involvement approach to setting the agenda and identifying the interventions, the plan would be to create a number of Action Research Programmes which can track and validate the impact of the interventions, and changes implemented, as part of a continuous process.

There would be continuous work with the community to facilitate evaluation of the impact of a range of interventions together with the internationally recognised research expertise at KHP

Phase 5 – Autumn 2012 onwards: in parallel with Phase 4 making changes to services, systems and resource allocations to give effect to the learning from the involvement exercise

- Support community groups and others to undertake the changes they wish
- Re-align public services to support the changes required to enable communities and individuals to continually improve public health and wellbeing.

6. Conclusion

KHP is committed to supporting Local Authorities in their lead role in improving the Health and Wellbeing of their local populations and wishes to offer its expertise across the full range of disciplines. By taking a research and evaluation approach to engaging local communities in setting the agenda and taking to scale agreed initiatives, KHP wants to support more sustainable improvements in the health and wellbeing of local people and provide the evidence of effectiveness required to guide future resource allocation decisions.

Zoë Reed
Community Involvement Public Health and Wellbeing
King's Health Partners

Dr. Jonathan Campion provided the evidence and incorporated the work of the time limited group

Professor Charles Wolfe approved the paper
May 2011

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Individuals from the time-limited Development Group attended 4 workshops/meetings through March and April 2011 and KHP is indebted to them for the insights, expertise and wisdom that they shared in the formulation of this report.

Local Action - representation from the initiatives listed below:
- Citizens UK and local organisations - Matthew Bolton and Stefan Baskerville
- Time banking UK and local organisations - Sam Hopley and Kemi Adeboye Paxton Green Trustee and member
- Mindfulness: Mental Health Foundation - Andrew McCulloch
- Health Education Centre - Tim Higginson, Evelyn Holdsworth, Nick Tildesley
- Health Empowerment Leverage Project - Dr. Brian Fisher and John Gillespie
- Mental Wellbeing/DIY Happiness - Tony Coggins
- MindApples - Andy Gibson and Tessy Britton
- Oxford Muse in Lewisham - Theodore Zeldin

Local Authorities
- Lambeth Council – Sophia Looney
- Southwark Council - James Postgate and Jayesh Patel
- Lewisham Council = Barrie Neale and Sarah Wainer

Public Health/PCTs
- Lambeth – Sarah Corlett and Lucy Smith
- Southwark – Rosie Dalton-Lucas

GP Consortia
- Southwark GP Consortium - Dr. Jonty Heaversedge
- Lambeth GP Consortium – Adrian McLaghlan
- Lewisham GP Consortium – Brian Fisher and Helen Tattersfield (Chair of Consortium) asked to be kept informed

KHP/KCL – Expertise on community organising and research/evaluation with capacity to translate our ideas into proposals
- Derek Bolton Professor of Philosophy and Psychopathology King's College London, Institute of Psychiatry
- Luke Bretherton Senior Lecturer in Theology & Politics and Convenor of the Faith and Public Policy Forum at King's College London.
- Harry Boyte Senior Fellow at University of Minnesota and heads Center for Democracy and Citizenship at Augsburg College
- Theodore Zeldin. Professor of history and philosophy at Oxford University

Ollie Smith (Director of Research and Innovation, GSTT Charity)

Charles Wolfe (Professor of Public Health, KHP)

Zoe Reed (Lead for KHP Public Strategy on Community Involvement)

Jonathan Campion (KHP Public Health Strategy coordinator)

KHP Public Health Strategy Coordinating Group

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Danny Ruta (Director of Public Health, Lewisham PCT)

Ollie Smith (Director of Research and Innovation, GSTT Charity)

Ruth Wallis (Director of Public Health, Lambeth PCT)

Graham Thornicroft (Director of Community Psychiatry, Head of Health Service and Population Research Department, Kings College London; Director of Research and Development, South London and Maudsley NHS Foundation Trust)

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Appendix 1

King's Health Partners Public Health Strategy Update

Charles Wolfe and Zoe Reed on behalf of KHP Public Health Strategy Coordinating Group April 6th 2011

Purpose and actions required of KHP Executive
This paper outlines the progress made in developing the strategy over the last 4 months and the proposed framework for delivering the priorities identified. It has been written for the KHP Executive but is also suitable, once agreed, for dissemination to all stakeholders in Lambeth, Southwark and Lewisham for further development.

We seek approval of the work to date and agreement on the timescale and delivery plans.

Summary
King's Health Partners Strategic Framework 2010-2014 states that it wishes to work with others to

- Improve the health and wellbeing across our ethnically and socially diverse communities and working to reduce inequalities
- Transform the nature of healthcare: by moving from treatment towards population screening and disease prevention
- Be inclusive: by designing systems and procedures so that everyone is actively encouraged to become involved and has the opportunity to do so

Hence, Public Health is recognised by KHP as central to its mission yet not currently central to its academic or clinical strategy. The Public Health agenda is necessarily broad, multi faceted and requires multi agency working. Here KHP present an offering developed with local communities, health and social commissioners and providers to address the agenda locally and further afield.

Over the next five years we aim to be recognised internationally for our academic and service innovation in Public Health in addressing local and international issues, with a focus on inequalities in health and healthcare delivery, particularly with regard to ethnicity and deprivation. In addition, KHP through its Clinical Academic Groups (CAGs) and the South London sector will be an innovative test bed to develop and test solutions in prevention and management of long term conditions of Public Health importance, thereby achieving academic, training and service delivery excellence.

A strategic framework is proposed for identifying the Public Health priorities, how we will address them with our partners in local communities and how success will be assessed. The themes identified are the enabling work streams that will deliver a distinctive strategy geared

towards innovative Public Health initiatives to reduce inequalities in risk of disease and improve health and wellbeing.

Five key interdependent themes have been identified for the KHP Public Health agenda which are:

A. Developing academic capacity to design interventions and contribute to delivery of the strategy
B. Developing the culture of Clinical Academic Groups so that they are Public Health focused in all their behaviours and priorities
C. Delivering Public Health interventions to reduce risk and improve health and wellbeing
D. Community Involvement to improve Public Health
E. Public Health Collaborative for joint working to identify priorities and maximise the offer and availability of expertise and information to secure change for improvement.

Within these key themes the following questions need to be addressed:

1. What is the vision and approach to working?
2. What are the priorities?
3. What interventions will deliver these?
4. How will these interventions be delivered?
5. How will we know we have succeeded?

The strategic framework for developing the strategy and how it will be delivered is outlined in Table 1.

Developing the strategy
Charles Wolfe was designated Public Health Lead for KHP supported by Zoe Reed in December 2010. An initial strategy document developed over the summer of 2010 formed the starting point for the KHP Public Health coordination group's strategy development. Current members include Graham Thornicroft (KCL Institute of Psychiatry (IOP) and Institute of Health, Policy and Evaluation (IHPE), Matthew Hotopf (KCL IOP and Specialist Biomedical Research Centre Nucleus), Anne-Marie Connolly (Southwark), Ruth Wallis (Lambeth), Danny Ruta (Lewisham), Ollie Smith (Guy's and St Thomas' Charity). The strategy has drawn on discussions with

- CAG leads at 2 KHP Leads meeting with more detailed discussions with several CAG leads and their teams (Diabetes (Amiel), Addictions (Strang), Women's Health (Poston, Oral Health (Gallagher), Medicine (Hopper)).
- The Mayor's Office (Pam Chester and Policy Leads), Lewisham Council (Quirk and Ruta)
- Community group representatives (e.g. Citizen's UK and Time Banking UK)
- Stakeholder Events: 4 events bringing people together to co-create the Improving Public Health *through* Community Involvement strand. Representation included community groups, Local Authority, GP Consortia and NHS PCT representatives from across LSL, KCL academics, GST Charity
- Dennis Gillings, Quintiles
- Comprehensive and Specialist BRCs developing their 'Population' and 'Nucleus' Themes respectively
- KHP IHPE, the Public Health theme of which is being delivered through the King's Health Partners Public Health Group
- University College and Imperial Academic Health Science Centre Public Health Leads (Raine and Riboli)
- Inner East London Public Health and Queen Mary's University London (Basnett, Trembath, Griffiths, Greenhalgh)
- Lambeth and Southwark Commissioners (McLachlan and Osonuga)

1) Vision and approach to working

Overall
During the last 10 years, there has been much progress within Public Health locally and nationally that this strategy acknowledges. Particularly, we must build on local success. More recently, there have been significant policy development including the public health white paper 'Healthy lives, health people' (DH, 2010) which is bringing considerable change to the provision of health and social care to which KHP can contribute.

KHP's broader Public Health aim is to work with other partners and existing resources to contribute to a local health and social care system that provides the best possible health and wellbeing for the population of

South East London through a coordinated and collaborative approach to excellence in Public Health practice, education and training, and research.

KHP's broader Public Health aim is to contribute to a local health care system that provides the best possible health and wellbeing for the population of South East London. KHP is committed to a world class Public Health and health care services which takes a life course approach and involves both:

- meeting current health needs through effective primary and community care, secondary and tertiary care
- promoting health and wellbeing to prevent future health needs

Such a strategy will benefit local communities across a broad range of outcomes with associated economic savings within health as well as other areas such as education, employment and criminal justice.

A. Developing academic capacity

- KHP aims to create a centre where world-class research, teaching/training and practice are brought together for the benefit of the population
- Effective collaboration with partners will highlight key Public Health gaps which KHP academic partners can help answer

B. Developing the culture of Clinical Academic Groups so they are public health focused

- Vision and approach of the Public Health strategy underlies its importance in developing the public health culture of CAGs
- There is a reputation element to this work in that the *way* our services and clinicians react to others in the system will demonstrate whether our strategic claim that we are taking public health seriously is perceived as real or not.

C. Public Health interventions to reduce risk and improve health and wellbeing

- Marmot review highlighted that in England, the annual cost of inequality is £56-58 billion.
- Public Health white paper highlights that ill-health is both a cause and result of inequality.
- Scale up effective interventions to national and then international level

D. Community Involvement to improve Public Health

- Recent work with a number of partner organisations highlights KHP's commitment to involving the community in development of the Public Health strategy
- Engagement with the community facilitates ownership and collaborative working also enhances implementation and effectiveness

E. Public Health Collaborative

- Local health and social care system which provides the best possible health and wellbeing
- Whole system approach

- Coordination and collaboration with other partners including those in public health service, LA's and CAGs to enhance effectiveness and efficiency

2) What are our priorities?

King's Health Partners commitment to local people and communities is described in the following terms:
We need to address the inequalities by using our resources to maximum effect. We will

- Strive to enhance healthy lifestyles and promote health and wellbeing by working with key stakeholders to address Public Health and clinical issues
- Continue to use our infrastructure to have a positive impact on the social, environmental and economic context in which local people live, and develop and deliver a challenging environmental sustainability strategy which is vitally important for the health and wellbeing of the population
- Work to eliminate the barriers to accessing our services, employment and education opportunities because we know that our population is diverse and within it there are vulnerable and disadvantaged groups
- Promote fairness and equality for all

A. Developing academic capacity

- Develop a School of Public Health
- Expertise and increased capacity is required to estimate and interpret inequalities and what drives them
- Increased capacity and expertise is required to develop, execute and evaluate interventions and scale up
- Infrastructure to deliver the interventions are required: integrated primary and secondary care databases with capacity to incorporate research databases to deliver personalised medicine

B. Developing the CAG public health culture

- Liaise and listen to views regarding priorities
- Different CAGs doing things slightly differently
- Identify common themes across CAGs e.g alcohol, smoking, obesity
- Use leading edge methodologies to secure cultural change

C. Public Health interventions to reduce risk and improve health and wellbeing

- Importance of considering social determinants of health
- Refer to all data sets including Joint Clinical Needs Assessment
- Identify areas with greatest need and high risk groups: likely to include smoking, obesity, exercise, drug misuse, alcohol
- In terms of improving health and wellbeing the Integrated Care Pilot is a priority

D. Community Involvement to improving Public Health

- Engage different community groups to identify priorities
- Work with range of partner organisations

- Recognise central role of local authorities in harnessing all that influences and improves health

E. Public Health Collaborative
- The London boroughs are developing their health and wellbeing strategies
- Key part of this strategy is identifying priorities for next 5-10 years
- Opportunity to go beyond other models
- Liaise with public health delivery organisations
- Liaise with commissioners and primary care

3) What interventions will deliver the priorities?
Working in partnership to deliver the themes
a. Developing the evidence base for and promoting interventions which prevent physical and mental illness and promote health and wellbeing with resultant behavioural change.
b. Developing the evidence base for interventions which improve public health and wellbeing though community involvement including around effective implementation
   - In setting the agenda
   - In developing the process around arriving at an informed decision around which interventions to choose
   - In implementing the interventions
c. Developing the cultural change programme so that public health activities are a priority for all Clinical Academic Groups
d. Developing a business offer providing Public Health information and support to commissioners and others
e. Building the academic capacity and links regionally, nationally and internationally to support our plans to deliver our Vision

A. Developing academic capacity
- Link academics with themes to identify expertise and capacity required
- Identify models of excellence internationally

B. Developing the CAG Public Health culture
- Link CAGs to Public Health community
- Liaise regarding range of interventions they can be involved with

C. Public health interventions to reduce risk and improve health and wellbeing
- Evidence on what works and what the gaps are
- Look at range of effective interventions

D. Community Involvement to improving Public Health
- Highlight practical issues with what has been tried already
- Identify gaps in access and delivery
- Recent work with a number of partner organisations has identified a number of community interventions available locally. Work done to:
   - Identify what LAs and commissioners want
   - Identify framework to choose partner organisations to lead, set and see agenda through

- Criteria of interventions to take to scale

E. Public Health Collaborative
- Knowledge of what has been tried and is known to work (or not)
- Mapping of available resources
- Highlight practical issues
- Develop a tool/offer

4) Delivery of interventions

Developing the Themes – process and timescale

Charles Wolfe and Zoe Reed to:
- Identify participants and ask them to join 'good enough' groups to take forward each strand and produce a clear delivery plan for each
- Establish a group to coordinate the work of the strands and produce the overall strategy
- Identify resources to support the development of each strand and the overall strategy
- Produce an outline strategy for consideration by KHP Executive and potential funders such as KCL and GSTT Charity by Spring 2011
- Produce a coherent, widely owned strategy and funding bid [s] by the Autumn 2011

A. Developing academic capacity
- Funding of capacity building to deliver the strategy
- Creating environment where Public Health can thrive

B. Developing the CAG Public Health culture
- Training for CAGs to be a part of wider delivery system-Public Health training (e.g. modules of Masters in Public Health)
- Explore latest thinking in ways to achieve cultural change across large social systems-Leadership training
- Employing a KHP Public Health physician to work across themes and particularly CAGs to deliver the strategy

C. Public Health interventions to reduce risk and improve health and wellbeing
- Develop delivery model(s) with D below
- Ensure fit with evaluation framework
- Develop proposals for funding in at least one area to scale of risk reduction and the Integrated Care Pilot

D. Community Involvement to improving Public Health
- Community as part of the solution, not being done to
- Early collaboration with KHP's academic team
- Develop proposals for funding to develop a theoretical framework for engagement with communities and link with interventions (C above)

E. Public Health Collaborative

- Work with colleagues across organisations
- Develop a training tool/offer to colleagues to become 'Affiliates' of KHP
- Develop proposal for funding sustaining coordination of the collaborative function

5) How will we know we have succeeded?

At this stage the shape and scale of the interventions to deliver the strategy require further development and the plan will then be to specify 1, 3, and 5 year measures of success.

Timelines and Funding

Immediate

- There is a need to draw down on KHP funding to employ someone to support the strategic development and development of proposals for funding and develop the themes

By Autumn 2011

- Develop proposals for a School of Public Health with KCL, GST Charity, Professor Gillings and the NIHR School of Public Health, - scope, structure, leadership, capacity in areas identified in this strategy
- Identify Public Health priorities for CAGs and develop proposals for interventions for funding-training, leadership and a Public Health Physician
- Identify priority areas for interventions through the Collaborative and Community Involvement themes and develop proposals for interventions for funding

Within 1 year

- Secured funding for aspects of the School of Public Health and appointed to key posts
- Secured funding for 2 CAG Public Health interventions and CAG culture change proposals
- Secured funding for 1 major intervention to reduce risk and evaluation of the Integrated Care Pilot

Public Health Strategy	**Themes for developing the strategy**				
	Developing Academic Capacity	*Developing the CAG Public Health culture*	*Public Health Interventions*	*Community involvement*	*Public Health Collaborative*
What is the vision and approach to working?	School of PH, Develop tripartite mission for PH,Work collaboratively to identify innovative solutions	Embrace KHP vision	Innovate locally and to scale	Develop civic society and social cohesion	Synthesise KHP strategic framework, grand challenges etc Establish values for joint working
What are the priorities?	Identify drivers to inequalities and health and wellbeing, Increase capacity for evaluation, Improve data integration across sectors	Identify common themes across CAGs	Refer to JCNA but likely to include smoking, obesity, alcohol, drug misuse, exercise. Integrated Care Pilot	Refer to JSNAs Engage different community groups	Refer to JSNAs and developing priorities for the Boroughs Knowledge of what has already been tried
What interventions will deliver these?	Academics to work across themes	Link CAGs to PH community	Evidence on what works and what the gaps are	Highlight practical issues with what has been tried already Identify gaps in access and delivery	Knowledge of what has been tried and is known to work (or not) Highlight practical issues
How will these interventions be delivered?	Funding, environment	Training for CAGs to be a part of wider delivery system. Training in PH, Leadership, Employ Public Health Physician	Develop delivery model(s) Ensure fit with evaluation framework	Community as part of the solution, not being done to	Joint working, Offer of KHP skills to sector, Develop training opportunity for colleagues
How will we know we have succeeded?	Needs milestone objectives based on full Strategy development	Needs milestone objectives based on full Strategy development	Needs milestone objectives based on full Strategy development	Needs milestone objectives based on full Strategy development	Needs milestone objectives based on full Strategy development

Appendix 2

Summary of actions to implement the five themes of KHP Public Health Strategy

A. Developing academic capacity to design interventions and contribute to delivery of the strategy

- Vision and approach: create a centre where world-class research, teaching/training and practice are brought together for the benefit of the population
- Priorities:
  - Develop School of Public Health
  - Identify drivers to inequalities and health and wellbeing
  - Increase capacity for evaluation
  - Improve data integration across sectors
- Interventions:
  - Academics to work across themes
  - Identify models of excellence internationally
- Delivery of interventions
  - Funding of capacity
- Evaluation against milestone objectives of full strategy

B. Developing the culture of Clinical Academic Groups

- Vision and approach: Develop the culture of CAGs so that they are Public Health focused in all their behaviours and priorities
- Priorities:
  - Liaise and listen to views regarding priorities
  - Identification of common themes across CAGs
  - Use leading edge methodologies to secure cultural change
- Interventions:
  - Highlight range of effective public health interventions relevant for each CAG
  - Link CAGs to PH community
  - Liaise regarding range of interventions they can be involved with
- Delivery of interventions:
  - Training for CAGs to be part of wider delivery system (e.g. modules of Masters in Public Health)
  - Cultural change through leadership training
  - Employ public health physician to work across themes and CAGs
- Evaluation against milestone objectives of full strategy

C. Delivering Public Health interventions to reduce risk and improve health and wellbeing

- Vision and approach:
  - Innovate locally and to scale
  - Scale up effective interventions to national and then international level
- Priorities:
  - Refer to all data sets including JSNA
  - Identify areas with greatest need and high risk groups

  - Likely to include smoking, obesity, alcohol, drug misuse, exercise, and those supported by the integrated care pilot
- Interventions:
  - Identify the evidence base for a range of effective interventions which prevent physical and mental illness and promote health and wellbeing with resultant behavioural change
  - Develop criteria for which interventions to implement
  - Decide which interventions to implement
- Delivery of interventions:
  - Develop delivery model
  - Develop proposals for funding in at least one area to scale of risk reduction and the Integrated Care Pilot
- Evaluation against milestone objectives of full strategy

D. Community Involvement to improve Public Health

- Vision and approach: Increased community involvement to build commitment to action and co-design in choice of interventions, delivery and evaluation resulting in increased likelihood of successful spread and take up
- Priorities: wider involvement to include process for deciding priorities in collaboration with existing stakeholders
- Interventions
  - Highlight and clearly communicate evidence base of what is known for different interventions
  - Highlight evidence base for impact of community involvement on effectiveness of interventions
  - Highlight practical issues with what has been tried already
  - Identify gaps in access and delivery
  - Decide interventions to be implemented with community and other partners
- Delivery of interventions
  - Community to be part of solution to effective implementation
  - Early collaboration with KHP's academic team
  - Develop proposals for funding to develop a theoretical framework for engagement with communities and link with interventions
- Evaluation against milestone objectives of full strategy

E. Public Health Collaborative for joint working

- Vision and approach: coordinate and collaborate with other partners including those in public health service, LA's and KHP CAGs to enhance effectiveness and efficiency
- Priorities
  - London boroughs are developing their health and wellbeing strategies
  - Key part of this strategy is identifying priorities for next 5-10 years
  - Opportunity to go beyond other models
  - Refer to JSNAs and what has already been done
  - Liaise with public health delivery organisations
  - Liaise with commissioners and primary care
- Interventions
  - Highlight evidence for range of public health interventions

  - Knowledge of what has been tried and is known to work (or not). If effective interventions have not worked, identify reasons
  - Mapping of available resources
  - Highlight practical issues
  - Develop a tool/offer
- Delivery of interventions
  - Offer of KHP skills to sector
  - Training opportunities for colleagues
  - Develop proposal for funding sustaining coordination of the collaborative function
- Evaluation against milestone objectives of full strategy

Appendix 3

Several interventions including facilitation of community involvement

The following section includes summaries of some interventions and work of organisations which contributed to the working group which developed Strand D on Community Involvement. These were

A. Community Organising and London Citizens
B. DIY Happiness
C. HELP project
D. John Donne school
E. Mindapples
F. Mindfulness interventions
G. Mental Wellbeing Impact Assessment
H. Oxford Muse
I. Time Banks

A. Community Organising and London Citizens

What is Community Organising

Community Organising is a particular approach to community engagement. Professional Community Organisers work with a membership of established local civic institutions, primarily faith communities and schools. This gives access to large numbers of local people, in relationship with one another, in a permanent institutional setting. In each of these local institutions, teams of community leaders are identified and trained in Community Organising. They run a 'Listening Campaign', which builds an authentic, locally owned set of priorities for social change, through thousands of conversations and small group meetings. This includes genuine interactions with relevant statutory agencies and professionals. The value of the Community Organising Listening Campaign lies in the co-production of a specific, achievable agenda that has a body of organised citizens owning it and ready to act and persevere to make it happen.

