HEALTH, ADULT SOCIAL CARE, COMMUNITIES AND CITIZENSHIP SCRUTINY SUB-COMMITTEE

MINUTES of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Tuesday 18 September 2012 at 7.00 pm at Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Mark Williams (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Patrick Diamond
Councillor Eliza Mann
Councillor The Right Revd Emmanuel Oyewole
Coucillor Neil Coyle

OTHER MEMBERS PRESENT:

OFFICER SUPPORT: Zoë Reed: Executive Director of Strategy and Business Development
Cha Power: Deputy Director - Mental Health Older Adults and Dementia
Steve Davidson: SLaM Service Director - Mood Anxiety and Personality Clinical Academic Group
Andrew Bland: Managing Director of the Business Support Unit (BSU) CCG
Gwen Kennedy: Acting Director of Client Group Commissioning & Partnerships
Sarah Feasey : Legal Officer
Julie Timbrell: Scrutiny Project manager

1. APOLOGIES

1.1 An apology for absence was received from Councillor Norma Gibbes; Councillor Neil Coyle attended as a reserve.

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

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the open section of the meeting held on 9 July 2012 were agreed as an accurate record.

4.2 The update provided by Professor Moxham on Marina House will be circulated with the minutes.

5. MENTAL HEALTH OF OLDER ADULTS

5.1 The chair invited Cha Power, Deputy Director - Mental Health Older Adults and Dementia, and Zoë Reed - Executive Director of Strategy and Business Development, to present. The SLaM directors reported that the Equality Impact Assessment had been completed. The Home Treatment Team pilot is up and running and quarterly data will follow as agreed.

5.2 The Deputy Director reported that recent activity data shows that the service took 49 admissions last year and this year the service has made 43 admissions, which is a marginal decrease . He explained that there had been 120 referrals. The chair asked what happens to people who are not accepted and the Deputy Director explained that they are either admitted or sent to the community health team.

5.3 A member said that he understood that the service have more beds because of homelessness and deprivation. The Deputy Director explained that the service does accept people of no fixed abode, but the numbers are quite small. He went on to comment that the service would not really expect people without homes to be treated much differently by the mental health team, and the expectation is that service users would be housed in a hostel, if appropriate, or admitted to a ward , if needed .

5.4 The Deputy Director was then asked if someone in that situation, who was refused admission, would get support and he responded

that the service often get people with quite complex problems, for example: mental health, dementia and social problems. The service director was asked how about the numbers of people referred to the service who were homeless and he responded that it was less than ten every two years, however, he added, this could rise with cuts to welfare. He went to comment that the service is seeing a rise in acutely unwell people. The chair asked for supplementary information on homelessness and the rise in acutely unwell people.

5.5 The Deputy Director was asked if he thought that two or three treatments a day from the Home Treatment Team is accurate, and he confirmed that this is what the evidence is showing. He went on to comment that home treatment seems to be working and maintaining people in their home – and it is also helping with discharge. A member asked if the service is monitoring to see if service users need admitting, and he responded that we are monitoring. He explained that they had been asked to do this by the commissioners and the service is capturing data and stories.

5.6 A member asked if people can access talking therapies and he was assured that they can, if needed. He was then asked to elaborate on the concerns about safeguarding noted in the paper. He explained that a patient receiving home treatment would have a dedicated case worker who visits 3 or 4 a day. He was asked if they would spend time with the service user and the Deputy Director explained that sometimes a visit would just be providing reassurance that the patient is well, and this could be a short visit of around 30 minutes, however, longer visits also take place of about two hours . He was asked if services such as meals on wheels would be used and he confirmed that they would.

5.7 A member said that he was told about someone who was informed that to get a service he would need to go to his GP - but he was too ill and anyway did not see the need. He commented that if these barriers exist then someone with a mental health problem could end up in a crisis. He asked how we can get people support and a referral when the family is concerned. The Deputy Director explained that the service do have an open access referral policy form both families and professionals. He added that the service also takes referrals from Accident and Emergency and that they want to make the service accessible. He reported that many older people with mental health problems are known, however some people are resistant to receiving treatment. He explained that the service do have recourse to mental health legislation if they are a danger to self or others. He said there is a balance of risks because hospitals are sometimes not good places to be and there is a risk of institutionalisation.

