Open Agenda

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Tuesday 18 September 2012
7.00 pm
Ground Floor Meeting Room G02B - 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 Sunil Chopra
Councillor Neil Coyle
Councillor Rowenna Davis
Councillor Paul Kyriacou
Councillor Jonathan Mitchell

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

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Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 10 September 2012

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Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Tuesday 18 September 2012
7.00 pm
Ground Floor Meeting Room G02B - 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.	
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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: 10 September 2012

Agenda Item 5

South London and Maudsley NHS
NHS Foundation Trust

MHOA &D (CAG)

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13th July 2012

Councillor Mark Williams
c/o Members Room
160 Tooley Street
London
SE1 2QH

Dear Councillor Williams

Re: Home Treatment Team and Overview and Scrutiny Committee July 9th 2012

I have forwarded a copy of Equality Impact Assessment document and Risk Register document relating to Home Treatment as discussed in the meeting.

There was a number of questions from the floor by LINKs relating to the social care input to patients under home treatment. The intention is that the Home Treatment team will have some staff that are from a social care or occupational therapy background so that will be able to provide individual bespoke care to service users and their families.

While the team is working with service users there will be no extra burden placed on Social Services. As part of the monitoring process social services have been invited to our reference group and will be asked to give us feedback.

The statistics relation to the numbers seen by HTT , the number home visits, Hospital admissions, hospital admissions and emergency week-end admissions will be provided on a quarterly basis. We will ask our reference group if they can provide a service user representative when we are next requested to attend.

Yours sincerely

Cha Power
Deputy Director, MHOA&D CAG

South London and Maudsley NHS
NHS Foundation Trust

Equality Impact Assessment Guidance

What is an Equality Impact Assessment?
An equality impact assessment (EIA) is a systematic way of analysing a policy, function or proposed service change / development to check its potential or actual impact on equality of treatment or outcomes. The EIA process is in two parts; an initial screening and a full assessment. The screening should start as soon as planning is under way, as this will inform and strengthen your planning.

Why carry out Equality Impact Assessments?
EIAs are a method for individuals and teams to use to think about the likely impact of their work and to make sure that, as far as possible, any negative outcomes for disadvantaged groups are eliminated or minimised and that opportunities for promoting equality are maximised. It is a process that will help to identify groups who may be receiving differential treatment or outcomes that are discriminatory or unfair.

The Equality Act 2010 requires public authorities such as SLaM to have due regard [which means an adequate evidence base for decision making] to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

These three aims apply to the following 'protected characteristics:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion / belief
- Sex
- Sexual orientation
- Marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]

SLaM is legally required to conduct analysis of the effects on equality of new or revised policies or service changes/developments. To conduct this analysis policy reviewers/authors and leads for service change/developments should conduct an Equality Impact Assessments to show this has been taken into consideration in all decisions, policies and practices. 'Policies and practices' covers all proposed and current activities which the authority carries out.

An initial screening is carried out to decide if any part of the policy or service change/development is likely to have an impact on equality for any group or groups; that is to identify where differential treatment or outcomes that are discriminatory or unfair may exist. Where it is likely that the proposed policy or service change/development may have a

negative impact it is important to remove or minimise as far as possible any disadvantages suffered by people due to their protected characteristics and to take steps to meet the needs of people from protected groups (often referred to as protected characteristics) where these are different to the needs of other people.

Where required to implement a decision over which the Trust has no control an equality impact assessment should still be conducted, and where there is a likely impact to consider mitigating measures or alternative ways of doing things to minimise the impact and to meet our legal requirements as outlined in the public sector duty.

What equality groups need to be considered?
The EIA process should cover the following areas:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion / belief
- Sex
- Sexual orientation
- Marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]

THE PROCESS:
When should an EIA be carried out?
The process of conducting an equality impact assessment should not be an after-thought, but part of the 'day to day' work, and the initial screening used as early as possible in:

- the development of new policies and procedures
- the review of current policies
- the development of a business case
- the planning stage of all new services changes/developments/projects

The full EIA assessment should be conducted for:

- All policies, functions and service developments where an adverse or negative impact on equality group(s) has been identified during the initial screening process.

Who should conduct the EIA?
It is important that the process is conducted by those working and planning the policy, function or service change/development. They will have expertise in that particular area as well as a thorough understanding of the main aim, objectives and intended outcomes.

Part 1 – the initial screening

The initial screening prompts, through a series of questions, an assessment of negative impact or gaps in knowledge about likely impact. It should be a relatively short process which uses a range of information, such as:

- personal knowledge and experience
- relevant research and reports
- previous consultation results
- analysis of complaints, comments, surveys or audits
- demographic data and other statistics including census results
- Trust equality monitoring data
- specialist advice (internal and external)

The information collected during the initial screening should be analysed to decide whether the policy, function or service change/development could potentially affect different groups of people/protected characteristics, and whether any of these differences are likely to result in a negative impact. As well as a negative impact, the screening process may highlight a neutral impact, a positive impact or a differential impact (where the impact on one or more protected characteristic may be greater than for another).

Neutral impact
There may well be some policies that are assessed as having no specific impact or relevance to equalities. This will become evident during the initial screening process and, where there is a neutral impact, the full assessment is not required although it is important to always set out the evidence for this decision.