Evidence base for Community Organising

i) Effectiveness of community organising to engage people

- Community organising has been used in 14 family health care projects to successfully engage people to enable them to address a variety of issues including overscheduled children, diabetes and challenges faced by unmarried fathers (Doherty et al, 2009)
- The London Citizens membership now stands at 240 civil society institutions (approximately 250,000 people). Each member institution pays between £700 and £2000 annual dues, as evidence of their ownership of the alliance.
- The effectiveness of Community Organising as a means of community engagement is demonstrated in the regular participation and large turn-out of this membership at London Citizens events, Assemblies and actions. This has not been researched but it is evident in the coverage of our work.

ii) Effectiveness of community organising to improve health outcomes.

Evidence from the USA highlights that Community Organizing can improve public health as a result of local ownership and civic capacity built around health. The following studies find that Community Organising adds value to or out-performs the more conventional agency-led approaches:

- Community organising has been associated with changes in alcohol related behaviour among 18-20 year olds as well as reduction in establishments selling alcohol to young people although the study did not include statistical analysis of whether this was significant (Wagenaar et al, 1999)
- Community organising can engage young people and adults in prevention of drug, tobacco and alcohol use as well as violence although the study did not include statistical analysis of whether this was significant (Bosma et al, 2005)
- Community organising has been used to reduce tobacco smoking although studies did not find statistically significant effects (Blaine et al, 1997; Forster et al, 1998)

In UK, there are several examples of Community Organising although this has not been evaluated. Three examples of relevant work include:

- The London Citizens Living Wage campaign which has strived to lift 10,000 London families out of poverty. The Living Wage is specifically mentioned in the Marmot Review as a way to combat health inequalities.
  - http://www.guardian.co.uk/society/2011/may/01/living-wage-campaign-10-years
  - http://www.london.gov.uk/media/press_releases_mayoral/record-rise-london-living-wage-puts-%C2%A355-million-pockets-capital%E2%80%99s-low-p
- The South London Citizens Lunar House Enquiry and subsequent engagement with the UKBA resulted in the redevelopment of the Lunar House Centre in Croydon which aims to improve the well-being of vulnerable asylum seekers.
  http://www.croydonguardian.co.uk/news/4816303.New_waiting_area_at_Croydon_s_Lunar_House_finally_completed/
- The CitySafe campaign that has involved thousands of citizens in a street safety initiative, building effective relationships between police, Local Authority and shopkeepers and improving the feeling of security amongst young people.
  http://news.bbc.co.uk/1/hi/england/london/8368108.stm

Local capacity of London Citizens

- As the primary UK Community Organising charity, London Citizens has a 20 year track record of using this approach to build civic capacity and make change (see earlier examples).
- Trained Community Organisers – 25 professional staff in London practicing a particular approach to leadership development and social change that has a 70 year track record in the States and a 20 year track record here.
- Strong relationships with civic institutions in South London – particularly schools and faith communities. Currently there are about 40 schools, churches and mosques across Lambeth, Southwark and Lewisham that pay membership dues to South London Citizens and where we have trained and active teams of community leaders interested in working on health.
- Relationships with leading researchers and practitioners in the States such as Professor Harry Boyte (University Minnesota) and Professor Marshall Ganz (Harvard) who are using Community organizing to turn local civic institutions into engines of public health and to enable health institutions themselves to change and become more engaged with communities.

Description of community organising proposal evaluation to improve public health in London

- Our interest is in a well-researched UK example of using community organizing to enable schools and faith communities in South London – in partnership with health professionals – to build a public agenda that they own and will drive through.
- Project would use the methods of Community Organising to engage local communities in setting and implementing a community health agenda. The key feature of this model of Community Organising is working with

community leaders in existing civic institutions to identify, agree on and take forward common concerns.

- The methodology – "Listening Campaign" in the terminology of the model – will include in this application: establish and maintain interest and ownership amongst partners including NHS & LA (as you are already doing)
  - Identify teams of community leaders within specified local institutions (schools, faith communities, GP practices) already associated with London Citizens and train them in tools of Listening Campaign: 'power analysis', '121 conversations', 'house meetings', 'problem to issue', etc.
  - The trained teams of leaders carry out thousands of 121 conversations and small group meetings, larger neighbourhood meetings and local democratic assemblies in order to build community capacity around a common agenda.
  - This will be a distinct set of health priorities with specific plans for action, each having a dedicated team of committed community leaders to take it forward and ownership amongst health professionals.

Effect of Community Organising

- A health agenda that has been authentically developed through very many face to face conversations and small group meetings. This agenda will include proposals for community-led health education and behaviour change, proposals for adjustments to local health service provision, and proposals for broader social and economic change that benefit health outcomes.
- An organised body of people – teams of community leaders, working with partners in the NHS & LA – who have ownership of that agenda and are willing to act and persevere to see it carried out.
- Implementation of the initial stages of the agreed agenda/plan for a specific community health project – and co-write a grant application to a relevant funding body to fund it. The initial work will include collection of pilot data to support the application.
- Learning and refining how the Community Organising methodology can be focussed explicitly on health issues and localised to South London communities.

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Wagenaar AC, gehan JP, Jones-Webb R et al (1999) Communities mobilising for change ion alcohol: Lessons and results form a 15-community randomized trial. Journal of Community Psychology, 27(3), 315-326

B) Do-It-Yourself Happiness

What is it?
DIY Happiness (DIYH) uses humour, creativity and the evidence emerging from the field of positive psychology to increases people's ability to 'bounce back' from adversity, reduce both the physical and the psychological impact of stress, increase resilience, and build durable personal resources. It has been operating for the last 3 years in 20 of the Lower Super output areas (LSOA's) facing the greatest health inequalities in London. DIYH is funded by the Big Lottery as part of a wider programme of work - Well London (http://www.london.gov.uk/welllondon/).

How the project operates
"[In order to be effective] Health improvement needs to move away from unexciting, piecemeal propositions – 'eat less fat', 'walk more' – to an aspirational vision selling satisfied and lives, integrating physical health with mental and emotional well-being. Health improvement also cannot be imposed. The public have to get enthusiastically involved for efforts to be not only effective, but also sustainable." CSIP, Social Marketing and Mental Health briefing, Oct 2007

The project consists of three parts:

1 . Can Money Buy Women Happiness – create understanding and inspire
A series of 8 participative workshop/experiences run over 2 months around the theme of Can Money Buy Happiness? Each includes explicit information based on the 'science of happiness', practical activities, and take-away information and advice about health and well-being. Each workshop enables women to explore and discuss evidenced-based messages relating to well-being inspired by the 'Five ways to Wellbeing' identified in the Foresight report. (Connect, be active, keep learning, take notice, give.)

2. Dare-to-Dream (D2D) – taking control
As well as exploring 'the science of happiness' in an experiential way, each participant is encouraged to 'dare-to-dream' – to develop their own idea for something that they feel will increase happiness locally for themselves, their families and/or their communities. Participants are encouraged to use the Foresight report's 'Five Ways to Well-being' to underpin their ideas and to develop and cost their ideas based on a budget of up to £500 and then supported to put them into action.

3. Can Money Buy Happiness kits - spreading the message
A social marketing company worked with participants to design a DIY Happiness kit that they would give to others to promote happiness and well-being. This approach aims to support the women to spread the 5 ways messages and what they have learned about well-being to their families, friends and communities.

Results
A total of 160 workshops involved 320 women from 20 LSOA's in 60 investments in happiness and well-being as part of Dare-2-Dream. An evaluation undertaken by the University of East London concluded that the project had succeeded in engaging women in activities which impacted on their subjective wellbeing by changing their knowledge, attitudes and practices regarding their mental health, self care and ways of working with others.

- The project was successful at engaging from a range of ages and targeting those who were unemployed and from ethnic minority background
- Statistical analysis of 141 individuals found that mental and subjective wellbeing was higher following the workshops and participants were more optimistic about the future, felt more resilient, were more appreciative of social relationships and had experienced more trusting relationships with others
- Participants had greater understanding of their mental health and wellbeing, its close association with physical health as well as how to enhance and protect it

Qualitative analysis of narratives, generated by four focus-groups and six one-to-one interviews with women from across a range of London boroughs, collaborates and expands further the statistical results and shows the following as some of the key, recurrent themes:

Being with others: establishing new, positive networks
The opportunity to establish connections with others by sharing positive experiences, was reported as one of the *most* valuable aspect of the project by all the participants.

> *"They wouldn't be people that I would normally see and say hello to in the street, you know…I'm always going to look at it I have something to learn from them and equally they to me. So, you know, it changed my attitudes …"*

A catalyst for gaining positive control (empowerment)
The DIYH workshops were described by the participants as a catalyst for a view that feelings of happiness can be self-cultivated, given the right tools.

> *"What I learned here is that I can bring happiness by myself. I don't have to get it from someone, 'cause I can do it, I can create the happiness. […] They show us how I can do it for myself. […] And they think I can do it and, yes, eventually I will be happy and then like I said earlier if I get happiness, my kids gonna be happy."*

The reported impact of the DIYH in these women's lives also translated beyond the facilitated context of the workshops. Their experiences on project and the kick-start of the Dare2Dream financial component also served as a catalyst for *practical* changes alongside emotional changes:

> *"I've signed up for a few more courses so it's sort of given me inspiration to have a sense of community spirit, all that stuff, so for my personal growth I'm starting an introduction to social work course which is something that I've been wanting to do for a very long time and um I've felt it was something I needed to do for me. Although I'm*

a mum, there are still things that I could do that's going to fulfil me. I felt […] I had to also give something back to my community as well"

"Be the change you want to see": increased self determination and resilience capacity

Their experiences on the project fuelled their hope; engendered a sense of personal control (seeing they can make a difference to their ways of being in the world) and confidence in themselves as agents of change. It activated their resilience capacity:

> "*Yes, to be positive and to go forward and whatever you want to achieve you can achieve it if you go forward without looking back 'cause I think the aim of it was the DIY happiness to look forward other than to look back. So that's what it has enabled me to do. To um, you know, look forward."*

You can follow DIY Happiness at:
Twitter: www.twitter.com/DIYHappiness
Facebook: http://www.facebook.com/pages/DIY-Happiness/191365004228760
Website: www.diyhappiness.co.uk
Email: hello@diyhappiness.co.uk

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C. Health education centre proposal by John Donne school

This sets out a proposal by John Donne School and partners in response to the KHP objective to improve public health through community engagement. John Donne Primary School is a two form entry primary school offering places from Nursery to age 11. The school community is committed to the concept that life chances and therefore education… are dramatically affected by your social relationships and personal well being and our offer addresses this directly.

Case for intervention in Peckham
Strong evidence indicates that public health is more than a process of treating illness is compelling and growing. Recent research below covers some of the concerns about inequality and its impact on public health from local, national and international perspectives.

Substantial inequalities remain in the Southwark so that boys born in Surrey Docks ward can expect to live 17 years longer than boys born in Nunhead ward and girls born in Chaucer ward can expect to live 10 years longer than girls born in Nunhead ward (Southwark`s Children's and Young People`s Health – 2008-9` Report by the Director of Public Health, Southwark).

Furthermore, the following public health statistics exist for Southwark (from briefing on health in Peckham by Dr Jin Li, Consultant in Public Health, NHS Southwark & Southwark Council):

a. Births and maternity
- The more socially deprived areas have higher rates than the less deprived parts of the borough.
- Southwark has a considerably higher infant mortality rate than London and England. There is a strong association with deprivation. Higher infant mortality rates are also seen amongst Black African women and young mothers (under 20 years old).
- Previous analyses have identified teenage conceptions to be of concern.

b. Childhood obesity
- Southwark has the highest obesity rates nationally for Reception and Yr 6 children. Peckham is identified as one of the hotspots for obesity and overweight children.

c. Heart disease
- Peckham GPs have a lower ratio of reported versus expected prevalence of CHD compared to the rest of the borough and nationally, and for some practices, the management of cholesterol and blood pressure can be improved.

d. Diabetes
- Type 2 diabetes is strongly associated with unhealthy weight and poor lifestyles. The recording and detection of diabetes is relatively high for Peckham GPs which may be a reflection of the local socio-demographics: For most of the Peckham practices, there needs to

be considerable improvement including addressing unhealthy weight, promoting healthy eating and physical activity and smoking.

e. Respiratory

- There is wide variation in the detection of chronic obstructive pulmonary disease between the Peckham GPs and some variation in the diagnoses confirmed by spirometry.

f. Cancer screening

- Screening coverage is relatively low for the Peckham GPs and do not meet national targets. Improved screening and awareness raising can highlight the importance screening and how to access this.

'The Spirit Level: Why Equality Is Better for Everyone` by Wilkinson and Pickett (2010) highlights the vital importance of social relationships to human health and well-being and show that higher levels of income inequality damage the social fabric that contributes so much to healthy societies. Now, a major new review of the evidence from almost 150 studies confirms the important influence of social relationships on health. People with stronger social relationships were half as likely to die during a study's period of follow-up as those with weaker social ties.

The Home Front report by Balzalgette and Maro (2011) highlights case studies all from John Donne School. The report recommendations are organised according to five key policy aims:

- build the parenting skills base
- target parenting support according to need
- apply the early intervention principle beyond the early years
- make shared parenting a reality
- support social networks and collective efficacy

The Peckham health information at General Practice (GP) level is based on the APHO profiles (February 2011) and NHS Southwark Polysystem Profiles (Mar 2010). The practices considered are:

- 4 practices in the Lister (Peckham Road)
- Acorn Surgery (Peckham High Street)
- Queens Road Surgery (Queen's Road Peckham)

Proposal to move GP practice to opposite John Donne School

For the last 2 years the school has been developing a vision to combine priorities in health and education. This vision has 3 sources of inspiration:

- The Peckham Experiment (an iconic investigation into health and wellbeing from the 1920-40s)
- The School Governors and staff
- The wishes of the parents and carers of John Donne children: `*The Home Front` Jen Lexmond, Louise Bazalgette, Julia Margo, Demos 2011*

A unique opportunity presents itself now in the form of the site of Tuke School, across the road from John Donne. The site was vacated in September 2010 and is due to be sold as part of Southwark's housing programme.

1. Use of Tuke site would allow the school`s vision to be expressed fully:
- Moving he Queen's Road Practice 20 yards away, which would maintain services for the 6,000 list
- Social space for community use… café, education, recreation
- Facilities for provision of out of hospital care and pilot projects to address local health priorities
- Multidisciplinary training (teachers, health professionals, social workers)
- The facilities and support for the development of other public health activities typified by organisation such as `Time banking ` and `Citizens UK`. The inclusion of these organisations would further help the growth of a dynamic and enterprising community and the close links with health care and education would establish a strong cohesive community in Peckham

2. This proposal would:
- Mitigate the long term impact of material deprivation and poor wellbeing scores on the long term health of Southwark children through reducing childhood poverty and improving life chances for those in the most deprived circumstances.
- Act to continue to reduce the numbers of excess deaths amongst young people.
- Further work is needed to improve on the unhealthy lifestyles of Southwark's secondary school pupils.
- Work with local communities to raise awareness of long term conditions and access to services, support health advocacy groups and the development of culturally relevant self-management condition groups.
- Recommendations of the Home front report (2011) can be addressed with a public health and education link project at John Donne school using the Tuke building.

3. The project would allow new focus of inter-agency governance to be tried and evaluated and the scheme would lend itself to formal evaluation by KCL.

4. Much of the initiative would be funded through community agencies:
    - Primary care facilities and services through NHS commissioning
    - Out of hospital care through NHS commissioning
    - Multidisciplinary training through the relevant agencies

5. Other funding would be required for project management and evaluation, minor capital works and rent of the Tuke site.

Initial discussions show that the Queen's Road Practice, the outgoing NHS Southwark and King's College Hospital were very supportive, and the concept has also been discussed with the leadership of KHP and the Guy's and St Thomas' Charity. Southwark Council remains reluctant to allow an asset which is included in the housing programme to be used for other purposes. However, they may be willing to support the vision if the support of partners and the wishes of local people were clearly expressed.

Many of the educational activities will be extensions of the school`s current activities.

Project evaluation

We would see a way to evaluate the project through:

a) addressing the challenge of sharing targets across the different disciplines

b) succeeding in addressing the challenge of governance in a multi-disciplinary organisation

c) using the markers indicated in the DEMOS research as a way of determining the impact of the project on the community

D) Health Empowerment Leverage Project

What the HELP intervention involves
HELP provides an accelerated form of community development designed to achieve effects economically within a given timescale. It builds on 15 years of experience in 6 sites. It focuses on geographical areas such as the most deprived estates, both rural and urban. The HELP process ensures that the intervention prioritizes issues that matter most to local residents and helps agencies deliver more responsive services.

It begins with gearing up service providers to listening to residents and joint problem-solving and goes on to create a partnership of residents and service providers in which health and other improvements are identified and action taken. Local leaders emerge, difficult issues are tackled (not without conflicts), residents gain confidence and services are stimulated into responsiveness. A facilitator leads the residents and agency staff through a seven step programme called C2 (shorthand for Connecting Communities (see http://www.healthcomplexity.net) which is the HELP fieldwork model of choice. The process depends on local health and other agencies working together with residents to target the things they have identified as making life better on the estate.

The HELP project is funded by DH to explore the business case for community development

HELP programmes and antecedents
This form of intervention was developed by frontline health practitioners with support and evaluation by academics from Peninsula Medical School at Exeter University. It has a track record of transformative health and wellbeing outcomes in several different sites over a number of years.

The intervention was carried out in a disadvantaged neighbourhood in each of three contrasting PCTs during 2010. Inputs and outcomes are being tracked. These are some of the outputs achieved within one year in Dartmouth (Townstal):

- A new dental service was established
- A derelict area, the estate's only central open space, was transformed into a playpark
- Well attended social events and football sessions were regularly held
- Relations with the local housing associations were improved and tenants were more satisfied.
- Summer holiday activities for all ages took place
- Anti-social behaviour was reduced
- A plan for social renewal through further activities was agreed
- Community partnership provided citizenship lessons at community college
- Youth community forum established
- New weekly community 'hub' for activities at community hall

A review of the longer term effects of an earlier C2 project on the Beacon Estate in Penwerris, Cornwall, found major improvements between 1995 and 2000 in education, health, employment and crime (Stuteley and Cohen, 2004; Durie et al, 2004). Attempts to substantiate these statistically remain uncertain since numbers were small and chains of cause and effect complex, but improvements appeared to outstrip national trends at the time, and the sense of an overall positive momentum of development driven by the project was attested in successive meetings of residents and service providers.

The complexity of effects is illustrated by the project's relationship to a regeneration grant. The creation of the neighbourhood partnership opened the way to applying for a national 'Capital Challenge' grant of £1.2m. Having a credible residents' organisation was a condition of the grant, which was then matched by a further £1m by the local authority. The resident-led partnership negotiated successfuly for a leading role in how the grant was used. The resulting improvements to the estate's housing were therefore felt as 'owned' by residents, reinforcing all that they were doing through a plethora of new community groups, social projects and volunteering. The dynamic interaction of the physical and social improvements was undoubtedly of great benefit to the estate and provided an impetus to self-generated improvement which is still reaping rewards in 2011.

Comparable results have been seen in Balsall Health, an estate in Birmingham that independently developed a similar method (Atkinson, 2004). Dr Atkinson is also supporting the HELP pilot intervention in Solihull.

Systematising HELP to be replicable and cost-effective

HELP will continue to run a small number of local projects directly whilst also providing training based on the C2 7-step method to enable local people, both lay and professional to apply the system in their locality and to link with the growing network of projects. Facilitating links between new and mature sites is a key part of the process. The training programme is appropriate for a wide variety of frontline service providers, such as health visitors, housing staff, community development workers, health trainers, voluntary sector workers, teachers, police officers and indeed local councillors and other residents. The programme responds to the need for change, responsiveness and flexibility as seen by health commissioners, local authorities and other service agencies.

At the same time HELP is continuing its work to produce a model for demonstrating the cost-benefits of this form of intervention in terms of savings to health and other public budgets, and will produce an overall report within 2011.

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Durie, R, Wyatt, K and Stuteley, H. (2004) *Community Regeneration and Complexity* Oxford: Radcliffe Medical Press

Stuteley, H and Cohen, C. (2004) 'Developing Sustainable Social Capital in Cornwall' *Journal of Integrated Health and Social Care*, September.

E) Mental Well-being Impact Assessment – a toolkit for well-being

What is Mental Well-being Impact Assessment?
Mental Well-being Impact Assessment (MWIA) is a methodology developed over the last 6 years and tested on over 500 programmes in England (Cooke et al, 2011). It combines robust Health Impact Assessment methodology with up to date evidence on the determinants of mental well-being. It engages a wide range of partners in systematically assessing a policy, programme, service or project and making recommendations for improvement and monitoring. MWIA can be used as part of other impact assessments or as a stand alone process. The MWIA toolkit provides a practical step by step guide.

The process enables a shift in thinking and resources to improving well-being. This enables partners and sectors to transform systems from those that concentrate on managing the consequences of poor well-being (high crime, unemployment, illness, intolerance and underachievement) to ones that tackle its determinants: control, resilience, participation & inclusion.

The MWIA is cited as a helpful tool in:
- The Mental Health Strategy *No health without mental health* (HMG 2011) supporting document *Delivering better mental health outcomes for people of all ages* (HMG 2011)
- *The Commissioning mental wellbeing for all- A toolkit for commissioners* (2010, NMHDU/UCLAN)
- *The role of Local Authorities in promoting population wellbeing* (2010) report commissioned by NMHDU and LGID
- *'Public mental health and well-being – the local perspective.'* The NHS Confederation 2011

Benefits of undertaking MWIA
The outcomes from undertaking MWIA have been positive and suggest that MWIA has a central role to play in:
- Improve focus to create better responses to improve well-being.
- Developing shared understandings and coherence of mental well-being with a range of partners.
- Evaluation: Ensuring policies, programmes, services and projects have a positive impact on well-being, with meaningful indicators of success.
- Actively engaging all partners in service development and fostering co-production of well-being.
- Supporting community needs assessment and the development of relevant and meaningful local indicators.