5.8 A member commented that she understood that there is predicted

to be an increasing number of older people living in Lambeth and Southwark. She asked if the service needs more capacity, can the beds be brought back, and noted the cost pressures. The Deputy Director commented that the service is working closely with demographic experts in commissioning to predict need. He explained that the service also have capacity to flex resources to meet demand as it fluxes. He said that if the estimates show that the service needs to provide additional beds then these can be provided. A member asked how this could be done if the NHS budget is flat and the Deputy Director responded that the service have long stay beds, which have some under used capacity, so these might be looked at if there was an acute need .

5.9 A member commented that the report shows a lower number of users from both Southwark and Lambeth, compared with Croydon and Lewisham, and a lower number of Southwark BME groups than Lambeth and Lewisham. She asked for an explanation and the Deputy Director said he will look into this and report back.

5.10 The SLaM Directors were asked if the Home Treatment Team is about increasing productivity or reducing costs, and the Deputy Director responded that he has always had concerns about the ability of community services to provide services in the evening and over weekends. He explained that this new service provides this option. He explained that in-patient admission can be very traumatic for older people; the service has to work very hard to return older people home, so admission should be an absolute last resort, which is better avoided.

5.11 A member commented that the paper talks about cost saving quite a lot, and surely there is a trade off between cost and quality of services. The Deputy Director responded that this is not about getting rid of beds – it is about providing better care. He was then asked if he would be rationing in-patient care and he said that he would expect that there will be a reduction. He explained that the service will be looking at the evidence of the pilot cases to see if there is a need for adaptations. He added that the demographics show that there will be a growth in demand. There is a rising BME population which will mean an increase in vascular dementia.

5.12 A member asked if more home treatment means more medication and the Deputy Director responded that he would not expect that. He explained that the Home Treatment Team is a mixed team that is not particularly medical led and that the emphasis will be on recovery. He explained that a lot of the dementia drugs are not that effective anyway – and additionally those older people with dementia and challenging behaviours who are taking drugs that deal with these conditions need very close monitoring. He said that we do not always get the balance of risk right, but the service try and balance community treatment with hospital admission.

5.13 A member asked how many members of staff were involved in the Equality Impact Assessment. The Executive Director of Strategy and Business Development explained that she, the Deputy Director, and another member of staff worked on the document. The member said that the evidence and analysis on the 'Gender Reassignment' and 'Religion/ Belief' category was weak. The Executive Director responded that they aim to continuously improve and that they are seeking advice from the Lesbian, Gay, Bisexual & Transgender patient group and from other stakeholders and partners. A member commented that the committee want to see more evidence that that the Equality Impact Assessments are used as an active tool in order to improve services, and not just an irritant at the end, and furthermore there is a duty to comply with the law. He pointed out that there is a risk of being judicially reviewed and this happened to Birmingham Council.

RESOLVED

The Equality Impact Assessment will be developed.

An additional analysis of spare capacity will be provided.

Supplementary information will be provided on the service offered to homeless older people with mental health needs.

Additional information will be provided on the rise in acutely unwell people.

An explanation will be provided for the lower number of users from both Southwark and Lambeth, compared with Croydon and Lewisham, and why there is a lower proportion of Southwark BME service users compared with Lambeth and Lewisham.

Data and patient journey vignettes will be provided on medication levels used by the Home Treatment Team.

6. PSYCHOLOGICAL THERAPY SERVICES

6.1 The chair welcomed Steve Davidson, SLaM Service Director - Mood Anxiety and Personality Clinical Academic Group, and Zoë Reed, Executive Director of Strategy and Business Development, to provide an update on the Psychological Therapy Service.

6.2 The Service Director said since the large stakeholder event on 16

May they have been developing a framework that has focused on looking at the patient experience and monitoring activity. He explained that the service now has a single point of entry and referrals are considered by a group of senior therapists. He reported that the service now knows much more clearly what the demand is.

6.3 A member asked about honorariums and noted that the paper says that it is hard to provide data on their hours and modalities as this had not been fully monitored. The Service Director responded that we now have a clearer idea of the data, as their activity is now more closely supervised as a condition of the contracts with schools. He reported that formerly there was not enough oversight of this by management.

6.4 The Service Director reported that the honorariums who came to the consultation event gave feedback. He explained that the honorarium therapists would come onto training programmes, but the service can only supervise honorariums if there are sufficient senior enough therapists. He explained that SlaM could be quite selective as the hospital is quite prestigious, and the service would get as many honorarium as could be properly supervised and managed. He said this practice will continue.