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F) Mindapples

Mindapples is an award winning London-based social enterprise started in 2008 that that works with health professionals, employers and individuals. It uses social marketing and engagement techniques along a life-course framework to draw people into a conversation about mental health and wellbeing. It takes a question-based, non-prescriptive approach, using the 5-a-day metaphor, to show individuals that they have control over their own mental wellness. It stimulates people to consider their mental health and wellbeing; reflect on what they need and take simple actions to look after themselves better. It uses participatory events and scalable digital tools to gather individual suggestions and create powerful, personalised behaviour change campaigns that respect individual and cultural values. Mindapples reaches out to mainstream audiences to build a shared sense of control and responsibility for mental wellbeing and to move discussions about mental health to a more constructive and positive framework.

The Mindapples approach is based on a synthesis of constructivist learning theory; self-regulation and co-regulation; metacognition; behavioural change; personal agency theories and social research in the area of preventative approaches to mental health.

Mindapples engages with a variety of organisations ranging from large commercial firms such as British Gas to public sector institutions such as the South London and Maudsley and local groups such as Transition Town Brixton. In March 2011 it won two innovation challenge prizes from the Cabinet Office Innovation Hub and NHS Innovation Centre. It has received significant media attention, endorsements from the Guardian, Young Foundation, RSA, University of East London, BBC and the NHS Confederation, and a huge array of positive responses from the 5000+ individuals who have taken part.

Mindapples is now working in partnership with South London and Maudsley NHS Foundation Trust and NHS South East London and is currently being trialled by seven self-selected GP surgeries in Lambeth following successful initial public pilots all around the UK in 2010. Peer-reviewed evaluation of this programme is currently being conducted by the Institute of Psychiatry at Kings College London.

Mindapples uses subjective and objective data collection methods in the form of short questionnaires, semi-structured interviews, focus groups, insight and demographic data to robustly measure the success of its approach. It uses a number of indicators and outcomes to measure its impact that centre around: perceived helpfulness; the number and type of stated preferences and self-directed actions by participants that benefit mental wellness; the extent of increased perceived individual control over their health (the core Mindapples's message); change in conversations and attitudes about mental wellbeing; and the number and type (demographic, attitudinal) of people engaged in the learning process of the Mindapples experience.

Early findings have shown high levels of engagement, positive response and learning outcomes, and have attracted funding from Guys and St Thomas's Charity for further study. Personal preference data is collected during the Mindapples questioning process which offers valuable insights for policy design and appraisal.

www.mindapples.org

G) Mindfulness interventions

Effect on health
Mindfulness-based interventions have substantial benefits for both reducing distress and enhancing mental wellbeing in a range of groups including those with physical health disorders and prison populations (Grossman et al, 2004). One meta-analysis which considered 21 studies of MBCT or MBSR found overall medium effect size at follow up (*d* = 0.59) (Baer, 2003). Another meta-analysis of 20 studies (including 7 RCTs and 3 quasi-experimental designs) which included 1605 subjects found overall medium effect sizes for physical and mental health benefit (d = 0.50-0.53) (Grossman et al 2004).

Mental health benefits
A meta-analysis of MBSR identified 10 studies (including 6 RCTs) showing its effect on reducing stress in those without mental illness (Chiesa and Serretti, 2009). A meta-analysis of 39 studies of more than 1,140 participants found that mindfulness-based therapy had at least medium effect sizes on improving anxiety and depression (Hofmann et al, 2010). Furthermore, effect sizes were even larger for patients with anxiety and mood disorders (0.97 for improving anxiety symptoms and 0.95 for improving mood symptoms). Mindfulness Based Cognitive Therapy (MBCT) has been shown to be at least as effective as maintenance antidepressant medication in preventing relapse in recurrent depression and more effective in reducing residual depressive symptoms, psychiatric comorbidity and quality of life (Kuyken et al, 2008). MBCT is included in NICE (2009) guidelines for the management of recurrent depression.

Physical health benefits
Additionally, RCT level evidence highlights benefits in physical health for both patient and non-patient samples. A systematic review which included 3 RCTs highlighted benefits for cancer patients (Smith et al, 2005). Improvements have also been found in reduced health risk taking behaviour, including smoking cessation and drug misuse services in prisons (Bowen, 2006).

Children and schools
A review of mindfulness-based interventions for children and adolescents found general support for this intervention although highlighted lack of high quality studies (Burke, 2009).

Local availability
- The Mental Health Foundation website highlights several 8 week courses costing £200-300 http://bemindful.co.uk/learn/find_a_course
- Various other courses in South London vary in price from £200-411
- Maudsley Psychotherapy Service MBCT for Southwark, Lewisham and Lambeth as part of IAPT patients provides 3 groups per year.
- Lewisham primary care has just started but probably able to offer 3 groups per year.

- Southwark IAPT offers 5 groups per year with each group having 10 places. They have also just started offering a drop in support one evening a month. A course was also run by Jim Clark for carers

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H) Oxford Muse intervention

Background
The Oxford Muse Foundation has pioneered three methods to counter isolation and its impact on mental health and well-being: (1) Structured Conversations between strangers (2) Written and Video Self-Portraits (3) Mental health at Work

Intervention
1) Conversations (one-to-one) using the Muse Menu of Conversation which enables strangers and people from social or ethnic categories that seldom meet to be better understood, to clarify their own aspirations and to cement relationships with others from a different background.

Evidence of impact: 2000 participants from different communities and socio-economic level show over 90% high satisfaction. Grant from Esme Fairbairn Foundation to pursue these conversations.

2) Portraits Written Self-Portraits of 2-4000 words created with the help of the Muse template enable people to explain themselves, and use them as 'passports' that are much more accurate than CVs. A selection of these portraits can be found on the Oxford Muse website and in two volumes: *Guide to an Unknown City* (2004), which contains the writings of a wide variety of Oxford residents, revealing the limits of contacts and understanding between and within communities, and *Guide to an Unknown University (*2006) which allowed professors, students, alumni, administrators and maintenance staff to reveal what they do not normally tell one another, and which showed how little contact there was between these groups. 50 Video Portraits have been made by MA Film Studies Students of London University as a pilot for a project to teach young people to make portraits of their communities using mobile cameras. The relevance of these portraits to health professionals as a way of engaging with and understanding the background of their patients is being investigated in a project just beginning in a South London area with a highly mobile and changing population.

Evidence for impact: 150,000 visits last year to the Muse website on which these portraits are exhibited; comments by portrait writers on the effect of the experience on website; exhibition of video portraits at National Portrait Gallery

3) Remedying the damaging effects of work is being investigated in a project with salespeople at IKEA in which a Muse was established inside the Cardiff IKEA store, introducing a variety of educational and cultural activities.

Evidence of effectiveness: The IKEA project was filmed and is now being edited to demonstrate results visually and from the comments of those who went through this experience.

Potential local capacity in south London
Lewisham Borough Council and a Network of Community Leaders in Lewisham have inaugurated a project with the Oxford Muse and its subsidiary the Lewisham Muse to implement these strategies, awaiting funding.

References
For the evidence about the effects of social isolation on mental health see statistics in *London Foresight Mental Capital and Well-being Project* (2008), 5-11. AgeUK and Gulbenkian Foundation, *Campaign to End Loneliness* (2010)

I) Time banking

What is time banking?
A time bank is a 'virtual' bank where people can deposit the time they spend helping each other and withdraw that time when they need help themselves. It is essentially a mutual volunteering scheme using time as a currency. Time banks have been widely used within broader regeneration and urban renewal programmes. There are also a number of examples of their use in primary care, in recognition that feelings of isolation may be a significant source of poor health status and that many presenting problems are social, rather than medical, in origin.

Types of time banking
Three broad approaches to time banking include:

- Person-to-Person model: This usually involves a 'broker' who facilitates exchanges between individuals and develops the membership of the time bank. There are different ways that person-to-person Timebanking services are set up:
  - *An independent, stand-alone local organisation run as a self help group, a co-operative, not-for profit organisation or charity*
  - *A two-way service run by statutory agencies utilising existing staff time and resources in*
  - *A two-way service run by a third sector organisation or social enterprise as one of many services they provide for the local community.*
  - *A service commissioned by local statutory and voluntary agencies in response to identified needs - communities of interest Small local neighbourhood time banks run and shaped by neighbours*
- Person-to-Agency model: This is coproduction in action. An organisation enlists people to contribute to its mission or objectives. Service users or local communities act as agents to help an organisation to realise its goals and are rewarded with time credits. The main aim is to encourage a culture change within the agency so that paid staff see themselves as facilitators of co-produced services as well as service providers.
- Agency to Agency in which organisations are using time credits as a medium of exchange to share skills and resources with each other. The internet is used to inform organisations of the offers and requests and to record the exchanges. This model has been extensively developed as Camden Shares and Timberwharf TB sees the 'Shares' model as possibly being the best way to gain wide interest and support for timebanking within the broadest range of partner organisations within LB Hackney

Evidence for time banking
The first major evaluation of time banks in the UK found that they are successful in attracting participants from socially excluded groups and people who would not normally volunteer including older people, black and minority ethnic groups, those with disabilities and long term illness, and those on low income (Seyfang and Smith, 2002; Seyfang 2003). 60% of referrals to time banks were from GPs and health workers. Evidence is

limited although Friedli (2007) reported improved quality of life through social interaction and having practical needs met. For those with depression, it resulted in confidence, friendship and new skills. It was also an alternative for people reluctant or unable to use psychological therapies and served as a system of social support for more vulnerable patients. Time banks are associated with increased social capital buy including isolated groups into broader social networks (Collom, 2008). Several time bank programmes have been associated with improved wellbeing and fitness as well as reduced hospitalisation and medication which were attributed to reduced isolation as well as the specific programmes (Boyle et al, 2006; NEF, 2008). Time banking can increase the amount of social contact for isolated people and also facilitates being able to contribute which in turn can lead to feeling valued and having meaning in life (NEF, 2008). Time banking also promotes inclusion of those with mental health problems with the wider community which can reduce stigma associated with mental illness. A survey of 160 members of a hospital affiliated time bank found that improvement in mental health were associated with average number of exchanges and attachment to the organisation (Lasker et al, 2011).

National and local capacity

Time bank UK estimated that in 2011, there were 90 active time banks, 142 developing time banks, 2 neighbourhood time banks and 15,483 participants actively involved in time banks (Time Bank UK).

Regarding local capacity, there are five time banks in Lambeth which operate using the 'person to person' model described above in which people give their time, receive credits and so are able to 'buy' time from others. So far, most work has been done in relation to health objectives, especially mental health

- Paxton Green Time Bank has approximately 90 members and operates from Paxton Green surgery (Gipsy Hill ward, Lambeth) and Kingswood Estate (London borough of Southwark) and serves the catchment area of the surgery which covers both boroughs. The Time Bank is being promoted on the Lambeth NHS Choices site.
- Clapham Park Time Bank has been operating for five and a half years and was run by SLAM NHS Trust funded through Neighbourhood Renewal funding. There were approximately 130 members based around the Stockwell and Clapham area.
- Waterloo Time Bank is not currently funded, but has a database of members and a part time volunteer.
- Lambeth Playschemes and Progress teamed up with Clapham Youth Centre to build a food garden in a housing estate with local teenagers. Eight young people have formed a team called ECOSTARS and have been volunteering at weekends to turn Glenbrook Primary School into an Eco school using the timebanking principle and being rewarded for their time with trips such as playing tennis and going to restaurants.

There are seven time banks in Lewisham (LTBDS, 2009-2012). The following three are cited as examples:

- Rushey Green time bank has over 200 members who have generated 33,000 hours of mutual exchanges such as housework, clearance/

decluttering, simple DIY, gardening, befriending, escorting to shops, admin and ITC help, shopping, help with CVs, picking up prescriptions, healthy walks, chair based exercises, a poetry group, workshops and general help at the practice

- Lee Fair time bank has 65 members many of who are isolated and lonely. They swap skills and experiences ranging from gardening, baking, craftwork, sewing and DIY to car maintenance, computer support and language help. Members also support each other with shopping, lifts and form-filling, and group activities include allotment-working, lunch get-togethers, and reading and healthy walking clubs.
- 'My Time Your Time' time bank is supported by Hexagon Housing Association and has 100 members from Lewisham, Southwark and Greenwich. DIY has remained a central element although the time bank also exchanges hours on gardening. Members include teenagers and elders from a variety of different ethnic communities, and people with mental health problems and physical disabilities. 23 organisations are members of the time bank and include community centres and care homes.

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Time Bank UK http://www.timebanking.org/index.htm

Agenda Item 5

Item No:	Classification:	Date:	Meeting Name:
	OPEN	28 November 2011	Health and Adult Social care scrutiny committee
Report Title:		Preparing for the scrutiny interview	
Ward(s) or Group affected:		All	
From:		Scrutiny project manager	

BACKGROUND INFORMATION

1. The Cabinet member for health and adult social care: Cllr Dora Dixon - Fyle annual interview with the Health and Adult Social Care scrutiny sub committee is scheduled for 28 November 2011. The Cabinet member formal responsibilities are set out at Appendix A. Extracts form the Council plans are set out in Appendix B

2. Members of the committee have chosen 6 themes to structure the interview around

1) Clinical Commissioning (one of our reviews)
2) Southern Cross (one of our reviews)
3) Ageing of Adults with Complex Needs (one of our reviews)
4) Public Health Duties (which come over to the council as part of the Health & Social Care Bill)
5) Southwark Health & Wellbeing Board.
6) Older People and Personalisation

3. OSC agreed to use cabinet member interviews to raise performance questions based on the council plan. These will be incorporated into the themes. The Cabinet member's formal responsibilities are set out at Appendix A. Extracts form the Council plan are set out in Appendix B and Appendix C (Schedule C : Measures for Health and Adult Social Care, page 5).

4) The chair has requested that any specific performance targets for each theme are also reported on, particularly around Public Health. These are attached at Appendix D. (To follow)

BACKGROUND DOCUMENTS

Background Papers	Held at	Contact
Full council plan	160 Tooley St SE1 2TZ	Julie Timbrell

APPENDICES
Cabinet member for health and adult social care responsibilities
Extract from Council Plan - Health and Adult Social Care
Council Plan Portfolios (see schedule C for Cabinet member for health and adult social

care responsibilities)
Relevant performance targets (To follow)

Appendix A

The Cabinet member for health and adult social care responsibilities

To improve the health of the borough and to safeguard the needs of vulnerable adults, including health promotion, the provision of personal social services, services to older people, services to people with disabilities, services to those with HIV/AIDS and/or those with drug and alcohol problems, services to those with mental health needs and "supporting people". The portfolio holder will work closely with the cabinet member for children's services (with regard to children's health), with the cabinet member for culture, leisure, sport and the Olympics (with regard to public health and healthy lifestyles) and the deputy leader (with regard to the housing needs of vulnerable adults).

The portfolio holder will have particular responsibility for:

• ensuring that the council delivers savings identified in the 2011/12 budget within health and adult social care

• developing the council's new public health role and promoting healthy living

• delivering changes to adult social care, including personalisation to make the service sustainable

• overseeing the council's response to the changes to the NHS being made by the Government's Health and Social Care Bill

• ensuring that information for users of adult social services is accessible

• relationships with relevant voluntary organisations and helping the third sector in the area of health and adult social care to develop sustainable funding models which do not depend on shrinking council funds

• ensuring that health services are accessible to all and working to integrate services into regeneration schemes

• developing networks of community volunteer champions.

Appendix B

Extract from Council Plan

Health and Adult Social Care

1. Supporting people to live independent lives and encouraging more people to take control over their own care is fundamental to securing a fairer future for all. This is particularly so for those who rely on high quality health and social care. For the most vulnerable in our society we will also ensure there are sensible safeguards against the risk of abuse or neglect, striking the right balance between managing risk and promoting independence.

2. The scale of the budget cuts facing the Council has meant that tough choices have to be made across all services. But at the same time we pledged to reduce the price of meals on wheels by half. A phased reduction has begun and by 2014/15 hot and frozen meal charges will be half the 2010/11 price.

3. Our vision includes a strong focus on re-ablement services, which provide cost effective short term support to restore people's independence wherever possible. Where a longer term support service is required we aim to maximise people's choice and control through the provision of personal budgets.

4. We will shift the balance of care from residential provision to more effective support for people in their own homes, including the use of telecare technology and specialist equipment designed to efficiently promote people's independence and safety. Supported housing services have been extensively redesigned to secure greater value for money and deliver savings, forming an important part of the range of provision that promotes independence.

5. We will provide a dedicated telephone response for all queries about help for older and vulnerable people and their carers, including information about universal access and voluntary sector services. There will be enhanced focus on targeting services to better meet the needs of carers. Transforming day services will also allow a more personalised outcome focused approach.

6. We will deliver our Charter of Rights for all service users.

7. Partnership working with health services will remain a key priority, adapting to the changes occurring in the National Health Service in a way that builds upon our strong historic ties in this area. In particular we will continue to ensure people who receive both health and social care services do so in an integrated, seamless way. The Council may soon take on a new public health role including the promotion of healthy living, bringing together a range of responsibilities that effect local wellbeing. There will be a need to do things differently, working in partnership with community and voluntary organisations in a smarter and more efficient way.

Schedule A
Council Plan: Measures for Finance and Resources

This schedule sets out the key priority actions and targets over the next three years across the Finance and Resources portfolio to support a fairer future for all.

Chief Officer: Duncan Whitfield, Finance Director

		Lead Officer	Current performance	Targets 2011-12	2012-13	2013-14
1	Contain Council tax increases within inflation in line with the Medium Term Resources Strategy	Duncan Whitfield		0% increase	2.5% increase	2.5% increase
2	Deliver a balanced revenue budget and capital programme	Duncan Whitfield	N/A	Not greater than 2% variance of actual spend against balanced budget.		
3	Improve Council Tax and National Non Domestic Rates (NNDR) collection rates	Duncan Whitfield	20010-11 NNDR 97.6% Council tax 92.7%	To maintain existing performance through 2011/12	0.5% increase	0.5% increase
4	Reduction in all debt owing to the Council	Duncan Whitfield			1% reduction	1% reduction
5	To target an increase in general fund balances to £20m and maintain that level in line with similar London authorities	Duncan Whitfield	£20m represents 6.25% of the Council's general fund budget of £320m for 2010/11	£20m	£20m	£20m
6	To have a fully funded capital and housing investment programme in place that is profiled and annually reviewed	Duncan Whitfield and Gerri Scott	To be confirmed	To be confirmed	To be confirmed	To be confirmed
7	Generate capital receipts for the housing revenue account and general fund (commercial property holding account)	Duncan Whitfield and Stephen Platts		To be confirmed following agreement of Capital Programme 2011-2021		

8	Maintain an active anti fraud and internal audit programme of delivery that achieves cost reduction through an annual savings target for the Council	Duncan Whitfield		£0.5m savings	£0.5m savings	£0.5m savings
9	Ensure all our staff are in fit for purpose, suitable office accommodation	Duncan Whitfield				Provide new and improved office accommodation in the southern half of the borough (Peckham and south)
10	Reduce the unit cost of customer contact by encouraging residents to access the Council through online services and improving the efficiency of delivery of Council services	Duncan Whitfield		To be confirmed, described as cost per transaction	To be confirmed, described as cost per transaction	To be confirmed, described as cost per transaction
11	We will develop a customer experience strategy to ensure our services provide good quality customer care	Gerri Scott		Strategy in place March 2012		
12	To be fully compliant with all regulations with regard to the government's openness and transparency agenda	Duncan Whitfield		Verification reported through internal and external audit	Verification reported through internal and external audit	Verification reported through internal and external audit

Schedule B
Council Plan: Measures for Equalities and Community Engagement

This schedule sets out the key priority actions and targets over the next three years across the Equalities and Community Engagement portfolio to support a fairer future for all.

Chief Officer: Deborah Collins, Strategic Director of Communities, Law and Governance

		Lead Officer	Current performance	Targets 2011-12	2012-13	2013-14
1	Progress towards implementing the recommendations of the Democracy Commission	Stephen Douglass	Council assembly changes implemented	Review community councils by 31 March 2012	Implement community council review including savings	
2	Maintain the high percentage of local people who think that Southwark is a place where people from different backgrounds get on well together	Stephen Douglass	80% net agree	80%	80%	80%
3	Once the details of the public sector equality duty are confirmed by national government, we will set measurable equality objectives in line with the requirements of the duty	Graeme Gordon	We expect the duties to be confirmed in July 2011. When these are set they will be published online as part of the Council Plan.			
4	Implement the recommendations of the Voluntary and Community Sector Commissioning Task and Finish Group once they are published	Stephen Douglass		Recommendations published by December 2011		
5	Maintain the influence that we have on the success of local Voluntary and Community Sector organisations despite the challenging budgetary situation, as measured through the National Survey of Third Sector Organisations or by Community Action Southwark.	Stephen Douglass	15% of third sector organisations rate local statutory bodies as having a very positive or positive influence on their success	15%	15%	15%
6	Reduce transactional costs for the council and the Voluntary and Community Sector so that we are not imposing unnecessary burdens on the council or the sector.	Stephen Douglass	Baseline to be established			

7	Agree a volunteering strategy and implement the action plan set out in the strategy	Stephen Douglass		Strategy published by end October 2011		
8	Maintain the extent to which local people feel involved in decisions the council makes	Stephen Douglass	49% agree 42% disagree 7% net agree	7% net agree	7% net agree	7% net agree

Schedule C
Council Plan: Draft Measures for Health and Adult Social Care

This schedule sets out the key priority actions and targets over the next three years across the Health and Adult Social Care portfolio to support a fairer future for all.

Chief Officer: Susanna White, Strategic Director of Health and Community Services

ref	Key objectives and measures	Lead Officer	Current performance	Targets		
				2011-12	2012-13	2013-14
1	Maximise people's choice and control through the provision of personal budgets	Sarah McClinton	30% of eligible service users hold a personal budget	60% of eligible service users hold a personal budget	90% of eligible service users hold a personal budget	100% of eligible service users hold a personal budget
2	Reduce the charges for meals on wheels by 50%	Jonathan Lillistone		phased implemenation		50% reduction achieved
3	Provide effective support for people to live in their own homes and shift the balance of care away from residential care: measured by reduced permanent admissions to care homes	Sarah McClinton	196 permanent admissions 2010/11	5% reduction per annum in care home admissions	5% reduction per annum in care home admissions	5% reduction per annum in care home admissions
4	Increase the proportion of people with learning disabilities who are supported to live at home, measured by "% in settled accommodation" indicator	Sarah McClinton	60%	65%	70%	75%
5	Ensure there are sensible safeguards against the risk of abuse or neglect	Sarah McClinton	2010 Care Quality Commission rating "performing well" on safeguarding outcomes	Targets to be developed after new national outcomes framework safeguarding measures are finalised (2011/12)		

6	Expand re-ablement services, which provide cost effective short term support, to restore people's independence wherever possible	Sarah McClinton	70% of users of reablement service require no long term services	Targets to be developed after new national outcomes framework reablement measures are finalised (2011/12)		
7	Redesign supported housing services to secure greater value for money and support independence	Jonathan Lillistone		Savings delivered using 4 borough Supporting People framework agreements	Further develop strategic priorities for the future of housing support services	
8	Transform day services to allow a more personalised and outcome focused approach	Sarah McClinton		Review and re-shape day services across all client areas	Implement revised service models	
9	Deliver our Charter of Rights for all service users	Sarah McClinton	Charter agreed	Charter of Rights fully implemented		
10	Provide a dedicated telephone response for all queries about help for older and vulnerable people and their carers, including information about universal access and voluntary sector services	Sarah McClinton		Key project milestones to be finalised		

Schedule D
Council Plan: Measures for Housing

This schedule sets out the key priority actions and targets over the next three years across the Housing portfolio to support a fairer future for all.

Chief Officer: Gerri Scott, Strategic Director of Housing

		Lead Officer	2010/11 performance	Targets		
				2011-12	2012-13	2013-14
1	**Warm, dry and safe housing** Implement a minimum housing investment programme of major works of £308m to ensure that the Council's homes meet the Government's Decent Homes Standard by March 2016	David Lewis	Not applicable	£66.2 million	£58.1 million	£60.4 million
2	**Fair charges for leaseholders** Deliver the leaseholder audit action plan Bill all those who are liable for service charges for major works to their properties fairly, and in a timely manner, explaining the charges clearly to them	Martin Green Martin Green	Not applicable Capital billing = £8.8m; Capital arrears = £13.6m	by March 12 Capital billing = £9.73m; Capital arrears = £14.3m	- -	- -
3	**Improve the housing repairs and other service standards** % satisfaction with overall repairs service Repairs completed right first time (survey) Implement the recommendations from the Overview and Scrutiny Committee housing repairs key performance indicators review of February 2011 Implementation of the end to end review of repairs Expand on newly developed Local Offers and review annually	David Lewis David Lewis David Lewis David Lewis Darren Welsh	73% 64% Not applicable Not applicable 11 LO in place	75% 70% by March 12 by March 12 Expand by March 12	77% 72% - - Annual review	79% 74% - - Annual review
4	**Improve the Council's efficiency** Deliver Housing Revenue Account savings identified over 3 years	Senior Management Team (& Ian Young)	Not applicable	£9.1m	£6.4m	£4.3m

5	**Use our housing stock effectively** Average void turnaround times in calendar days Number of illegally occupied properties recovered annually	Shaun Holdcroft Shaun Holdcroft	25.9 calendar days 198	22 calendar days 250	21 calendar days 275	20 calendar days 300
6	**Increase the supply of housing and minimise the number of people in temporary accommodation** Number of empty private homes brought back into use Minimise number of accepted households in Temporary Accommodation	Darren Welsh	147 755 (at 31/3/11)	135 750 (at 31/3/12)	150 <750 (at 31/3/13)	170 <750 (at 31/3/14)
7	**Involve tenants and leaseholders in ongoing improvement of service delivery** % overall satisfaction with landlord services (in-house composite survey) % satisfied with the opportunity for participation in decision making (in-house composite survey) Delivery of revised Resident Involvement strategy	Senior Management Team Darren Welsh Darren Welsh	69.5% 54.4% Not applicable	71% 56% by March 12	72% 57% -	74% 58% -
8	**Publish every fire risk assessment and make the register of when they were last done an online public document** Publication of register of fire risk assessments	David Lewis	Not applicable	October 2011, April 2012	October 2012, April 2013	October 2013, April 2014
9	**Effective re-housing arrangements** Review policy on re-housing residents who need to move due to major regeneration projects	Darren Welsh	Not applicable	by March 2012	-	-

Schedule E
Council Plan: Measures for Children's Services

This schedule sets out the key priority actions and targets over the next three years across the Children's Services portfolio to support a fairer future for all.

Chief Officer Romi Bowen, Strategic Director of Children's Services

ref		Lead Officer	Current performance	Targets		
				2011-12	2012-13	2013-14
	Whole-service rating					
1	Ofsted overall assessment of Council Children's Services	Romi Bowen	Adequate (2010)	Performs Well	To determine appropriate level in new system	
	Key objectives					
2	Introduce free healthy school meals for all primary school children	Kerry Crichlow	Not applicable	Roll out to all primary schools, certain year groups only	Roll out to additional primary age groups	All primary schools covered by academic year 2013/14
3	Give young people real power over 20% of the youth service budget	Merril Haeusler	Not applicable			Young people to have power over 20% of youth services budget by 2014
4	Champion improved educational attainment in all settings, holding all schools to account to deliver continuous improvement:					
4a	Reduction in schools below current minimum "floor" standards	Merril Haeusler	9 schools (June 2011)			0 schools
4b	% achieving Level 4 Maths and English at Key Stage 2	Merril Haeusler	73% (2010)	78% (2011)	To be agreed after analysis of 2011 results and benchmarking	
4c	% achieving 5 or more A*-C grades at GCSE or equivalent including English and Maths	Merril Haeusler	55% (2010)	60% (2011)	To be agreed after analysis of 2011 results and benchmarking	

4d	Narrowing the gap between the lowest achieving 20% in the Early Years Foundation Stage Profile (EYFSP) and the rest	Merril Haeusler	32.1% (2010)	30% (2011)	To be agreed after analysis of 2011 results and benchmarking	
4e	Ofsted assessment of educational settings - % "good" or "outstanding" of those inspected in the year	Merril Haeusler	Primary schools 73% Secondary schools 67% Children's Centres 40% Post 16: 44%	Primary schools 75% Secondary schools 75% Children's centres 65% Post 16: 65%	Set targets in context of new inspection to be rolled out by Ofsted	
5	Guarantee that every child that wants a place in a local primary school gets one	Merril Haeusler				Guaranteed places for all delivered by 2014
6	Continue to invest in our schools through our primary capital and Building Schools for the Future (BSF) programmes: BSF milestones	Sam Fowler		Phase 1 completions	Phase 2/3 completions	Phase 2/3 completion
7	Respond to the recommendations of the Teenage Pregnancy Commission, which seek to reduce teenage pregnancy rates	Kerry Crichlow	Teenage pregnancy rate 63 per 1,000 (2009)			Reduction delivered, closing gap with comparator group
	Key outcomes for our young people					
8	Increased rates of employment, education and training of young people - NEET rate	Merril Haeusler	8.7% Not in education, employment or training (measured at previous NEET definition)	Appropriate measures to be developed in context of changing national policy framework around NEET services and data during 2011/12.		

9	Reduced youth offending rates	Rory Patterson	221 first time entrants to the youth justice system 1.04 reoffences per young offender	New targets to be agreed in context of Youth Justice Board and performance framework changes.
10	Key children's safeguarding outcome measures	Rory Patterson	Not applicable	Measures to be developed after analysis of final Munro report outcome indicators
11	Educational outcomes for children looked after: Children in care achieving 5 A*-C GCSEs (or equivalent) at Key Stage 4 including English and Maths)	Merril Haeusler	13.7% (2010)	To be agreed after analysis of 2011 results and benchmarking
12	Targeted early intervention: Children with additional needs will be supported by strong universal services so that early intervention resources can be targeted towards more vulnerable children and their families at the first signs of low-level abuse or neglect	Rory Patterson	Not applicable	Referrals measures to be developed after analysis of final Munro report outcome indicators around referrals

Schedule F
Council Plan: Measures for Community Safety

This schedule sets out the key priority actions and targets over the next three years across the Community Safety portfolio to support a fairer future for all.

Chief Officer: Gill Davies, Strategic Director of Environment

		Lead Officer	Current performance	Targets 2011-12	2012-13	2013-14
1	Increase the percentage of people who feel safe walking alone after dark	Jonathon Toy	70% at March 2011	2% increase from 2010/11 to 72%	72%	72%
2	Reduce violent crime, in particular serious violence	Jonathon Toy	Police measure, not equivalent to previous national indicator	-2.00%	Maintain at 2011-12 level with reduced resource	Maintain at 2011-12 level with reduced resource
3	Increase in public confidence in the council and police in tackling antisocial behaviour, measured by response to: "The police and local council are dealing with the ASB and crime issues that matter in the area" in the police attitude survey.	Jonathon Toy	51% for 2010/11	5% increase from 2010/11 to 56%	Maintain at 2011-12 level with reduced resource	Maintain at 2011-12 level with reduced resource
4	Increase the average number of detections of crime per CCTV camera	Jonathon Toy	Baseline to be confirmed	10% increase from 2010/11	10% increase	10% increase
5	Improve the effectiveness of drug treatment services in the borough - increase the number of problematic drug users leaving treatment in a planned way	Tanya Barrow	2010/11 performance 35%	47%	New targets to be set by National Treatment Agency in 2012/13	New targets to be set by National Treatment Agency in 2012/13
6	Increase the proportion of premises that comply with environmental health and trading standards regulations	David Littleton	2010/11 performance 70% compliance	75% compliance	75% compliance	75% compliance

7	Value for money through effective partnership working in reducing violence, by using the financial information provided by the Home Office economic cost of crime survey	Jonathon Toy	2009/10 baseline year	2% reduction	2% reduction	Maintain at 2012-13 level
8	Using value for money as a tool to access the most cost effective crime prevention initiatives as part of our problem solving approach (measure to be confirmed)	Jonathon Toy	To be confirmed	Baseline year	To be confirmed	To be confirmed

Schedule G
Council Plan: Measures for Culture, Leisure, Sport and the Olympics

This schedule sets out the key priority actions and targets over the next three years across the Culture, Leisure, Sport and the Olympics portfolio to support a fairer future for all.

Chief Officer: Gill Davies, Strategic Director of Environment

		Lead Officer	Current performance	Targets 2011-12	2012-13	2013-14
1	Increase public satisfaction with libraries (all residents' satisfaction with the libraries service)	Adrian Whittle	63% (Baseline at March 2011)	70%	70%	To be confirmed
2	Increase public satisfaction with leisure centres (all residents' satisfaction with leisure services)	Adrian Whittle	49% (Baseline at March 2011)	55%	58%	To be confirmed
3	Increase the average number of visits to libraries per head of population	Adrian Whittle	Baseline is 7.1 in 2010/11	8.0	8.4	To be confirmed
4	Increase the number of items issued by our libraries	Adrian Whittle	1,395,347 in 2010/11	1,465,295	1,538,559	To be confirmed
5	Sustain course completion rates of adult learners	Adrian Whittle	80%	80%	80%	To be confirmed
6	Reduce the cost per visit for libraries	Adrian Whittle	£2.57	£2.50	£2.45	To be confirmed
7	Reduce the cost per visit for leisure	Adrian Whittle	£2.40	£2.35	£2.30	To be confirmed
8a	Improve participation rates in cultural activities - Arts participation	Adrian Whittle	53.8% 2010 Active People survey	55% 2012 Active People survey	No survey 2013-14	To be confirmed
8b	Improve participation rates in cultural activities - Museums and galleries participation	Adrian Whittle	65.5% 2010 Active People survey	68% 2012 Active People survey	No survey 2013-14	To be confirmed

9	Invest capital in our leisure provision	Adrian Whittle	Not applicable	£3.045 million	£12 million	£6.5 million
10	External funding achieved for culture, libraries, learning and leisure	Adrian Whittle	Not applicable	£180,000	£150,000	£150,000

Schedule H
Council Plan: Measures for Transport, Environment and Recycling

This schedule sets out the key priority actions and targets for each portfolio over the next three years across the Transport, Environment and Recycling portfolio to support a fairer future for all.

Chief Officer: Gill Davies, Strategic Director of Environment

		Lead Officer	Current performance	Targets 2011-12	2012-13	2013-14
	Prioritise a clean borough					
1	Maintain the standard of our streets (% of streets and highways inspected as having unacceptable levels of litter and detritus)	Ian Smith	Litter 4% Detritus 9%	Litter 4% Detritus 9%	Litter 4% Detritus 9%	Litter 4% Detritus 9%
2	Maintain our resident satisfaction with street cleanliness	Ian Smith	89%	89%	89%	89%
3	Improve the cost of street cleanliness per head of population	Ian Smith	£31.87	£26.95	£26.60	£26.60
4	Maintain our resident satisfaction with street cleanliness, parks and open spaces, roads condition and street lighting	Des Waters	Parks = 79% Lighting = 82% Roads = 51%	Parks = 81% Lighting = 83% Roads = 52%	Parks = 83% Lighting = 84% Roads = 53%	Parks = 85% Lighting = 85% Roads = 55%
	Reduce, resuse or recycle everywhere we have influence					
5	Improve recycling collection rate	Ian Smith	25%	32%	34%	40%
6	Increase the amount of waste diverted from landfill	Ian Smith	62.73%	67.1%	68.3%	69.8%
7	Reduce the cost of recycling per tonne	Ian Smith	£73.83	£56.68	£53.99	£46.66
8	Maintain the very low rate of missed collections	Ian Smith	0.016% collections reported as missed in 10/11	0.016%	0.016%	0.016%

	CO2 emissions and air quality					
9	Reduce carbon emissions from council operations	Ian Smith	41,036 tonnes in 2008/9	37,441 tonnes	32,467 tonnes	27,493 tonnes
10	Reduce carbon emmissions and NOx pollution from five Southwark housing estates by connecting to new heat network from SELCHP	Gill Davies	8,000-10,000 tonnes pa CO2 and 2 tonnes pa NOx emissions from five gas-fired boilers	Sign agreement and contract	Construction of heat network	Reduction in emssions of 8,000-10,000 tonnes pa CO2 and 2 tonnes pa NOx
11	Increased numbers of big emitters working with us to reduce carbon	Ian Smith	52 members at May 2011	60 members	90 members	120 members
	Accessible, safer and enjoyable public realm for all					
12	Phase one of Burgess Park improvements completed by March 2012	Des Waters	Not applicable	Not applicable	Mar-12	Not applicable
13	Increase the biodiversity of Southwark's green spaces	Des Waters	73%	76%	81%	83%
14	Reduce the cost per hectare of managing parks by 20% over three years	Des Waters	£24,158	£22,663	£21,168	£19,236
15	Burial capacity within Southwark's cemeteries	Des Waters	Currently under consideration and subject to consultation.			
16	Increase the level of street trading and markets across the borough (% of occupied pitches)	Des Waters	61%	64%	67%	70%
17	Reduce the level of successful appeals against parking penalties to that of the best performing London Boroughs	Des Waters	50%	47%	44%	40%
18	Increase the percentage of parking fines recovered to that of the best performing London Boroughs	Des Waters	64%	66%	68%	70%
19	Increase the number of highway and lighting repairs carried out within 24 hours by 20% over three years	Des Waters	9,960	10,624	11,332	12,088
	Sustainable transport					
20	Reduction in the number of children being driven to school	Simon Bevan	15.7%	-1.2%	-1%	-0.5%
21	A 10% increase in the number of children receiving cyclist training in 2011/12	Simon Bevan	566 (average per year 2008-11)	623	N/A	N/A
22	A 10% increase in the number of adults receiving cyclist training in 2011/12	Simon Bevan	580 (average per year 2008-11)	638	N/A	N/A

Schedule I
Council Plan: Measures for Regeneration and Corporate Strategy

This schedule sets out the key priority actions and targets over the next three years across the Regeneration and Corporate Strategy portfolio to support a fairer future for all.

Chief Officer: Eleanor Kelly, Deputy Chief Executive

		Lead Officer	Recent Achievements	Targets		
				2011-12	2012-13	2013-14
1	**Progressing major regeneration to benefit Southwark's communities**					
1a	Regenerating the Aylesbury estate and building the first new family homes - Building the first homes and a resource centre on four sites, A - D, as part of phase 1a of the estate regeneration programme.	Steve Platts		First block complete on first development site (site bounded by Westmorland Road, Albany Road, Red Lion Row, Boudary Lane and Bradenham Close) - total 52 units.	First development site complete (site bounded by Westmorland Road, Albany Road, Red Lion Row, Boudary Lane and Bradenham Close) - total 261 units	
				Aylesbury Resource Centre to open - Q2 2011.	Commencing partner selection for Bradenham, Arklow, Chartridge and Chiltern	
				Creation Trust Funding Agreement to be signed Q2 2011		
				Marketing to commence for 1-59 Wolverton located on corner of East Street and Thurlow Street,		
1b	Progressing the Elephant and Castle area regeneration	Steve Platts		Secure the empty Heygate estate by erecting a security fence by January 2012	Complete the second phase of the demolition of the Heygate estate by April 2012	
				Agreement with St Modwen on Elephant and Castle shopping centre		
					Core Area – Planning application spring 2012	Planning approval for main scheme
				Formation of a Regeneration Forum	Supplementary Planning Document – Spring 2012	
				Commence consultation on the master plan		
					Leisure centre planning application spring 2012	Construction of leisure centre commences
				Delivery of off site housing 198 completed in 2011/12		
				Completion of the Southern Junction infrastructure	Planning application on Stead Street 2012/13	
1c	Rotherhithe/Canada Water	Steve Platts		Maple Quays (Site A) total units 165 (126 private, 39 affordable)	Maple Quays (Site A) total units 220 (146 private, 74 affordable)	Maple Quays (Site A) total units 139 (82 private, 57 affordable)
				Shopping Centre Planning Application 2012/12		
				Plaza Completed Autumn 2011		
				Library Completed Autumn 2011		
				Proposals for Albion Street to be developed and strategy agreed 2011/12		
1d	Bermondsey Spa	Steve Platts		Start on site of phase 2 of Spa Road shops and residential units (Site G - Hyde Housing) December 2011	Additional 400 homes completed by March 2013	
				Start on site of site Grange Walk site (C5 - Notting Hill Housing). Demolition to start August 2011 and construction work to start March 2012	Completion of sale of 19 Spa Road October 2012	

		Lead Officer	Recent Achievements	Targets		
				2011-12	2012-13	2013-14
1e	Maximising the benefit of major regeneration schemes - working with developers to get the best possible result by helping people into work and supporting local businesses	Steve Platts		Elephant & Castle - an important part of the Council's agreement with Lendlease for the regeneration of the Elephant and Castle is to guarantee that people are helped to secure jobs during construction and after completion of the development. The specific means to do this will be negotiated and agreed prior to Lendlease submitting any planning applications to the Council. Therefore targets cannot yet be quanitifed but will be published once negotiations and consultation have taken place.		
2	**Planning and development**					
2a	To sustain performance on planning applications processed on time at a minimum of 75%	Simon Bevan	Current performance is Major: 71% Minor: 71% Other: 77%	All: 75%	All: 75%	All: 75%
2b	Enforcement	Simon Bevan				
	To be an effective statutory planning authority, ensuring that breaches of planning regulations are resolved within a timely manner		To be confirmed: % resolved within 8 weeks	60% of valid enforcement investigations closed within 8 weeks.		
				A decision taken on proposed action on all valid enforcement investigations within eight weeks.		
				70% of appeals against enforcement notices dismissed		
3	**Local area regeneration**					
3a	Revitalising the local retail economy by improving local shopping centres across the borough.	Steve Platts	Work is in progress on 12 shopping areas	12 shopping areas currently due to complete by the end of July 2012		
3b	Investing in smaller regeneration schemes that will make the borough a better place to live, work and visit	Simon Bevan	Public consultation has informed development of local Area Action Plans.	Canada Water Area Action Plan adopted by Council Febraury 2012		Council adopts Peckham and Nunhead Area Action plan June 2013
3c	Strengthening local area plans in Elephant and Castle, Dulwich, London Bridge, Borough and Bankside and Camberwell through improved supplementary planning documents	Simon Bevan		Elephant and Castle supplementary planning document (SPD) adopted by March 2012 Consultation on Dulwich SPD completed by December 2011 Adopt Dulwich SPD February 2012 March 2012 review work carried out on neighbourhood planning and decide approach to taking forward SPD or Area Action Plan for London Bridge Borough and		Adoption of Camberwell action area SPD in January 2014
3d	Camberwell: improving the town centre as a place to live, work and do business though better co-ordination of regeneration activity and Council service delivery	Steve Platts			New library opens - Autumn 2012 Thamesreach Academy opens - April 2012. Start of modelling and design work for Camberwell town centre improvements	
3e	Housing regeneration and renewal in east Peckham and Nunhead 2011/12	Steve Platts		Implementing solar heating, street lighting and tree planting improvements in renewal areas.		
3f	Bringing high quality, new homes to the Wooddene and Elmington sites	Steve Platts		Wooddene – Enter into contract by March 2012		
				Elmington phase 2 – submit planning application by February 2012	Elmington phase 2, achieve planning consent and delivery	Elmington phase 2 completion
				Elmington phase 3 – completion of Benhill Nature garden by December 2011 and developer selection approved by Cabinet by March 2012	Elmington phase 3, submit planning and delivery	Elmington phase 3 completion

		Lead Officer	Recent Achievements	Targets		
				2011-12	2012-13	2013-14
3g	Regenerate the housing estates, that are most in need of investment.	Steve Platts		Abbeyfield Estate - undertake option appraisal of Maydew House, including implications for Thaxted Court & Damory House and report back to Cabinet in October 2011	To be agreed - pending consultation	To be agreed - pending consultation
		Steve Platts		Hawkstone Estate - undertake option appraisal of low rise blocks and report back to Cabinet in October 2011	To be agreed - pending consultation	To be agreed - pending consultation
		Steve Platts		Four Squares Estate - undertake option appraisal and report back to Cabinet in October 2011	To be agreed - pending consultation	To be agreed - pending consultation
4	**Increase the housing supply**					
4a	Providing more affordable homes across the borough to improve access to housing locally	Steve Platts		600 additional affordable homes	600 additional affordable homes	600 additional affordable homes
4b	Bringing additional homes to the borough by working with local developers and housing providers	Simon Bevan	1445 as at Dec 2010	1450 net new homes 2011/12	1450 net new homes 2012/13	1450 net new homes 2013/14
5	**Increasing employment and jobs**					
5a	Employment: commissioning support to help residents into training and jobs.	Steve Platts		271 people will start new jobs and continue to receive support to make sure they stay in work. Additional support will be maintained for people who started jobs in 2010-11.		
5b	Increase Southwark's employment rate and bring it up towards the average for London. The employment rate is the proportion of the working age population in employment.	Steve Platts	At Dec 2010: Southwark 67.5%; London 68.97%	To increase Southwark's employment rate to 68.0%	Target for 2012/13 to be calculated based on the London average for 2011/12.	Target for 2013/14 to be calculated based on the London average for 2012/13.
5c	Enterprise: commissioning support for business start-ups and promoting business survival and growth through the recession	Steve Platts		Our aim is to provide support to 15 new business start-ups and provide support to a further 150 existing businesses, subject to the agreement of contracts in August 2011.		