6.5 A member asked for clarification on whether all the modalities would continue and the Service Director responded that some will be delivered across different therapeutics. A member asked about the specialist trauma team and the Service Director said that some trauma work will be picked up by the cognitive therapy team and more significant trauma integrated into the psychotherapeutic service. He said there is now a much smaller contribution to the national team. A member asked if there will be a reduction in the number of specialised therapists, and commented that he knew of two who have been redeployed and not working on trauma any longer. The Service Director said it would be hard to say if there would be a reduction but overall there will be less provision. The member voiced concerns about the needs of armed forces personnel and asylum seekers, remarking that both groups often suffer trauma.

6.6 The Service Director commented that the former trauma team was a national team, so the number of Southwark and Lambeth beneficiaries was small. He went on to say that the service is committed to providing a service for people with complex needs, and explained that because the team is co-located with a social work team they can now better support the social needs of service users, for example improving access to housing benefit. The member reiterated the importance of the armed forces receiving an excellent service. He pointed out that asylum seekers often need access to complementary services, such as language services.

6.7 A member questioned the inconsistencies in some of the documentation and asked for clarity on whether there is going to be a reduction in Psychodynamic Psychotherapy. The Service Director responded that a single point of service will help by bringing together a single pathway, and being clear about what is on offer, what the pathway is, and the length of time service users will wait to access and for how long they will receive treatment. He remarked that there is good evidence that some therapeutic interventions can help over a shorter amount of time. He assured the members that while the number of full time therapists has gone down the service has maintained the same level of honorariums. However, he added, demand is not the same as supply and the single point of service will allow the service to better map need. He ended by answering that this is a completely new service so it is hard to answer.

6.8 A member commented that it sounds like the health service do not know the level of demand but has reduced the supply. The Service Director elaborated that formerly SLaM had separate services working in different ways, however, he said that he did not think it was entirely helpful to say we want to maintain the same level of service. A member asked if residents in Southwark are getting a poorer service and the Service Director responded that much of the Southwark service is now delivered through the IPPT service, which scores the best in the country. He explained that many people will now be offered and receive this service.

6.9 A member asked if SLaM have done any modelling on the effect of universal credits , and that housing benefits being paid to a named person in the house monthly, rather than the landlord, could exacerbate family conflict. He noted that pilot areas have demonstrated rising homelessness. SLaM directors responded that they are working with the council on reviewing the likely effects of the welfare cuts and introduction of the universal credit.

6.10 A member asked about the number of referrals received and made for domestic abuse service and SLaM directors said that they would provide additional information.

6.11 The chair then invited Gwen Kennedy, Director of Client Group Commissioning, to comment. She explained that commissioners are scrutinising the data coming through and that they have prioritised people being seen as quickly as possible and being offered a service at the right time. She reported that the commissioners will be monitoring the new service, and in particular the delivery of psychodynamic therapy and trauma services.

6.12 A member asked how the Director will ensure that consultation and engagement with staff and community takes place. She responded

that commissioners will be ensuring that the Equality Impact Assessment is completed right at the beginning and that there will be consultation and engagement early on, and that user representation is around the table.

6.13 A member asked how the commissioners will ensure that the users are the right people and not just selected. The Director explained that they have been holding thematic events that people have shown an interest in participating in. A member commented that he would like to hear not just about consultation, but involvement. Furthermore the committee would like to see evidence on how involvement has led to service change. He said that the distribution of power in the hands of doctors can be very concentrated and that patient involvement can provide a more balanced view point.

6.14 The Director reported that GP practices have patient groups and that there is a sub group of the Clinical Commissioning Group board. A member commented that patient groups participants are often retired people. She explained that commissioners are focused on ensuring that the right people are engaged around an issue, for example Dulwich Hospital and health services. She went on to remark that there are wonderful doctors in Southwark and model practices .The Director explained that they are working on developing engaging communities and learning from the local authority .She reported that commissioners have employed an outside agency to assist with engagement work.

6.15 A member asked the Director whether Southwark has the right balance of different psychological and psychotherapeutic service modalities, and if she was concerned that Lambeth's provision of psychotherapeutic services is higher. She responded that there is an inheritance and Southwark developed practiced IPPT in a good way. She went on to report that the CCG will be looking at the data at the beginning of the new financial year in order to consider the most sensible decisions to be made. She added that the CCG are investing in data in order to make more informed decisions.