Agenda Item 6

Southwark Health and Adult Services Scrutiny Committee

December 2011

Lambeth, Southwark & Lewisham (LSL) HIV Care & Support Review

Report Author: Jess Peck, Commissioning Manager- HIV & Sexual Health (Lambeth, Southwark & Lewisham), NHS Lambeth.

Executive summary

This report provides an update on the progress being made across Lambeth, Southwark and Lewisham (LSL) in assessing the local needs of people living with HIV and reviewing the current portfolio of services providing HIV care & support services. The paper gives an overview of the rationale for this project, the project accountability and timelines including the engagement & consultation plans and presents proposed service model and future commissioning intentions across the three boroughs. These recommendations are subject to a 3 month public consultation which was launched on 7th November 2011 until 6th February 2012.

Recommendations

1. That that Committee endorses the engagement & consultation plans (Appendix E) for the project and comment on any recommendations for improvement.

2. That the Committee notes the proposed service model, options appraisal of current provision (Appendix C), and summary commissioning intentions from the project.

3. That the Committee comments on the project proposals to feed into the consultation process.

4. That the Committee notes the consultation process and events scheduled.

Appendices

Attached at **Appendice A** is an extract from the 2011/12 HIV Care and Support needs assessment of Southwark's HIV epidemiology. The data, intelligence and processes contributing to the needs assessment have informed the proposals made in this paper.

Attached at **Appendice B** is a breakdown of the current investment (11/12) and activity (10/11) by Borough for the portfolio of HIV Care and Support services being reviewed as part of this project.

Attached at **Appendice C** is the Summary of the Options Appraisal for current service provision

Attached at **Appendice D** is the Terms of Reference for the LSL HIV Care & Support Review Steering Group.

Attached as **Appendice E** is the project's Engagement & Consultation Plan.

Update on LSL HIV Care & Support Review- October 2011

1. Context

Sexual Health and HIV continues to be a major public health problem across Lambeth, Southwark & Lewisham (LSL). All three boroughs have some of the highest rates of HIV, Sexually Transmitted Infections (STIs) and teenage pregnancy in the UK. Such exceptionally high prevalence of sexual ill health reflects the level of deprivation and inequalities experienced by our communities.

LSL PCT's have invested significantly in sexual health & HIV over the last 5 years to ensure that local services are at the forefront of service provision and innovation that deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda. This has included a range of projects and service developments including:

- Modernising local services to provide integrated sexual health services providing contraception and sexually transmitted infections in a one-stop shop (initiated through the Modernisation Initiative for Sexual Health- 2003 to 2008)
- Provision of Emergency Hormonal Contraception (Morning after pill) and more recently oral contraception within Pharmacy
- Expansion of HIV testing within primary care as part the new registration process
- Provision of Opt out HIV testing in acute setting following a diagnosis of clinical indicator diseases (TB, Hepatitis, and Lymphona).

HIV is the greatest risk within sexual health, in terms of both the public health need and the financial costs associated with growth in diagnoses and diagnosing patients late. There has been a 50% increase in the number of people living with diagnosed HIV accessing care in LSL between 1999 and 2008[i] (an average 8% annual increase in the numbers of people accessing HIV care)[1]. If the local picture of exceptionally high levels of HIV infection continues at this rate, the costs of HIV treatment will double in the next 10 years (currently £26M in Lambeth, £20M in Southwark, and £11M in Lewisham).

NHS Southwark has identified HIV as a high priority issue in terms of prevalence and are currently working on delivering a number of strategies across the HIV pathway (including prevention, testing and treatment) as part of long term QIPP Plans, these include:

a) Promotion and expansion of HIV testing and treatment as a key prevention strategy to diagnose the undiagnosed[2]
b) Reducing late diagnosis[3] by ensuring that people are diagnosed early to maximise health and social care outcomes and reduce HIV related morbidity and mortality
c) Modernising HIV care & support services to reflect the changing needs of HIV positive patients in line with the epidemiological changes of HIV and biomedical advances of treatment.

[1] SOPHID 2008
[2] It is estimated that people who have undiagnosed HIV infection are 3.5 times[2] more likely to transmit HIV than those who are diagnosed, demonstrating the potential impact of effective interventions in reducing the undiagnosed population
[3] Late diagnosis (diagnosis with a CD4 count <200 will have had the infection for at least seven years) is the most important factor associated with HIV-related morbidity, mortality and inpatient care in the UK. The costs of treating a late diagnosed patient are estimated to be 200% higher[3] in the first year of HIV treatment, this estimate does not account for additional acute care costs incurred from associated HIV related illnesses

d) Developing a model of care for HIV as a long term condition which shifts the care of stable patients into non-specialist settings

The delivery of these strategies must be sustained in going forward if we are to successfully address the local spread of HIV. A needs assessment on HIV prevention was completed in 2010/11 and recommended the inclusion of 'HIV test and link' (into HIV treatment centres) as a composite part of HIV prevention strategies. Southwark already has a strong track record of expanding HIV testing in primary care as part of the new patient registration since April 2011. It is an objective of this review of HIV Care and Support to identify some level of efficiencies to reinvest and support the ongoing expansion of HIV testing locally.

With the proposed transfer of sexual health & HIV prevention commissioning into Public Health/Local Authorities (as outlined in the Health & Social Care Bill), HIV will need to be a priority for Health & Well Being Boards, Local Authorities, Commissioning Support Units and Clinical Commissioning Boards.

This paper specifically provides a summary of the review of HIV care & support services which will inform the 'modernisation of HIV care & support services to reflect the changing needs of HIV positive patients in line with epidemiological changes of HIV and biomedical advances of treatment' (strategy C outlined above).

2. The Public Health Need of HIV

In 2010, the HPA reported[4] that there are 6516 individuals resident in LSL living with HIV (2855 in Lambeth, 2301 in Southwark, and 1360 in Lewisham) with a further estimated 28% being unaware of their infection. LSL alone accounts for approximately 11%/24% of diagnosed HIV infections in the UK/London. Although Lambeth and Southwark are the two most affected boroughs in the UK with prevalence rates of 13.88 per 1000 and 11.25 per 1000 respectively; the average prevalence rate for HIV across London is 5.24% per 1000.

In the UK the pattern of HIV infection primarily affects two main client groups, men who have sex with men (MSM), and black African heterosexuals. These at-risk population groups are particularly over-represented in LSL, although the populations differ across the three boroughs. Within Southwark there is a 50/40 split of MSM and Black African heterosexuals living with diagnosed HIV, compared to Lambeth where there is a 60/40 percentage split and Lewisham where there is a 40/60 split

Late diagnosis of HIV (diagnosis with a CD4 count <350 which can be an indicative of infection for approximately 7 years) is the most important factor associated with HIV related morbidity and mortality and inpatient care in the UK. Recent definitions of late diagnosis have been revised, a CD4 count of <350 is now the recommended point at which anti retroviral treatment is initiated (HAART). Very late diagnosis is now indicated by a CD4 count < 200. Across LSL, approximately a quarter of the new HIV diagnoses were classified as very late in 2009. Late diagnosis accounted for 51% of new diagnoses in Lewisham; 50% in Southwark and in 45% Lambeth[5]. The three PCTs have selected the 'reduction of late HIV diagnosis' as their Staying Healthy target for HIV.

Significant advances in HIV treatment means that if diagnosed early, HIV is now a treatable medical condition and the majority of those living with the virus remain fit and well on treatment. This improved life expectancy has resulted in the shift in the age distribution of people living with HIV; showing clear signs of an ageing population. Of particular concern is the rapid increase in the number of patients over 50 years as these are likely to be affected both by long

[4] HPA (2010), Diagnosed HIV prevalence in Local Authorities in England, 2010
[5] HPA(2010) HIV Late Diagnosis in London December 201: Update for Commissioners

term anti-retroviral treatment (ART) side effects and age related chronic conditions such as cardio vascular disease, chronic obstructive pulmonary disease and diabetes requiring wider health and social care services for older people.

3. Rationale and Project Aims

Over recent years the wide availability of highly effective ART has transformed HIV from an almost universally fatal illness to a manageable chronic condition, if diagnosed early. With treatment advances it is now commonly accepted that most patients can be expected to have a near normal life expectancy and live active and fulfilled lives. Some however will have complex medical and social needs which can impact on health outcomes and onward HIV transmission.

These issues signify a major concern in terms of managing the growth of new diagnosis, reducing onward transmission and responding to an ageing HIV+ population within existing financial envelopes. In addition, a number of currently commissioned services are jointly funded through health monies and Local Authority (LA) contributions through the AIDS Support Grant (ASG) (see appendix B for a breakdown by service) which will be subject to reductions in the Local Area Based Grants by April 2014. In light of the continually increasing patient populations, changing long-term care needs and the resource challenges, LSL commissioners have initiated a review of the existing portfolio of HIV care & support services and assessment of need to inform future commissioning intentions. This project aims to ensure that LSL provision for HIV care & support is modernised to reflect the changing needs of HIV positive patients in line with the epidemiological changes of HIV and biomedical advances of treatment.

The project objectives are:

- To carry out a comprehensive needs assessment for care & support needs of HIV positive service users reflecting the changing face of HIV as a long term condition
- Review current provision of HIV care & support services to identifying gaps and effectiveness of current provision
- Identify future commissioning intentions for services commissioned by LSL PCT and Local Authority AIDS Support Grant (ASG)
- Review current investment & release efficiencies to meet NHS & LA efficiency targets and provide funds for re-investment into 'HIV test & link to treatment prevention strategies'
- Mainstream HIV care & support within generic health & social care where appropriate as part of the normalisation agenda and recognition of HIV as a chronic long term condition.

4. Project Timescales, deliverables and accountability

4.1 Project Timescales & Deliverables

The project was initiated over the summer with the intention to complete by the beginning of September; the project is now it is final stages and will go out to public consultation for three months from 1st November until 31st January 2012. Consultation responses will be collated and considered by the steering group before finalising recommendations and future commissioning intentions in early February 2012. Recommendations for immediate implementation such as re-specifications and modernisation of existing providers and de-commissioning of any duplication will be initiated for April 2012. Any required procurement processes will be started immediately with the intention for services to start from September 2012.

4.2 This project consists of four key components:

a) Needs assessment & evidence review
b) Service review
c) Options appraisal & recommendations for future commissioning
d) Engagement & consultation

The key project deliverables are detailed in the table below including progress to date:

Table 4.1:HIV Care & Support Review Project Deliverables, timelines and progress to date		
Deliverable	**Timescales**	**Progress to date**
a) Needs Assessment & Evidence Review • Population analysis: deprivation & mobility ▪ Demography and risk groups, migration ▪ Review of current HIV epidemiology and trends in LSL (SOPHID new /late diagnoses • Review of current national and international HIV prevention care & support guidance • Summary of biomedical treatment advances • Review of the evidence base and best practice for effective interventions including literature review	July/August 2011	All elements have been covered in a public health lead needs assessment and evidence review that was completed late August.
b) Service Review • Extensive service mapping (type of activities, outputs, location, target groups) ▪ Review of effectiveness of current provision ▪ Analysis of care & support service usage activity ▪ Analysis of mainstream HIV related activity (Social Care/Mental Health) • Gap analysis ▪ Value for money analysis	August/Sept 2011	Service review completed in September.
c) Options Appraisal & recommendations for future commissioning • Provisional options appraisal discussed with steering group • Final recommendations for consultation signed off by steering group • Equality Impact Assessment completed	Sept/Oct 2011	Options appraisal and recommended commissioning intentions endorsed by project steering group on October 18th 2011i.
d) Engagement & Consultation • Development of an LSL wide steering group • Steering group to be shadowed by Service User Reference Group (SURG) • Stakeholder pathway mapping event(s)	July 11-Jan 12	LSL Steering group running since June. Stakeholder mapping events held in July (including a separate Lewisham event attended by

• Public consultation across LSL		18 Health & Social Care Commissioners and providers). SURG have met three times during Sept/Oct and scheduled to meet early Nov to develop easy read report for distribution during consultation scheduled for Dec & January.

4.3 Accountability:

This project is being delivered by the LSL Sexual Health & HIV Commissioning Team with the support of the SEL SH & HIV Network. A project steering group has been set up across LSL to oversee the project (see appendix F for TORs). This group is chaired by Ruth Wallis, Lambeth DPH, and membership includes LSL SH & HIV commissioners, representation from all LSL Public Health departments, social care commissioners and provider leads from each LA, clinical leads from all local HIV specialist services and NHS Patient & Public Involvement leads. This group reports progress to the Lambeth Southwark and Lewisham Sexual Health & HIV Programme Board. Recommendations for future commissioning intentions will be made to PCT Clinical Commissioning Boards and Local Authority Commissioning Boards across LSL.

5. Engagement & Consultation Plan

An LSL wide Engagement & Consultation Plan (appendix E) has been developed with NHS Patient and Public Involvement Leads, which has subsequently been consulted on with the LSL Stakeholder Reference Group (SURG) and endorsed by the project steering group.

Engagement has been central throughout the project by ensuring that a wide range of stakeholders have been identified to oversee the project via the steering group. In addition, two successful stakeholder mapping events were held in early July (14th & 19th) to inform the service review process. Service user representation at the stakeholder events was significant, although this has been further strengthened with the development of a Service User Reference Group (SURG) to shadow the steering group. The intention is that this group will inform the agenda and discussion for the steering group and makes recommendations for consideration. The SURG will be an ongoing group that continues throughout the consultation phase and also goes onto support and inform subsequent implementation plans.

Consultation was launched on 7th November 2011 and run for three months until 6th February 2012 with clear processes for submitting written responses to the recommendations. During this time, two consultation events will be held in each borough, these will be open to all stakeholders including service users and members of the public. These events will be held across LSL on the following dates:

- 9th December 2011, 9.30am-12.30pm, Roben's Suite, Guys Hospital
- 12th December 2011, 2-5pm, Assembly Rooms, Lambeth Town Hall
- 13th December 2011, 9.30am-12.30pm, Lewisham Town Hall
- 5th January 2012, 6-9pm, Roben's Suite, Guy's Tower, Guys Hospital
- 9th January 2012, 6-9pm, Assembly Rooms, Lambeth Town Hall
- 10th January 2012, 6-9pm, Lewisham Town Hall

In addition, a number of focus groups will be held to discuss proposals with both MSM and Black African communities through existing services to ensure that both patient groups are sufficiently consulted. The SURG will also oversee the Consultation Process to ensure adequate service user engagement.

6. Portfolio of Services

The Services reviewed within this project are those that sit within the LSL Sexual Health & HIV Commissioning Team's portfolio. These include services that are jointly funded by health and Local Authority monies (via the ASG). A full breakdown of the services, including commissioned activity and cost by borough can be found in Appendix B. It should be noted that these services are commissioned as part of a number of collaborative commissioning arrangements, either across LSL or wider geographical areas. These arrangements will therefore need to be considered in the development of recommendations and will require necessary consultation with other potentially affected commissioners.

The steering group acknowledges that findings and recommendations made within this project could impact on services outside of the LSL sexual health & HIV commissioned portfolio such as paediatrics and social care. In this instance, findings and proposals will be noted within the project recommendations and discussed with relevant commissioners for further consideration.

7. Themes / findings to date

Stakeholder engagement, mapping of services and analysis of current service provision has been completed to inform this service review. This process has identified key themes or issues of concern amongst the current service provision. These include a lack of defined care pathways resulting in difficulty navigating the system and consistency in access to care, lack of clear thresholds of care amongst specialist services, duplication across services and case management functions, and a tendency to rely on specialist services for PLHIV resulting in inequality of access to mainstream health & social care services. In conclusion, it has been identified that there is a need for improved access to mainstream services, more effective use of specialist services/resources, better defined care pathways and thresholds of care, and stronger commissioning based on outcomes related to the changing needs associated with varying stages of the disease progression.

7.1 **Proposed Service Model:**

To take this forward, commissioners have developed a proposed service model to modernise services to reflect the changing needs of PLHIV and address the issues identified through the service review. This has enabled identification of future commissioning intention. The proposed service model aims to deliver the following principles:

- Ease of navigation across services through clear defined and well published care pathways
- Use of appropriate levels of care in response to the individuals needs during the progression of their disease
- Equality of access to mainstream health & social care services
- Phased implementation of the new system to ensure continuity of patient care and sustainability of specialist knowledge and skills.
- Effective and appropriate use of resources
- Shift of care from specialist services where clinically appropriate

The service model has been broken down into three key specific components which have been briefly detailed below:

i) Access to mainstream services: This report proposes that mainstream health and social care services should be considered the primary option for all non-complex care needs of PLHIV. The model specifically identifies access to primary care, mental health, community services, intermediate and palliative care as care needs that should be prioritised for improved access to mainstream services. This will require varying degrees of service redesign across these care pathways which may include raising awareness amongst specialist HIV agencies as referring agents, development of referral protocols, and training and development of the workforce within mainstream health & social care services. Implementation Plans will need to be developed across each care pathway and the development of shared care arrangements across primary care and specialist HIV treatment services will be prioritised within this programme of work

ii) Provision of interim specialist support services to facilitate the mainstreaming of HIV as a long term condition: There is a long term commitment to ensure PLHIV have appropriate and equitable access to mainstream health and social care services in line with other long term conditions. However, it is acknowledged that this change in culture and shift of care pathways will take some time. It is therefore proposed that certain specific care needs will require specialist resources during a development phase but that these services are interim services that will be decommissioned over time as mainstream pathways become embedded. The care needs identified for this specialist resourcing in the development phase include: counseling/low level psychological support for mild and moderate anxiety and depression, specialist mental health services for PLHIV and day care services for physical rehab.

iii) Specialist services for specific HIV related needs:

It is recognised that there are specific HIV related needs, specifically at significant points of an individual's disease progression or with complex patients, which require specialist services that cannot be provided within mainstream health & social care. It is therefore proposed that such specialist services remain an essential part of the local service models. The following services are considered essential services:

- Specialist HIV treatment services (responsible for prescribing of anti-retro viral treatment and other medical interventions)
- Specialist advice & advocacy services for PLHIV (acknowledging the complexity and discrimination involved with PLHIV accessing health & social care services)
- Specialist Peer Led/Mentoring Programmes for PLHIV (commissioned with clear health & social care outcomes such as expert patient programmes, newly diagnosed courses, and positive self management)
- Specialist Family Support for PLHIV (providing support to pregnant women and a holistic family approach to families infected and affected by HIV), Specialist Community Nursing Services for PLHIV (providing intense case management and community nursing services to complex patients)
- Specialist services for HIV related cognitive impairment (providing specialist HIV related cognitive impairment interventions.

Following the development of the above proposed service model a detailed options appraisal was conducted on the current service provision to identify commissioning intentions for each of the existing commissioned providers. This options appraisal considered the risks and benefits of three options for each of the existing services within the reviewed portfolio; maintain status quo/no service change, remodel & redesign, decommission/re-commission. These options were discussed and preferred options endorsed by both the Project Service User Reference Group and Project Steering Group (please see summary in appendix C)**.**

7.2 Recommendations / Commissioning Intentions

Recommendations for service developments and commissioning intentions have been highlighted throughout the report. The table below summarises how the proposed service model will be implemented under the three key components of the model: Improving Access to mainstream services; Provision of Interim Specialist support services to facilitate mainstreaming HIV as a long term condition and Specialist services for HIV related needs.

Commissioning Intentions associated with the proposed service model		
Services	**Delivery Mechanism**	**Financial Implications/ funding source**
i) Improving access to mainstream services		
Primary Care	Pilots of 'shared management' to: • Improve access to primary care services • Develop involvement in case management	i) Cost neutral ii) Potential need for pump priming
Mental Health	Shift of activity from specialised services to: • IAPT • Community Mental Health Services	Potential need for transfer of resources from specialist HIV services to mainstream services
Community Services	Access to mainstream services	Potential need for transfer of resources from specialist HIV services to mainstream services
Intermediate Care	Access to mainstream services	Potential need for transfer of resources from specialist HIV services to mainstream services
Palliative Care	Access to mainstream services	Minimal activity hence expected to have no significant cost pressure
ii) Provision of interim specialist support services to facilitate mainstreaming HIV as a long term condition		
Counselling	Potential renegotiation of existing provider/Tender for new service	Reduction in existing contract value
Specialist Mental Health Services for PLHIV*	Redesign/Respecify	Reduction in existing contract value
Day care for physical rehab	Maintain spot purchasing arrangements with reduction in activity	Potential for reduction in existing contract value
• **Specialist services for specific HIV related needs**		
HIV Treatment Services	Service Improvement through specialised commissioning	To be included in costs under national tariff, potential for short term funding
Advice & Advocacy	Potential renegotiation with existing provider/Tender for new service	Within existing contract value
Peer Led/Mentoring Programme	Tender for new service	Need to cost up new service, shift of £86k from existing peer support provision
Family Support	Redesign/Respecify	Maintain existing contract value
HIV Community Nursing Services	Redesign/Respecify	Potential for reduction in existing contract value
Community & Inpatient HNCI	Maintain cost & Volume contracting arrangements	Within existing contract value

* Future work is required on assessing the need for community services for HIV specific Mental Health needs i.e. HNCI long term

7.3 Financial Implications:

It is not yet possible to ascertain accurate financial implications of the proposed service model at this point and this requires further work which will be undertaken during the consultation process. However, there has been no additional service needs identified during this process and no additional cost pressures are envisaged as a result of the proposed recommended service changes. The initial financial assumptions regarding the proposed service changes have been highlighted in the table overleaf that lists the proposed commissioning intentions.

Key areas that require immediate further work include:

- Scoping of potential efficiencies to be released from shift of activity over three years
- Efficiencies released from decommissioning and redesign of services
- Cost of shifted activity in mainstream services
- Costs of re-tendered service provision

It is recognised that there is potential to release productivity and efficiency savings from the proposed service changes. Such efficiencies will be prioritised in the following areas:

- Reinvestment in the expansion of HIV testing as the key HIV prevention strategy across LSL
- Investment in mainstream services to increase capacity required to manage with shift from specialist HIV services to mainstream services
- Reinvestment into the HIV care pathway to mange growth in new infections
- Efficiencies required as a reduction to the Comprehensive Spending Review

8. Results of consultation

8.1 See section 5 and appendix G for details of the projects Engagement & Consultation Plans. The results of the formal three month consultation process will be collated, published and considered for any necessary revisions to project recommendations/proposals in February 2012.

9. Organisational implications

9.1 **Risk management:**

The increasing HIV prevalence and in particular continuing high levels of late diagnosis in these vulnerable populations present great challenges for public health and local health and social care services. Nationally, late HIV diagnosis has become the single highest largest risk factor for HIV related mortality and is associated with survival by about a decade. NHS Southwark is implementing national testing guidelines to reduce undiagnosed and late diagnosed HIV as well as tackling HIV related stigma through HIV training and education to health professionals. If the planned proposals for increasing earlier diagnosis are successful, Southwark's figures will initially increase further, which will have initial resource implications for commissioners although these will be offset by costs avoided in the long term from the reduced onward transmission of HIV and reduction in HIV associated acute and social care costs.

9.2 **Equalities impact assessment:**

An equalities impact assessment (EEIA) screening has been drafted following the finalisation of recommendations and the development of the options appraisal and summary commissioning intentions. This will be further developed during the consultation process.

9.3 **Community safety implications:**
The focus for this report is the prevalence of HIV and local actions to reduce morbidity and mortality of HIV infected individuals. There are no direct community safety implications.

9.4 **Environmental implications:**
N/A

9.5 **Staffing and accommodation implications:**
N/A

9.6 **Any other implications:**
N/A

10. Timetable for implementation

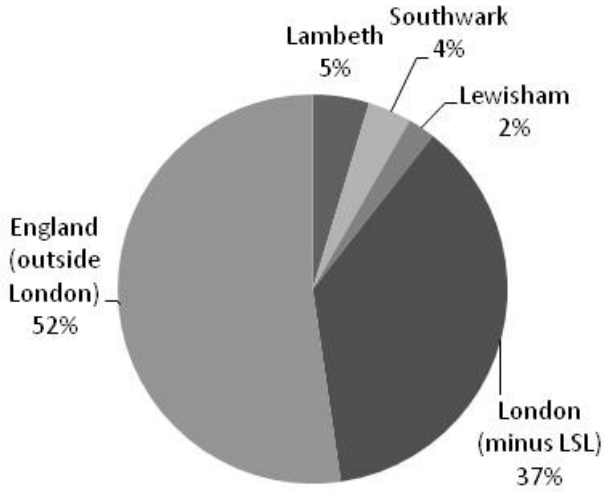
The key project milestones were:

- Review completed including recommendations, future service model, summary commissioning intentions **Mid October 2011**
- Three month consultation process**- 7th Nov 2011 to 6th Feb 2012**
- Final commissioning intentions and implementation plans signed off- **Early Feb 12**
- Initial service changes & decommissioning of duplication- **April 2012**
- Procurement of any new service provision- **Feb to July 2012**
- New service starts- **Sept 2012**

APPENDICE A: Lifestyle and Risk Factors: HIV

Lambeth, Southwark and Lewisham (LSL) have some of the greatest numbers of individuals known to be living with HIV in the UK. Based on SOPHID[6] in 2009, the 6,400 patients in LSL accounted for approximately 11% of the total caseload in England and 23% (almost one quarter) of all cases in London (Figure 1). For people aged 15 – 59 years, the prevalence of HIV in 2009 was 1.3% in Lambeth (highest in the UK), 1% in Southwark (2nd highest in the UK) and 0.7% in Lewisham (8th highest in the UK), all of which are significantly higher than the average prevalence of HIV in London at 0.5%.

Figure 1: Percentage of persons with HIV, by residential locality in England 2008 (based on SOPHID)



Southwark's HIV profile[7]

Sex

There were 2,197 Southwark residents accessing HIV-related care in 2009, 1,597 males and 600 females. This was the second highest PCT number in the SE London sector and equated to a prevalence rate of 11 and 4 per 1000 population for males and females respectively. Compared to 2008, increased rates were seen in both male (4% increase) and female patients (3%). The male to female ratio remained at 2.7, with 27 male patients to every 10 female. Compared to the overall UK rates by sex, the rate for males was over seven times higher, and more than six times higher for females in Southwark.

Age

In both sexes, the greatest numbers accessing HIV-related care were aged in the 35-44 year group (42% of all PLHIV accessing care, and 44% and 39% of males and females respectively). For men this equated to an age-specific prevalence rate of 25 per 1000, and for women 10 per 1000.

Ethnicity

The highest numbers of patients accessing care were white males and black Africans females, accounting for 66% and 74% of all male and female patients respectively. However, the prevalence rates were highest in black Africans for both sexes – 14 per 1000 in males and 27 per 1000 in females, respectively, compared to 12 and 1 per 1000 in those of white ethnicity, and 10 and 4 per 1000 in black Caribbean males and females, respectively. Between 2008 and 2009, prevalence rates increased for males and females for all ethnicities analysed, except black Caribbean males. Southwark had the highest known HIV prevalence rate in Caribbean males in the SE London sector.

Route of infection

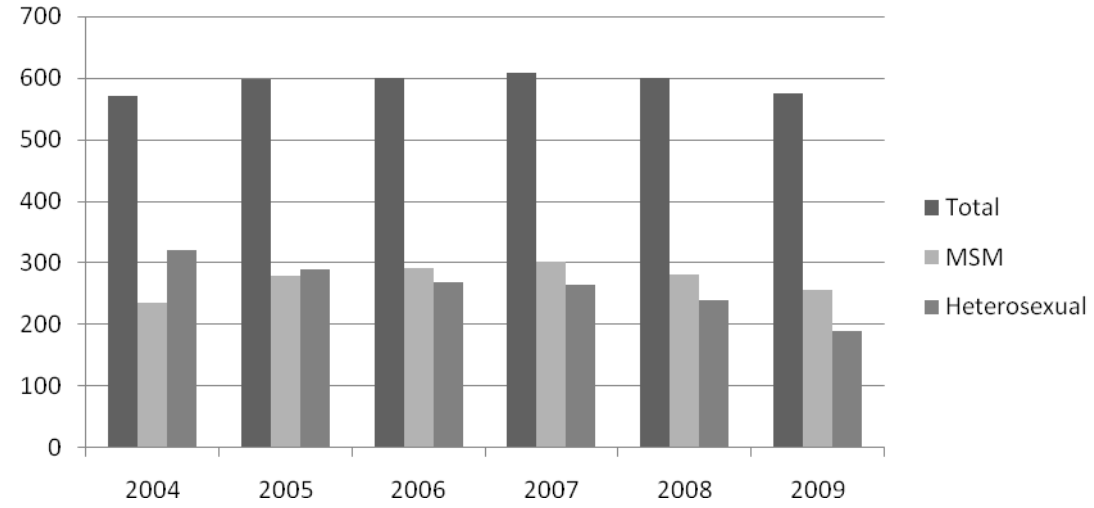
[6] SOPHID Survey of Prevalent HIV Infections Diagnosed
[7] Extracts from HPA SEL HIV report, 2009.

The largest proportion of patients resident in Southwark were infected via MSM (52%, n=1,135). Infection via heterosexual transmission was responsible for 39% (n=860). Other routes of infection, including IDU, mother to child transmission and via blood-borne products, accounted for a further 4% (n=85).

Incidence of new infections across LSL

Figure 2 illustrates the number of new HIV diagnoses in persons living in LSL at time of diagnosis 2004-2009. Annually there were between 550-600 new diagnoses among LSL residents. While heterosexually acquired diagnoses have steadily decreased since 2004, new diagnoses for MSM have remained stable. These local trends are in line with trends across England and the decrease in heterosexually acquired infections (largely acquired in sub-Saharan Africa) is thought to be due to changes in national immigration regulations). In the UK in 2009, it is thought that of new diagnosis among MSM four out of five probably acquired their infection in the UK. Of heterosexuals diagnosed in the UK in 2009, a third probably acquired their infection heterosexually in the UK.

Figure 2: Number of new HIV diagnosis[8] in LSL by mode of acquisition 2004 – 2009 (based on HPA linked SOPHID/HARS)



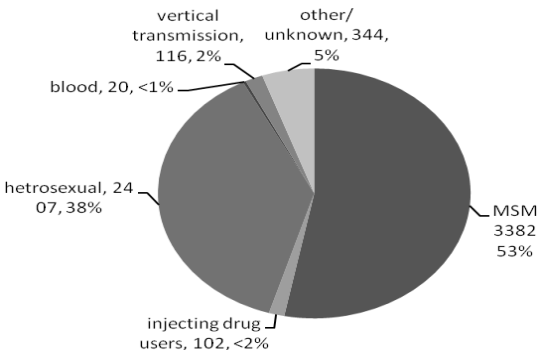
Population Characteristics

Routes of transmission

Figure 3 below illustrates the proportional breakdown by route of HIV acquisition for patients resident in LSL in 2009. Patients who acquired infection through sex between men accounted for 53%, followed by heterosexually acquired infections (38%). Other infection routes only accounted for only 9%, of which the route of infection was unknown in 5% of cases.

Figure 3: Number (and percentage of total PLHIV) patients in LSL accessing HIV care in 2009 (based on HPA SOPID)

[8] New HIV diagnoses (NB figures may vary from the HPA SEL HIV report as a more sophisticated methodology was used in this report)

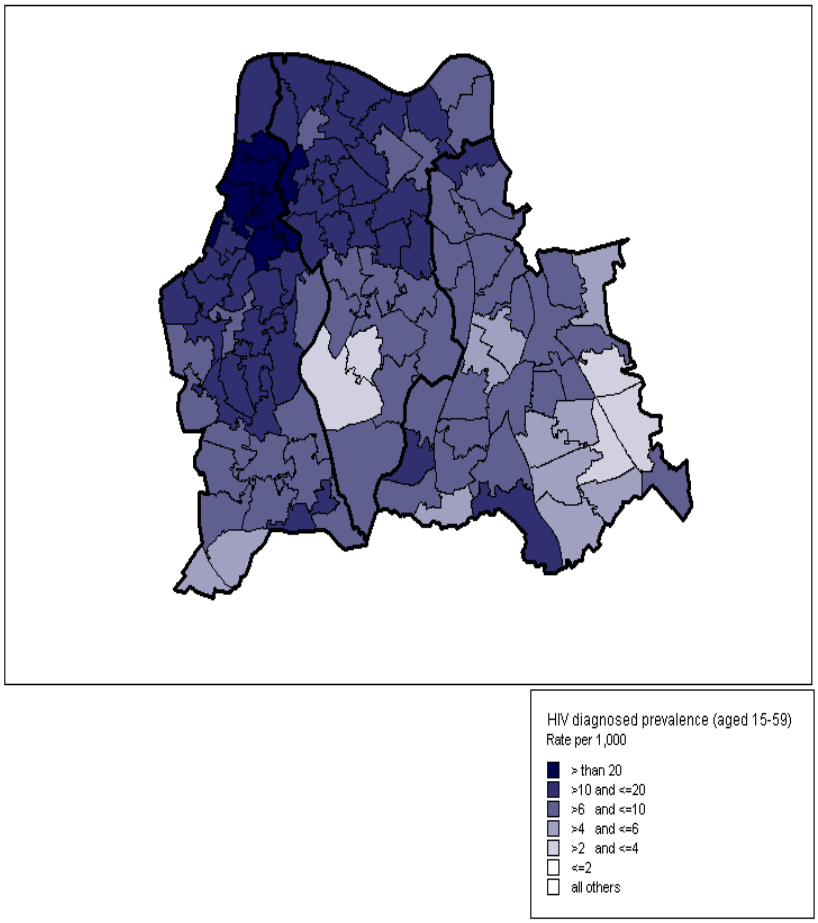


People of different ethnic groups living with HIV were more likely to have acquired their infections via different routes. In 2007-2009 in SEL (Figure 11), MSM was the most common route of acquisition for white males (82% of all infections in white males), while black African patients of both sexes were more likely to have been infected via heterosexual transmission (90% of all infections in those of BA ethnicity). The majority of black Caribbean patients were infected via sex between men and women (55%) but there was also a significant number in the black Caribbean male population who were infected via MSM (40%). For other routes, the majority of infection of HIV transmitted via mother-to-child occurred in black African women (89% of all infections via this route, n=136), while infection from IDU occurred mainly in white patients (82%, n=103). No data for LSL was available at the time of writing this report.

Geographical Distribution

There are distinct small area residential distributions between both groups. At small area level, the MSM epidemic is largely concentrated around north Lambeth and Southwark (which has a large resident MSM community, up to 16% of the male population in Lambeth) and clustering in these areas is likely to continue. In contrast the residential distribution of BA with HIV is more dispersed across LSL, with higher concentrations around mid Lambeth and Southwark, and Northern and Southern Lewisham. The distribution of BA living with HIV is largely congruent with the most deprived areas in LSL. Figure 4 shows the diagnosed HIV prevalence in persons aged 15-59 years by Middle Layer Super Output (MSOA) level (MSOAs are sub-PCT geographical areas similar to wards of approximately 7,500 people in 2009). In particular, the northern parts of Lambeth and Southwark had a diagnosed HIV prevalence greater than 1%, making HIV a common chronic condition in those areas.

Figure 4: HIV diagnosed prevalence by MSOA in LSL 2009 (based on HPA SEL HIV report)



The Changing face of HIV

The introduction of anti-retroviral therapy (ART) in 1995, has transformed HIV infection from a fatal disease to a chronic infection. The principle of ART for HIV is that the drug regime suppresses viral replication. At present there are five classes of therapeutic agents, primarily used in combination (usually three drugs) to ensure viral suppression. ART is highly effective but also expensive; drug costs currently account for approximately 65% of the London HIV consortium costs. Based on 2009 cost estimates, the lifetime drug treatment cost total £200,000 - £360,000 per patient[9]. Today, people diagnosed and treated in the early phase of HIV infection can expect a near normal life span with fewer side effects compared to earlier drug regimens. As a result of the availability of highly effective ART, opportunistic infections, AIDS defining conditions and the need for inpatient care declined significantly; and the service needs of most patients changed to an outpatient based model. This service model initially focused on the monitoring of effective pharmacological viral suppression and immune status. However there is increasing evidence on the incidence and prevalence of co-morbidities in long-term treated patients (e.g. ART side effects, drug-drug interaction, co-infections) in addition to common age related co-morbidities of an ageing patient population.

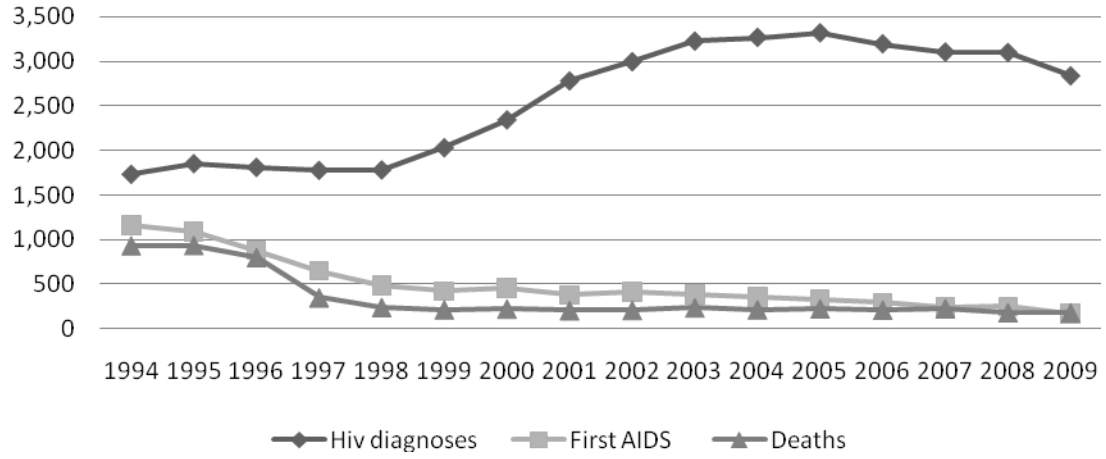
At a pan-London level there are clear signs of ageing HIV patient cohorts. It can be expected that within the next 5-10 years, the number of patients over 55 years of age will increase rapidly, given the size of the current aging cohort. Figure 5 shows the number of new HIV diagnoses, first AIDS diagnoses and deaths in London between 1994 and 2009. A key feature of this graph is the impact of the availability of ART on HIV related deaths since 1995/6.

It shows:

[9] NICE 2011, Increasing the uptake of HIV testing amongst men who have sex with men. Available from: http://guidance.nice.org.uk/PH34

- A steep increase in HIV incidence from 1999 to 2004, followed by a year-on-year decrease in line with the national trend.
- More than a 6 fold decrease in new AIDS diagnoses in London from 1994 to 2009.
- A corresponding decline in deaths over the same period.

Figure 5: Number of new HIV cases, AIDS diagnoses and deaths among PLHIV, by year of diagnosis in London, 1994 – 2009[10]



The ageing HIV population (National)

HIV infected adults aged 50 years and over accessing care more than tripled between 2000 and 2009 from 2,432 to 12,063, representing one in five adults seen for HIV care in 2009. This is due to an ageing cohort of people previously diagnosed, as well as an increase in new diagnoses among the over 50s. New diagnoses among older adults more than doubled between 2000 and 2009, and accounted for 13% of all diagnoses in 2009. Two-thirds (67%) were diagnosed late, with a CD4 cell count less than 350 per mm^3. Adults diagnosed when aged 50 years and over were more likely to present late compared with younger adults (15-49 years). A recent study showed that the risk of short-term mortality (death within a year of diagnosis) was 2.4 times higher for older adults compared with younger adults, and older adults diagnosed very late (<200 per mm^3) were 14 times more likely to die within a year of their diagnosis compared with those diagnosed earlier.

The age distributions show clear signs of an ageing cohort. The number of older patients is likely to grow substantively over the next 5- 10 years, as the high numbers of patients in older age groups (40-49 years in 2009) are ageing (Figure 6). Of particular concern is the rapid increase in patients over 50 years, (approximately 1,000 patients in 1999; 5,000 patients in 2009), as these patients are likely to be affected by both long-term ART side effects and age related chronic conditions such as cardiovascular disease, chronic obstructive pulmonary disease, and diabetes. There is currently insufficient data on the incidence/prevalence of these conditions in HIV infected patients, but is likely that ageing will pose additional clinical management challenges for this group.

The data in the tables below was provided on request from the HPA and provides baseline data on the number of LSL residents aged 60 years and over with diagnosed HIV.

Residents aged 60+ living with diagnosed HIV

		Aged 60+	
Area of residence	PCT of residence	Male	Female
Lambeth, Lewisham & Southwark	Lambeth PCT	85	23
Lambeth, Lewisham & Southwark	Lewisham PCT	36	17

[10] HPA: New HIV Diagnoses to end of June 2010 Available from: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1238055337604

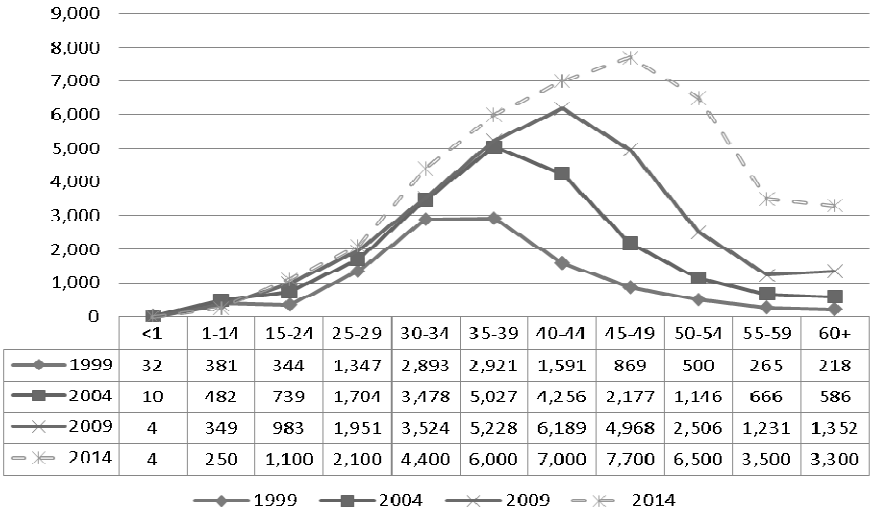
Lambeth, Lewisham & Southwark	Southwark PCT	65	18

Residents aged 65+ living with diagnosed HIV

		Aged 65+	
Area of residence	PCT of residence	Male	Female
Lambeth, Lewisham & Southwark	Lambeth PCT	32	14
Lambeth, Lewisham & Southwark	Lewisham PCT	21	6
Lambeth, Lewisham & Southwark	Southwark PCT	29	7

The second key observation is the increase in patients aged 15-24 years, which is likely to be a cohort effect from children with HIV growing older rather than new diagnoses. Transitional care planning (from child to adult HIV services) for this cohort is challenging and will require some consideration. Overall, there is cohort complexity amongst adolescents living with HIV, and early data from small numbers suggests that multidisciplinary transition services can improve healthcare experiences for young people. Adolescents living with HIV have additional complex medical and psychological stressors, many of which are not typically seen in other chronic diseases of childhood but potentially impact throughout transition and into adult care. Transition from paediatric to adult services occurs at a time when adolescents living with HIV are managing the wide spectrum of change associated with later adolescence and particularly influencing independence and autonomy, sexuality and personal identity.