6.16 A member asked about levels of referrals to SOLACE by doctors and noted that this looked low in recent data presented to the Overview and Scrutiny Committee, and that this might indicate a training need.

RESOLVED

More data will be obtained on GP referrals to SOLACE.

More information will be provided on the impact of the universal credit on mental health service.

7. UPDATE FROM SOUTHWARK CLINICAL COMMISSIONING GROUP (CCG)

7.1 The chair invited the officers from the CCG to update the committee. Gwen Kennedy, Director of Client Group Commissioning, explained that the constitution has been signed off by the CCG board. Officers explained that this includes the process for appointing members of the board: eight GP clinical leads have been appointed through an election/selection process and three lay people appointed. Officers reported that the senior managers and financial officer have also been appointed.

7.2 A member asked if the health representative from the council had been appointed and CCG officers responded that this will probably be taken up by Sarah McClinton, but this has not been confirmed. Members asked who they think should take up this post and the response was that this should be someone who can take commissioning decisions.

7.3 Members asked officers to explain the QUIPP programme and in particular why reserves are being used for over performance. Officers explained that activity levels have been higher than predicted in Acute Trusts.

7.4 A member asked how savings can be made and an officer explained that there are savings to be made on cheaper drugs, by using generic rather than branded products. It was explained that the CCG can see prescribing patterns, however how GPs manage these are part of their internal management arrangements. The CCG is not responsible for practices as this is the responsibility of national commissioning.

7.5 A member asked which GPs had to declare their interests and if this would only apply to the board members. The officers explained that this applies to all members, and that the GP Practices who signed the constitution are the members. Officers explained that this is fairly unique.

7.6 A member commented that the constitution does not set out the geographic requirements for board representation from GP practices. The officers commented that two are sought from each quadrant. The member said that this was not stipulated in the constitution. The officer explained that agreeing the constitution *is a complex process* as it is agreed by the secretary of state; however an addendum might be possible and agreed to look into this.

RESOLVED

The CCG will see whether is possible to add a stipulation to the constitution that GPs representation on the board is sought from each quadrant.

8. PUBLIC HEALTH REVIEW

8.8 The chair reported that a successful bid had been made to the Centre of Public Scrutiny for a review into public health and health inequalities – working with Gypsies and Travellers. He reported that this means expert support will be available, and the committee can learn from this and use this knowledge to inform other reviews, such as the Dementia review.

8.9 A member gave her congratulations for making a successful bid and commented that public health is an important area for the council now that responsibility is moving to the council.

8.10 A member commented that the committee also need to consider the wider public health needs and suggested that a report be requested looking at the three most significant health inequalities in Southwark.

RESOLVED

The committee will focus on the health inequalities of Gypsies and Travellers until December and then a report will be requested that identifies the three biggest health inequalities in Southwark.

9. DEMENTIA REVIEW

9.1 Members of the committee discussed who the review should take evidence from. It was noted that SLaM would like to give evidence. A member recommended the Making Decisions Alliance, and commented that they consider issues of whom is in control. It was suggested that Cambridge House is also approached.

RESOLVED

Evidence will be sought from SLaM, Making Decisions Alliance and

Cambridge House.

10. KING'S HEALTH PARTNERS REVIEW

10.1 The chair noted the Strategic Outline Case circulated. A member commented that the FAQ was weak. The chair recommended that the review focus on the possible risks of a merger, and commented that organisations can face optimism bias when considering mergers and big organisational changes.

10.2 A member recommended taking evidence from as wide a group of stakeholders as possible. The chair suggested working with Lambeth scrutiny committee and aiming to complete this review by January.

RESOLVED

Stakeholders will be sent a letter seeking their views on the proposed merger.

11. SOUTH LONDON HEALTHCARE NHS TRUST

11.1 The chair reported that the recommendations made by the Trust Special Administrator (TSA) will affect the whole of south east London health care system. There are three major problems: two large PFI's with badly drawn up contracts, structural problems with the provision of health care in south east London and inefficiencies at the Trust hospitals. A member commented that privatisation of parts of the system, or a hospital, are possible recommendations. The chair reported that south east London scrutiny chairs are concerned with the lack of engagement with scrutiny by the TSA.

RESOLVED

The Trust Special Administrator will be invited to the next committee meeting.

12. WORK PLAN

12.1 It was noted that the Cabinet member interview will take place in January .