Figure 6: Age distribution of patients accessing HIV care in London, 1999, 2004, 2009; and estimated for 2014



	<1	1-14	15-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
1999	32	381	344	1,347	2,893	2,921	1,591	869	500	265	218
2004	10	482	739	1,704	3,478	5,027	4,256	2,177	1,146	666	586
2009	4	349	983	1,951	3,524	5,228	6,189	4,968	2,506	1,231	1,352
2014	4	250	1,100	2,100	4,400	6,000	7,000	7,700	6,500	3,500	3,300

(Note: 2014 estimated numbers are for illustrative purposes only. Methodology: 5 year age specific number from 2009 (base) plus expected number of 5 year age specific new diagnoses)

APPENDICE B: Portfolio of Services (based on 10/11 activity and 11/12 forecasted spend)

Service (Provider) *Description of Service*	Lead Commissioner	Lambeth Expenditure (ASG/LA funding)	Lambeth Activity/ Outputs	Southwark Expenditure (ASG/LA Funding)	Southwark Activity/ Outputs	Lewisham Expenditure (ASG/LA Funding)	Lewisham Activity/ Outputs	LSL Total Expenditure (Total ASG/LA funding)	LSL Activity/ Outputs for 10/11 (* where stated commissioned activity as opposed to 10/11 performance data.)
CASCAID (SLAM) Specialist HIV Mental Health Service for people infected or affected by HIV	LSL Mental Health	£578,230	Approx 45%	£408,249	Approx 35%	£241,707	Approx 20%	£1,228,187	3350 appts (2711 attendances excluding DNAs & cancellations) 310-350 clients at any one time
HIV Community Nursing Service (GSTT Community Services) Case Management and ongoing medical support for people living with HIV.	NHS Lambeth Community Contract/ SH & HIV	£225,611	Approx 45%	£159,288	Approx 28%	£94,308	Approx 26%	£479,207	Approx 2776 face to face contact per annum. Approx 250 clients at any one time
Family Support (Positive Parenting & Children) Family Support Service delivered through a social care model for infected and affected parents, children & adolescents	LSL SH & HIV	£105,353 (50%/ £52,677)	Approx 43% of family work	£74,382 (50%/ £ 37,191)	Approx 25% of family work	£44,039 (50%/ £22,020)	Approx 31% of family work	£223,774 (50% / £223,774)	3000 hours of home*, community, or clinic based family support per annum. Estimated 100 families per annum.
Mildmay Residential & Day Care (Mildmay) Services for HIV related cognitive impairment and physical rehab	North East London Cluster	£343,940,	709 residential bed days & 269 day care days	£224,373	496 residential bed days & 81 day care	£139,896	254 residential bed days & 12 day care	£708,209	See PCT spit
Muslim Peer Support (African Advocacy Foundation) Muslim Peer Support	LSL SH & HIV	£3,019	Awaiting data	£2,526	Awaiting data	£2,455	Awaiting data	£8,000	50 group meeting per annum* Work with 40 families per annum*

Services									
Christian/Faith Based Peer Support (LEAT) Christian/faith based peer support service	LSL SH & HIV	£3,019	Awaiting data	£2,526	Awaiting data	£2,455	Awaiting data	£8000	25 group meeting per annum (10 clients per session)*
South London HIV Partnership (Partnership of Providers commissioned across South London -broken down by service below (a-g))	Croydon HIV	£343,617 (40%/ £137,447)		£267,113 (40%/ £106,845)		£159,490 (40%/ £63,796)		£770,220	See Below
a) First Point (Metro) Assessment & referral service	*Croydon HIV*	*£58,437*	*Awaiting Data*	*£45,426*	*Awaiting Data*	*£27123*	*Awaiting Data*	*£130,987*	*1216 assessment across South London/estimated 53% LSL= 644 assessments*
b) Advice & Advocacy (THT)	*Croydon HIV*	*£59,895*	*Awaiting Data*	*£46,559*	*Awaiting Data*	*£27,800*	*Awaiting Data*	*£134,272*	*547 Individuals seen LSL (57% of South London Activity)*
c) Counselling (THT)	*Croydon HIV*	*£48,474*	*Awaiting Data*	*£37,682*	*Awaiting Data*	*£22,499*	*Awaiting Data*	*£108,656*	*263 hours of counselling per annum* across south London No LSL Split activity*
d) Health Trainers (THT)	*Croydon HIV*	*£59,895*	*Awaiting Data*	*£46,599*	*Awaiting Data*	*£27,8000*	*Awaiting Data*	*£134,255*	*3000 sessions/800 individuals* Approx 47% LSL*
f) Peer Support (THT)	*Croydon HIV*	*£34,260*	*22%*	*£26,632*	*17%*	*£15,902*	*17%*	*£76,795*	*Approx 472 clients per annum 56% of total activity*
e) Monitoring, verification & Evaluation (NAW Solutions	*Croydon HIV*	*£20,249*		*£15,740*		*£9,398*		*£45,387*	*No service activity*
g) Infrastructure & programme office	*Croydon HIV*	*£62,405*		*£48,511*		*£28,965*		*£139,883*	*No services Activity*
Total Health Funding		***£1,432,669***		***£983,329***		***£590,623***		***£3,006,621***	
Total ASG/LA Funding		***£190,123***		***£144,036***		***£85,816***		***£419,975***	
TOTAL		**£1,621,792**		**£1,127,365**		**£676,439**		**£3,425,597**	

4. **N.B. More comprehensive activity information will be available from the service review.**

APPENDICE C: Options Appraisal for current service provision

Following the development of the proposed service model a detailed options appraisal was conducted on the current service provision to identify commissioning intentions for each of the existing commissioned providers. This options appraisal considers the risks and benefits of three options for each of the existing services within the reviewed portfolio; maintain status quo/no service change, remodel & redesign, decommission/re-commission. These options were discussed and preferred options endorsed by both the Service User Reference Group (SURG) and Project Steering Group. The options appraisal also identifies potential resource implications of the recommendations.

Figure 3.1 summaries the endorsed recommendations for each of the current commissioned services reviewed within this project.

Current Service (Provider)	Recommendations for future commissioning:
CASCAID (SLAM)	**Remodel & respecify** to provide an interim service which support shift to & capacity building within mainstream services. Release efficiencies from immediate shift/decommissioning and plan for **phased reduction in service/contract value**. Future direction of travel to explore need for specialist service to provide HIV specific Mental Health Services not delivered in mainstream mental health services such as HIV related cognitive impairment services
HIV CNS (GSTT Community Services)	**Remodel & Respecify** to ensure delivers to most complex services focusing on hospital discharge planning, provision of step down community nursing packages, case management of co-morbid and complex social issues, complex adherence programmes. Review case mix and required capacity for services in line with remodelling, **potential reduction in contract value.**
Family Support (Positive Parenting & Children)	**Remodel & Respecify**, maintain contract value but respecify to improve outcomes and focus existing service.
Mildmay Residential & Day Care (Mildmay)	Inpatient HIV related neuro-cognitive impairment (HNCI): **maintain status quo** of spot purchasing arrangements and placement panels. Outpatient HNCI: **maintain status quo** of spot purchasing arrangements and placement panels. **Potential to reduce activity** levels through shift to CASCAID/existing community physical rehab services. Inpatient Physical Rehab: **maintain status quo** of spot purchasing arrangements and placement panels. **Immediate Reduction in activity** levels through shift to intermediate care services with intention to **decommission** over time Outpatient Physical Rehab: **maintain status quo** of spot purchasing arrangements and placement panels. **Immediate reduction in activity** levels through shift to community rehab services/CNS with intention to **decommission** over time
Muslin Peer Support (AAF)	**Decommission** existing provision; consolidate with other peer support, **Recommission:** design and tender for new peer led/mentoring programme.
Christian/Faith Based Per Support (LEAT)	**Decommission** existing provision; consolidate with other peer support, **Recommission:** design and tender for new peer led/mentoring programme.
First Point (Metro-SLHIVP)*	**Decommission** mainstream assessment & referral service in Specialist HIV treatment services.
Advice & Advocacy (THT-SLHIVP)*	**Decommission & recommission** advice & advocacy service
Counselling (THT-SLHIVP)*	**Decommission & recommission** interim service with **phased reduction** and **intention to decommission** over time
Health Trainer (THT-SLHIVP)*	**Decommission**, mainstream provision through specialist HIV treatment agencies/Health Advisors/Peer led newly diagnosed programmes
Peer Support (THT-SLHIVP)	**Decommission** existing provision; consolidate with other peer support, **Recommission:** design and tender for new peer led/mentoring programme.

NHS Lambeth

APPENDICE D: Terms of Reference for HIV Care & Support Steering Group

Lambeth, Southwark & Lewisham (LSL) HIV Care and Support Needs Assessment Steering Group
Terms of Reference, July 2011

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1. Membership

Ruth Wallace DPH –Lambeth (CHAIR)
TBC-Lewisham Council Commissioning Lead
Peta Smith, Southwark Council Commissioning Lead
Elizabeth Clowes, Lambeth Council Commissioning Lead
Murad Ruf/Emma Robinson- Public Health Consultant,
Ruth Hutt – Public Health consultant, Lewisham
Gillian Holdsworth –Public Health Consultant, Southwark
Ali Young –Senior Sexual Health Commissioner
Jess Peck, Commissioning Manager, Sexual Health & HIV, LSL Alliance
Sima Chaudhury –Lead Commissioner SLHP NHS Croydon
Gary Alessio- SEL SH & HIV Network Coordinator
David Bello- Lambeth Council Social Services Lead
Jon Newton- Southwark Council Social Services Lead
Audrey-Marie Yates- Joint Commissioning, Contracts and Brokerage Unit, Adult Social Care Lewisham Council
Mary Poulton- King's HIV Service Lead
Nick Larbalestier- GSTT HIV Service Lead
Charles Mazude -LHNT HIV Service Lead

2. Frequency

The HIV Care and Support Needs Assessment Steering Group will meet monthly for the duration of the project. This is expected to be for a period of no more than 6 months, June- November 2011.

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3. Purpose of the group

This group will provide a multi-agency approach to oversee and monitor the delivery of the LSL HIV Needs Assessment and Service Review Project against the agreed PID and project plan.
The group will:

- ensure that the necessary milestones and products are met within set timelines
- review quality of products
- provide an advisory capacity in the analysis of information obtained within the project
- make recommendations for future commissioning intentions (for consideration by relevant commissioning groups)
- commit to collaborative working across Lambeth, Southwark & Lewisham where feasible and appropriate
- contribute to the development of a strategy for HIV as a long term condition.

4. Governance

The HIV Care and Support Needs Assessment Steering Group reports progress to the Lambeth Southwark and Lewisham (LSL) Sexual Health & HIV Programme Board that in turn reports into 'Planned Care' QIPP groups across LSL and into Local Clinical Commissioning Groups across LSL.
Recommendations for future commissioning intentions will be made to PCT and Local Authority Commissioning Boards and Scrutiny Panels, and Clinical Commissioning Consortia Groups across LSL. In addition, recommendations will feed into the PCT QIPP Planning process for 2012/13.

5. Ways of working

Agendas and supporting papers will be circulated 3-5 days in advance of meetings. Action notes of each meeting will be recorded and submitted to members within 14 working days of each meeting, and reviewed at each meeting.

6. Quoracy

There should be representation from each borough at all meetings where possible. The minimum number of members required in order to take decisions is 5 members were there is representation across the 3 boroughs.

7. Evaluation and Review

The Steering Group will oversee the delivery of the project against the agreed PID and project plan.

APPENDICE E: Communication & Engagement Plan

Communications and Engagement Action Plan for the HIV Care and Support Needs Assessment / Service Review

List here the communications / engagement objectives again so that you can refer to them in the first column.

1. Brief cluster & PCTS to address concerns / queries in relation to HIV Care and Support NA
2. Inform LSL Overview & Scrutiny Processes and allow for engagement & consultation throughout review
3. Engage with stakeholders throughout the review process
4. Develop Service User reference Group for NA/ Service Review to act as a shadow Board and to start beginning September
5. Consult with public, patients and key stakeholders across LSL on review findings & recommendations including focus groups and wider engagement activities

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
1	*Brief cluster & PCTS to address concerns / queries in relation to HIV Care and Support NA* • Meetings with PPE leads (LSL) and Communication leads within Cluster • Preparation of Communications briefing about Need Assessment, process, time lines and engagement • Briefing to PCT and Clinical Commissioners	Mid July Mid August Mid August	JP/AY/ CF KS	Public unawareness generates high levels of concern and lobbying	(a) Briefing available (b) Monitor level of public queries monthly
2	*Inform LSL Overview & Scrutiny Processes and allow for engagement & consultation throughout review* • Finalise OSG dates across LSL: Lambeth 19th Oct (report end of Sept) Lewisham 9th Nov (report 31st Oct), Southwark Dec 7th (report 25th Nov) • Prepare presentation/ briefing on NA/ Service review engagement plans for LSL Stakeholder Group meeting 17th August (sub group of Cluster	End July Mid August Mid August Beg Sept Beg Sept	JP/AY/RW JP/AY/RW JP/AY JP/AY	R: Service Review not complete and rec's not ready: MA: Provide progress report including extensive engagement R: Scrutiny Leads/ BSU leads not	Scrutiny dates finalised Reports submitted against deadlines Scrutiny leads briefed

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
	Commissioning Board) • Develop scrutiny paper • Identify Health Lead Councillors across LSL and brief prior to Scrutiny meetings • Brief BSU Managing Directors in advance of Scrutiny meetings • Arrange subsequent OSG dates to present recommendations & consultation feedback	 Beg Sept Sept-Nov Sept-Dec Jan-March	 AY/JP AY/JP AY/JP AY/JP	sufficiently briefed MA: Early intervention with Leads	
3.	*Engage with stakeholders throughout the review process* • Inform providers of review Process • Plan Stakeholder mapping event with providers and service users • 14th July -Lewisham LA event (attended by 18 LA Commissioners and providers, mapping existing Social care pathways, providers, services and NRPF) • 19th July – LSL Stakeholder event to map client journeys, services, referral pathways and gaps • LA Southwark and Lambeth event • Stakeholder Event results written up • Ensure service user feedback/intelligence informs service reviews • Consult with providers on Service reviews	July July July July End of Aug Sept August August	AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA	R: Providers attendance low and non representative MA: Promote with managers and Dept leads , chase confirmed attendees Ensure information about event and intended outcomes of event are clear Do not gain a full picture of Social care pathways including NRPF for all LSL LA's	Good attendance Event Outcomes met Information gathered useful and contributes to service developments /changes
	Develop Service User reference Group for NA/ Service		JP/AY/GA/	R: SURG not	SURG in place for

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
4.	*Review to act as a shadow Board and to start beginning September* • Recruit service users onto a Service User Reference Group (SURG) that will shadow project Steering groups • Recruit through (South London HIV Partnership (SLHP) as have data network and MVE work stream; HIV services patient reps (GST, Kings); Family Support Provider (PPC) particularly for younger people • Develop role outline and briefing for recruiters • Agree incentives and travel expenses • Assign lead to work with Service Users / PPE chair • Book meeting dates and room for first meeting early Sept (confirm date) • Develop draft TORs / outline • Co-ordinate meetings for lifespan or review and implementation phases • Ensure SURG feeds into Project steering group	Early /Mid Aug Early Aug Early Aug Early Aug Early Aug Mid Aug End of Aug Ongoing Ongoing	CF	representative PLHIV in LSL MA: Ensure recruiters have briefing outline of project and vision of SURG	September 2011
5.	*Consult with public, patients and key stakeholders across LSL on review findings & recommendations including focus groups and wider engagement activities* • Launch of final review and recommendations • Hold two public consultation events in each borough 1. 9th December 2011, 9.30am-12.30pm, Roben's Suite, Guys Hospital 2. 12th December 2011, 2-5pm, Assembly Rooms, Lambeth Town Hall 3. 13th December 2011, 9.30am-12.30pm, Lewisham Town Hall 4. 5th January 2012, 6-9pm, Roben's Suite, Guy's Tower, Guys		JP/AY/GA/ CF Mid Oct Nov- Jan Nov- Jan Nov- Jan	R: Consultation events not sufficiently promoted MA: Engage PPE support and guidance on format and promotion of the event	Events well attended from user representative PLWHIV in LSL Legacy document developed Responses to consultation made publically available

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
	Hospital 5. 9th January 2012, 6-9pm, Assembly Rooms, Lambeth Town Hall 6. 10th January 2012, 6-9pm, Lewisham Town Hall iii) Hold Focus group with white MSM, Migrant/non migrant African men & women as part of consultation iv) Ensure review findings/recommendations goes to SURG & peer support forums v) Inform/consult OSG on review findings/recommendations/consultation responses vi) Collate Consultation responses vii) Publish consultation and final review/recommendations		Nov- Jan Jan/Feb Jan/Feb		

COMMUNICATION AND ENGAGEMENT LOG

This log is a record of all the communication and engagement activity undertaken.

Date	Activity undertaken	Completed by	Notes
28th June 13th July	Meetings with PPE leads LSL Meeting with Communication leads SEL Cluster Engagement Plan completed	JP/GA JP/GA JP	Engagement/ Communications template provided / Ref group job roles
14th July	Lewisham LA Stakeholder mapping, Led by Ruth Hutt, Consultant in Public Health (NHSLew). Attended by 18 staff from Lewisham Social Care, CASCAID, HIV CNS, Alexis Clinic (HIV Specialist Services), joint commissioning team and 1 service user from Lewisham. 3 hour meeting to map client pathways into Social Care including Non Recourse to Public Funds (NRPF). Also outlined current generic, specialist HIV and voluntary sector support currently used by PLHIV.	RH / GA	The emerging themes from the event • That specialist HIV services are perceived as 'safe havens' • Disclosure of HIV status is still a major issue and potentially a barrier to accessing generic services • PLHIV need to travel out of Lewisham for many support services. For this reasons services which do home visits or provide transport are favoured • There is a tendency to refer straight into specialist services rather than go via generic services both on the part of the individual & the HIV clinicians (e.g. Go to CASCAID rather than CMHT, HIV specialist rather than GP) • There is a lack of local peer support groups available- loss of positive place means services don't know where to refer to (new group in New Cross identified) • Body & Soul highlighted as a popular service, even though currently not commissioned • A reluctance to use faith groups for support due to a mixed experience and concerns about

			the quality and accuracy of information and support given. • Training needs were identified for generic services and faith leaders.
19th July	Stakeholder Mapping event Robens Suite Guys attended by 67 staff across LSL Provider portfolio; HIV services, voluntary sector and commissioners Event write ups completed end July	RH JP/GA/RH	Preliminary notes completed, core themes: Clarified client pathways (in and out) Service usage Preliminary mapping of LA pathways (follow up meetings needed)
30th June 25th July 29th July Beg July	Paper to Lew CCCB 30th June Paper to Lam CCCB HIV NA/ Service Review paper presented at Lewisham Adult Joint Commissioning Board Recruitment process for Service User reference groups started with SLHP Nathan Williams	RH RW JP JP	Emails sent, phone confirmation 3/8, JP to develop briefing
4th Aug 8th Sept	LA meeting Southwark –Tooley Street LA meeting Lambeth – LBL Streatham	JP/AY JP/GA	**Southwark:** Led by Sexual Health & HIV Commissioning Team with Southwark Physical Disabilities Team Attended by 1 Senior Commissioning Manager for Children's Services; 1 Commissioning Support Officer and 1 Team Leader for the Physical Disabilities Team. **Lambeth:** Attended by the Team Manager and a Specialist Practitioner for Physical Disabilities in Lambeth and the Team Manager for the NRPF Team
12th Oct	SURG meeting 1 –TORs, methods of working agreed and project update.	JP/GA	**Attended by 5 LSL service users**
26th Sept	SURG meeting 2 –TORs signed off, update on Needs Assessment, Options Appraisal reviewed.	JP/GA	**Attended by 6 LSL Service users**
11th Oct	SURG meeting 3 – Options Appraisal revisited	JP/GA	**Attended by 6 LSL Service Users**
8th Nov	SURG meeting 4 (planned)	JP/GA	

Agenda Item 7

Southwark Health and Adult Social Care Scrutiny sub-Committee – November 2011

Interim Report into Southwark Clinical Commissioning Consortia

Part 1: Introduction

This report seeks to review, and make recommendations to improve, the transition to and operation of the clinical commissioning consortia that is being established in Southwark as part of the national government's changes to the National Health Service (NHS) in England. These changes will be enacted under the Health and Social Care Bill which is currently before the House of Lords at Committee Stage.

Whilst HASC committee members have deep reservations about the fundamental proposals contained within the bill and the potential detrimental impact on NHS services in Southwark it is beyond the remit of this committee, or Southwark Council, to stop them. Therefore this report seeks to investigate and make recommendations to enable the changes to work as well as they can in Southwark. The overriding concern of HASC Committee members is the provision of high quality healthcare provision that meets the needs of Southwark's population and continual improves

Importance (COMPLETE)
Importance of NHS to local population
Importance of existing work being undertaken (e.g paediatric liver unit at KCH)
Importance of maintaining viable health economy

Scope of 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

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.

Part 2: Scrutiny of Establishment of Southwark Clinical Commissioning Consortia

Southwark Clinical Commissioning Consortia (SCCC)

The SCCC gave evidence to the committee on 29th June and 5th October 2011, in addition the HASC Chair attended a SCCC public meeting in July and the NHS Southwark AGM in XXXX. The HASC Committee welcomes the open approach taken by SHC towards the scrutiny process and hopes that the recommendations contained within this report are received with the same openness.

Dr Amr Zeindeilne (Chair SHC) and Andrew Bland (Managing Director Southwark Business Support Unit) gave evidence to the committee to explain the transition to the consortia, the impact of cost savings (QIPP) on patient care and at the committee's request the SCCC provided further clarification of it's conflict of interest policies.

Consortia Background:
Southwark Health Commissioning was granted Pathfinder status in the first wave of GPs in England to have been selected to take on commissioning responsibilities. Pathfinders are working to manage their local budgets and commission services for patients alongside NHS colleagues and local authorities. The new commissioning system has been designed around local decision making and Southwark Health Commissioning believe that this will lead to more effective outcomes for patients and more efficient use of services for the NHS. GP Commissioning is not new in Southwark. Southwark's General Practices have worked together as a commissioning group since the beginning of 2007 when the Southwark Practice Based Commissioning Leads Committee was established. Local GPs have a record in commissioning and service redesign. Under existing arrangements GPs have been involved in the planning of several major areas of patient care such as outpatients, walk-in centres, and local community services. Southwark Health Commissioning has the support of local GPs and doctors' representatives and the Local Authority and will begin testing the new commissioning arrangements to ensure they are working well before formal delegation in April 2013.

Southwark Health Commissioning consists of a Board of eight GP members, four from the South of the Borough and four from the North. The SCCC is chaired by Dr Zeineldine who is also a member of the PCT Board. The current SCCC membership brings together the senior management team of the Southwark Business Support Unit, the Non Executive Directors (NEDs) of the Board with responsibility for Southwark and the consortium leadership team who represent their constituent practices. All of the above constitute the voting members of the SCCC, in which the eight clinical leads hold a majority. Other non-voting members include Adult Social Care, King's Health Partners, a nurse member, a Southwark LINk representative and a representative of the Southwark Local Medical Committee.

Whilst the previous Primary Care Trust structure was not perfect and did have a democratic deficit, the committee is concerned by the closed nature of commissioning consortia as set out by government, as the only people who can be guaranteed to sit on the board are local GPs. Whilst this may bring benefits it is also worrying that there is only a relatively small pool of people from which lead GPs can be elected (and indeed take part in election). This is not a criticism of existing GP leads but is made to highlight potential problems that could develop in the future and to try and mitigate against these. It is understood that Southwark Health Commissioning has co-opted members onto its board which is a welcome step. The committee recommends that this practice of co-opting members onto its board continues in the future to broaden the range of experiences available when making commissioning decisions.

Due to the controversial nature of the changes being made by national government it is vital the consortia builds trust with the resident population, council and other local providers and organisations. It is also important for patients to feel that they are being listened to, as David Cameron has said “no decision about me, without me”. Therefore the committee urges that a culture of listening and consultation with patients is developed and built upon to ensure that they remain front and centre in commissioners minds. Initial steps have already been taken by SHC, which are to be welcomed, however this must continue.

Southwark Health Commissioning 2011/12 business plan outlines the trajectory for delegation, whereby SHC takes on responsibility for commissioning (i.e. spending taxpayer’s money). The timetable for delegation can be found at appendix 1, essentially by January 2012 SHC will be responsible for a budget of £421million which is c.80% of total NHS spend in Southwark. Nationally GP-led consortia will be responsible for spending £80billion on an annual basis, this represents 80% of total NHS spending. It is critical the people responsible for spending this money have comprehensive structures to deal with conflicts of interest and prevent possible misappropriation of tax-payers money.

Conflict of Interest

The committee agreed to look at SCCC’s conflict of interest policy and their contract management arrangements. SCCC’s current conflict of interest policy can be found at appendix 2. HASC committee members feel that while these measures are a good starting point they are not rigorous enough. There are potential conflicts of interests that will arise for GPs in their new role as commissioners. GPs bidding as providers who are also commissioners is a key tension in the new arrangements set out by national government. As mentioned above the SCCC and NHS SE London are already looking at how conflicts of interest could be managed locally, but guidance should be set out nationally on how such conflicts are managed.

It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that such training continues and a programme of ‘refresher’ training and sharing experiences and best practice from other public bodies and clinical commissioning groups takes place.

In addition, given the importance of the SCCC’s work and the vital need for transparency to build public confidence in the new arrangements and to allow proper accountability the committee recommends the following:

a) All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.
b) All meetings of the SHC and SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private.
c) Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.
d) The register of interests should be updated on a monthly basis.
e) Southwark’s HASC committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark HealthWatch, SHC Chair and the local press.

f) If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.
g) Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.
h) In line with best practice a new clause be added to the SHC/SCCC's conflict of interest policy to emphasise: "That a member in possession of material none public information that could affect the value of an investment must not act or cause others to act upon that information".

King's Health Partners

On 5th October 2011 the committee took evidence from Professor John Moxham, Director of Clinical Strategy for King's Health Partners (KHP). KHP is an Academic Health Sciences Centre (AHSC), which delivers health care to patients and undertakes health-related science and research. This type of organisation is fairly common amongst the leading hospitals and universities around the world. KHP is one of the UK's five AHSCs. It brings together a world leading research led university (King's College London) and three NHS Foundation Trusts (Guy's and St Thomas', King's College Hospital and South London and Maudsley).

Their aim is to create a centre where world-class research, teaching and clinical practice are brought together for the benefit of patients. They aim to make sure that the lessons from research are used more swiftly, effectively and systematically to improve healthcare services for people with physical and mental health care problems. At the same time as competing on the international stage, their focus remains on providing local people with the very best that the NHS has to offer. The aim is for local people to benefit from access to world-leading healthcare experts and clinical services which are underpinned by the latest research knowledge. There will also be benefits for the local area in regeneration, education, jobs and economic growth.

Professor Moxham explained to the committee the importance of integration and collaboration for KHP to improve patient outcomes. Within KHP there are 21 'Clinical Academic Groups' (see appendix 3) that integrate services across the partners, this pulls together knowledge, experience and expertise across the different hospitals and leads to better patient outcomes. There are four main streams to this integration:

1) Integrating Services across the partners
2) Integration of clinical service with academic activity
3) Integrating mental and physical health
4) Integration of core patient pathways

He explained to the committee that this level of integration, to improve patient outcomes, is reliant on collaboration between all parts of the local health system, and indeed the local authority. Committee members have a very real concern that the introduction of private providers into this system through 'Any Qualified Provider' could have a detrimental impact to the development of KHP and the continual improvement of health outcomes for our residents. This concern is based on the reality that private providers' are in part motivated by profit (which is wholly understandable) and that if collaboration was not deemed to be in their business interests then further integration and improvement of patient outcomes could be jeopardised. Therefore the committee recommends that the SCCC's tendering process for any service includes standard clauses in the contract to ensure collaborative working and integration continue to take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority.

King's College Hospital and Guy's and St Thomas' Hospital Trusts

Committee members visited both hospitals (a visit to SLaM is being organised) and met with the Chief Executive and Chair of KCH and the Chief Executive of GST. Members also saw the Specialist Stroke Unit and A&E at KCH and the A&E at GST. The committee would like to thank both hospitals for hosting members and shining a light on the work that they do.

At KCH it was clear the hospital excels in certain types of treatment and care, for example Paediatric Liver Transplants, Neuro-Sciences and Stroke Care. At GST it was also clear that the size of the trust allows cross-working between types of clinician that leads to innovative forms of treatment for patients. As discussed in more detail above King's Health Partners is driving such integration and collaboration even further which is to be commended.

At KCH concerns were raised by management that if income streams were removed (i.e. other providers were commissioned by the SHC) then the financial viability of KCH would be put at serious risk. This is a serious concern of the committee, as it would be unacceptable for the specialism's and work of any acute trust and KHP to be put at risk as this would be detrimental to serving the health needs of the local population. This is not to say KCH (and GST and SLaM) should not be challenged to deliver more cost efficient forms of care, but that the viability of the institutions should not be put at risk. Therefore the committee recommends to the SCCC that they:

a) That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers.
b) That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASSC) for consideration – outsourcing beyond the NHS should be deemed a 'substantial variation' and be submitted to the HASC Ctte for scrutiny.
c) The committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'
d) The HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision.
e) As a contractural obligation all providers should be subject to scrutiny by the HASC Ctte just as NHS ones currently are.

[DRAFTING NOTE: Further advice will be provided by Southwark Council's conflict of interest specialist, this advice will be included in the report submitted to the HASC Ctte on 7th December 2011]

Impact of Cost Savings on Patient Care

In addition to the changes to NHS Commissioning described above the government has also required the NHS to make total savings in England of £20billion, this represents a XX% cut in funding at a time when inflation is 5% and demand on services continues to grow by approx X% a year. The impact of these savings on patient care in Southwark has been included in this report to highlight potential problems and areas of pressure within the system..

NHS Southwark Performance:

A full breakdown of performance data for Southwark can be found at Appendix 4 (taken from Southwark NHS' Annual Report 2010/11. This shows an underperformance for the 18 week waiting time target, it also shows worryingly high failures to meet targets for Breast Screening, Cervical Screening, Smoking Quitters and immunisation of children – particularly those aged 5. An additional area of concern is childhood obesity, currently at 25.7% of year 6 pupils (age 11-12). We will have to await next year's report to assess performance for the current financial year. Failure to improve on these targets would be of deep concern to the committee.

Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, it is recommended that the HASC committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health.

Contract Management

With delegation of budgets to the SCCC comes responsibility for making commissioning decisions and tendering contracts. This may be self-evident but is worth highlighting and dwelling upon. The SCCC currently uses the expertise of Southwark PCT's Business Support Unit (BSU) who provide them with X,Y and Z. In April 2013 SCCC will be able to decide who provides this commissioning support in the future.

One of the unfortunate consequences of central government's changes has been the breaking of the very close working between Southwark PCT and Southwark Council. In the immediate future the working relations developed between BSU and SC staff will almost certainly remain, however, in the future these working relationships may erode as they are not formally codified as they were in the past. This could lead to a lack of integration at all levels of both organisations which could impede improvement in health outcomes for Southwark's residents. The committee therefore recommends SHC and it's BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing).

As part of the move to 'Any Qualified Provider' it is more than likely that at some stage a private provider will be commissioned to deliver health services in some form in Southwark. Given the negative experience that parts of the public sector have had with private providers (e.g. Southwark's Housing repairs service and call centre) it is imperative that SCCC take a robust approach to contract management, both in drawing contracts up and in monitoring them when signed.

The recent experience and problems caused by the collapse of Southern Cross care homes and the levels of poor care provided at other privately run homes should act as stark warnings to health care commissioners. It took several years for their flawed business model to be exposed (when market conditions changed). To avoid any repeats of this in the health care system the committee urges the SCCC to introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on a regular basis on the financial position of the provider on a quarterly basis and that robust monitoring of satisfaction amongst patients placed with those providers takes place.

There have been previous instances of tendering out NHS services, for example in April 2004 it became possible to outsource primary care out of hours services to independent commercial providers. John Whitting QC, a specialist barrister in clinical and general professional negligence, has reviewed the subsequent CQC and DH reports and inquiries into this and in June 2011 stated that:

"It identified staffing levels that were potentially unsafe, significant failures of clinical governance caused directly by overly ambitious business growth and failures to investigate or act upon serious adverse incidents. The CQC chairman concluded that 'the lessons of these failures must resonate across the health service'." (John Whitting QC, New Statesman, 23/06/2011)

The committee recommends that SCCC works closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational abilities. The details of this arrangement should be for the SCCC to decide, but contract management and effective monitoring must not be an afterthought in any potential tendering process but at the centre.

Further info required: TUPE – If a service is tendered out to a private or other provider will the staff currently providing the service be covered by Transfer of Undertakings (Protection of Employment) TUPE legislation?

Part 3: Conclusions and Recommendations

In summary, the committee's recommendations are listed below, the body which the committee is seeking to adopt the recommendation are italicised in square-brackets at the end of each one.

Recommendation 1
The committee recommends that the practice of co-opting members onto the SCCC's board continues in the future to broaden the range of experiences available when making commissioning decisions. *[SCCC, NHS SE London]*

Recommendation 2
Given the importance of SCCC's work and of the vital need for transparency to build public confidence in the new arrangements the committee recommends the following:

a) All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.
b) Meetings of the SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private. A similar model to the council should be adopted where by any 'closed items' can be discussed in private, but minutes of the non-public part of the meeting should be published.
c) Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.
d) Declarations of Interest are recorded at the beginning of meetings and recorded in sufficient detail in the minutes.
e) The register of interests should be made public by being published online, in an easy to find location. To avoid confusion the SCCC should use consistent terminology when referring to *declarations* of interest and *the register* of interests.
f) Southwark's HASC committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark LINk/HealthWatch, SCCC Chair and the local press.
g) If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.
h) Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.
i) The SCCC ensures there is a non-executive non-GP 'Conflict of Interest Lead/Tsar' on its board and amends it's constitution accordingly.
j) In line with best practice a new clause be added to the SHC/SCCC's conflict of interest policy to emphasise: "That a member in possession of material none public information that could affect the value of an investment must not act or cause others to act upon that information".
k) The SCCC should develop a comprehensive policy for handling and discussing confidential information.
l) In the interests of transparency, the SCCC should publish the results of election ballots for the 8 lead GPs, in addition they should publish full details of the ballot process and who conducts the ballot.

[All of the above – SCCC/NHS SE London]

Recommendation 3
The committee recommends that the SCCC's tendering process for any service includes standard clauses in the contract to ensure collaborative working and integration continue to

take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority. *[SCCC, NHS SE London and Southwark Council]*

Recommendation 4
That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers. *[SCCC, NHS SE London and Southwark Council]*

Recommendation 5
That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASSC) for consideration – outsourcing beyond the NHS should be deemed a 'substantial variation' and be submitted to the HASC Ctte for scrutiny. *[SCCC, NHS SE London, HWB and Southwark OSC]*

Recommendation 6
The committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'. *[DH, via HASC Ctte]*

Recommendation 7
The HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision. *[HWB and Monitor through HASC Ctte].*

Recommendation 8
As a contractual obligation all providers should be subject to scrutiny by the HASC Ctte just as NHS ones currently are. *[SCCC, NHS SE London, Southwark OSC].*

Recommendation 9
Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, it is recommended that the HASC committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health. *[HASC Ctte].*

Recommendation 10
The committee recommends SCCC and it's BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing). *[SCCC, NHS SE London, Southwark Council].*

Recommendation 11
The committee recommends that SCCC works closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational capabilities. The details of this arrangement should be for the SCCC to decide, but contract management must not be an afterthought in any potential tendering process but at the centre. *[SCCC, NHS SE London and Southwark Council].*

Recommendation 12
That the Health and Wellbeing Board has as a central aim of stimulating integration and collaboration between local health care providers to improve patient outcomes. *[HWB].*

Recommendation 13
Patient views and perceptions of the level of care they receive are vitally important to improve services. It is therefore recommended that the Acute Trusts continue to conduct patient surveys, and the SCCC drives patient surveys at GP practices across the borough to capture patients' views and perceptions of their care to help understand what can be improved. *[Acute Trusts x 3 and SCCC]*

Recommendation 14
It is recommended that the SCCC introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on the financial position of the provider on a quarterly basis. *[SCCC, NHS SE London]*

Recommendation 15
It is recommended that robust monitoring of satisfaction amongst patients placed with private/voluntary providers takes place as a matter of course.

Recommendation 16
In addition to clinical standards, it is recommended that minimum levels of patient satisfaction are included in any contracts signed by the SCCC with financial penalties if these are not met, the exact levels should be a matter for the SCCC. *[SCCC, NHS SE London]*

Recommendation 17
Guidance on managing conflict of interest for GP commissioners should be set out nationally. It is recommended that the HASC writes to the Dept of Health requesting this to take place. *[HASC]*

Recommendation 18
It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that governance training continue for GP commissioners and a programme of 'refresher' training, sharing experiences and best practice from other public bodies and clinical commissioning groups takes place. *[NHS SE London, HASC]*

Recommendation 19
It is recommended that the SCCC consider their capacity for developing contracts and build this into their development plan, in particular where they will access expertise in drawing contracts up and monitoring them when signed.

Recommendation 20
It is recommended that the SCCC works closely with and pays close regard to the priorities of the local authority and health and wellbeing board to foster cooperation and meet the mutual goal of improving health outcomes of Southwark's residents.

Appendix 1 - timetable for delegation to SCCC

2011/12 Budget Delegation

Delegation Phase / Date	Budget Area	Budget (£m)	QIPP Gross (£m)	Detail / Complexity* (column consider the complexity of the commissioning area to inform phase)	
One – Jul 2011	Emergency PbR	49	4.8	This phase includes the following areas:	
	A&E PbR	12	0.1		
	New Outpatients	19	2.4		
	F-up Outpatients	22	1.5	Outpatient (GP referrals)	Low
	Drugs and Devices	11	0.5	Prescribing	Low
	Pri Care Prescribing	33	1.0	Urgent care (A&E / UCCs)	Med
	Corporate	17	2.0	Urgent care (Admissions)	Med
				Non GP referred outpatients	Med
				Intermediate Care / Reablement	Med
				Non-PbR Drugs and Devices	Med
Total		163	12.3	(6.3 delivered prior to delegation)***	
Two – Oct 2011	Community Services	33	1.5	This phase includes the following areas:	
	Other Acute**	166	2.6		
				Community Health	Low
				Direct Access Diagnostics	Low
				Sexual Health	Med
				Elective Care	Med
				Maternity	Med
				End of Life Care	Med
				Critical Care	High
				Specialist Acute Commissioning	High
Total		199	4.1	(3.6 delivered prior to delegation)	
Three – Jan	Client Groups	22	-	This phase includes the following	

2012	Mental Health	67	2.6	areas:	
				Community Mental Health	Med
				Voluntary Sector	Med
				CAMHS	Med
				Inpatient Mental Health	Med
				Physical Disability	Med
				Specialist Mental Health	High
				Continuing Care (inc. LD)	High
Total		89	2.6	(4.6 delivered prior to delegation)	
Other	Non-recurrent 2%	10	-		
	Reserves / Surplus	11	-		
Total		21	-		
Non-Delegated	Primary Care	68	1.2		
Total		68	1.2	(0.8 delivered - no delegation)	
Budget Total		**540**	**20.2**		

Notes:

***** SHC has sought to take early delegation for those areas that fall in areas of low or medium complexity. Complexity refers to the commissioning activity itself and SHC are equally aware of the different levels of control that can be secured over performance in these areas.

** Includes £30m budget for Specialised Commissioning which will continue to be led through the LSCG.

******* Clearly delegation is being made in-year and the figures provided above also seek to reflect the level of QIPP delivery undertaken ahead of delegation in the context of the overall QIPP challenge.

Appendix 2 - SHC's current conflict of interest policy

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.

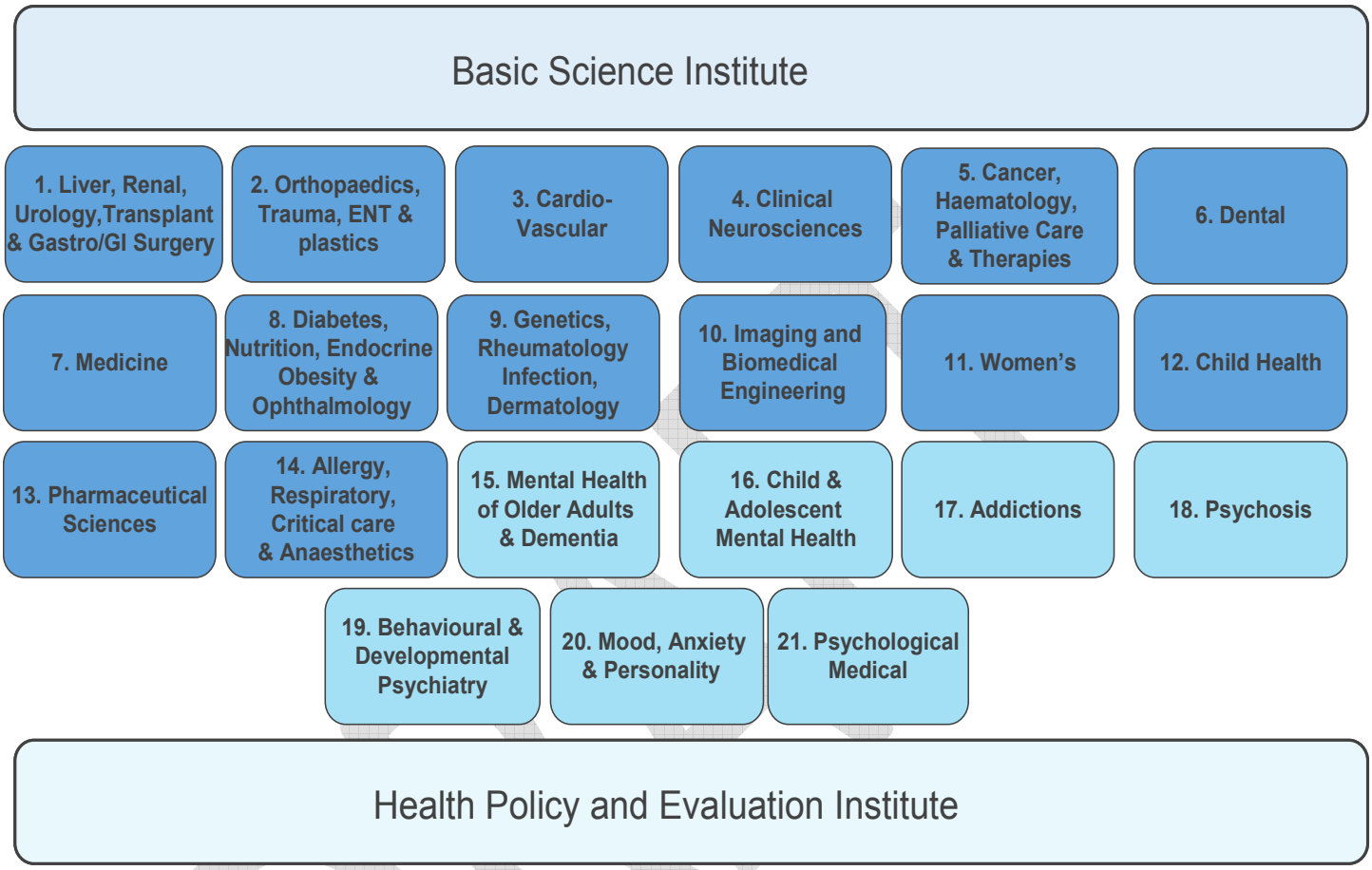
1.5. The Evaluation Panel, when called upon, will provide neutrality in the evaluation process and will have the following membership:

- 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.

Appendix 3 - King's Health Partner's Clinical Academic Groups

CAG and Research Group Structure



Appendix 4 – 2010/11 Performance data for NHS Southwark (from Annual Report)

To be copied in, see **http://www.southwarkpct.nhs.uk/documents/6930.pdf** page 6 for relevant info

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