Positive impact
The assessment may show a positive impact for one or more protected characteristics, or an improvement in relationships between people who share protected characteristics. This impact may be differential, where the impact on one group is greater than for another group.

Negative impact
A negative impact is where the way the policy, function or service change/development is implemented or provided may, often unintentionally, result in inequalities or discrimination being experienced. This disadvantage may also be *differential*, where the negative impact on one protected characteristic is likely to be greater than for another.

The process and findings of a screening need to be recorded, even when it highlights that a positive or neutral impact is likely.

Part 2 – the full impact assessment

If the initial screening shows that a negative impact seems likely a full assessment should be conducted to establish the extent of the impact and to make recommendations aimed at minimising any negative differential in outcomes.

As with the screening stage it is important to be clear of the aims, objectives and specific outcomes you hope to achieve from the proposed policy, function or service development.

Using the evidence
Which of the protected characteristics is likely to be affected? Consider the evidence, what does the data show? Is quantitative and qualitative information available in-house and externally from relevant community groups or networks? Is there strong evidence, some evidence with considerable gaps or is it anecdotal? Does the information need to be supplemented through new consultation exercises to fill the gaps?

Consultation and involvement
Internal and external consultation is an important and on-going part of the process. Identify and consult people from relevant groups who are likely to be affected, tailoring the methods used to best reach the various groups, e.g. using existing networks, consultation meetings, focus groups, reference groups and survey questionnaires. Local SLaM diversity groups will also be a helpful resource (CAG Equality Leads[1] will be able to provide details on these groups and also on local service user networks). Externally, identify relevant stakeholders who are interested in promoting equality from individuals to community groups.

[1] Each clinical academic group has at least one Service Equality Lead. If you are not sure who this person is, contact kay.harwood@slam.nhs.uk or phone 020 3228 2157 for guidance.

Remember to circulate results of any consultation and feed them back into your planning and decision making processes.

Assessing the evidence
This involves making a reasonable judgment on the evidence you have drawn together as to whether there is likely to be a negative impact on some protected characteristics. It may be that the evidence indicates both positive and negative impact is likely for some, and if this is the case you will need to balance these when making a decision about the likely overall effect of implementing the policy, function or service development.

The following questions may be useful when assessing the likely impact:

- Do you need to make changes in response to concerns raised by interested groups and relevant stakeholders, or issues raised during any consultation that has been conducted for the assessment process?

- Is there is potential for the policy, function or service change/development to be directly or indirectly discriminatory? If there is, you should find another way to meet the aims. If it is indirectly discriminatory and there is no alternative way can you justify the decision to proceed as it is?

- If the policy, function or service change/development is not directly or indirectly discriminatory is there still potential for some groups to experience a negative impact on equality of opportunity or good community relations? If a negative impact is likely can it be justified because of the overall objectives of the policy, function or service change/development, or can it be adapted so that it compensates for any adverse effects?

- Could other measures be taken to reduce or remove the negative impact without affecting the overall aim of the policy, function or service change/development?

- Will any changes to the policy, function or service development be significant and will you need to consult about them?

What should be published?
Results of all EIAs should be published. Even if the screening process shows that there is no negative impact, this should be published so that groups and individuals can see how this conclusion was reached and enable them to respond if they feel it is inaccurate. This is another reason why it is important to support your decisions with appropriate evidence. In order that is clear why a particular service development or policy has been assessed as having a neutral; positive or negative impact. Decisions on any changes made as a result of the assessment should also be noted.

Remember to feed back results to everyone who has contributed to the assessment and ensure that the information is available to all interested parties.

Where the full assessment is very detailed a summary of the assessment may be published, however, the complete documentation should be made available to anyone who requests it. Your CAG Equality Lead or Kay Harwood will provide advice on this, and they will also arrange for the assessments to be placed on the Trust website.

External verification

Once completed, EIA's relating to service developments may require external verification. Your CAG Equality Lead in consultation with the CAG Service Director/CAG Executive will advise if the process you have used is sufficient, or if external scrutiny of the assessment should take place, via a relevant group or groups, such as a local Partnership Board or Overview and Scrutiny Committee. If external scrutiny is required the CAG Service Director/Equality Lead will make the necessary arrangements.

Further advice

If you have any questions when working through the assessment contact your CAG Equality Lead or Kay Harwood by emailing: kay.harwood@slam.nhs.uk or phone: 020 3228 2157

South London and Maudsley NHS
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT
PART 1 – INITIAL SCREENING

SLaM wants to ensure that we provide accessible and equitable services that meet the needs of our diverse community and to meet the first principle of the NHS constitution – to provide comprehensive services available to all, paying particular attention to marginalised groups who are not keeping pace with the rest of society.

Under the Equality Act 2010 we are all protected from less favourable treatment or discrimination based on age; disability; pregnancy and maternity; gender reassignment; race; religion / belief; sex; sexual orientation; marriage and civil partnership [but only in regards to the first aim – eliminating discrimination and harassment]. As an organisation we are legally obliged to consciously think about equality as part of the decision making process in the design, delivery and evaluation of our services and policy development/review. This is why we ask you to begin / conduct the EIA at the planning stage and in a group, using the screening tool as a prompt to the necessary conversations about the impact of your work on equality. (See guidance for further information)

1. Name of the policy / function / service development being assessed?

Establishment of a Home Treatment Team as part of the Mental Health for Older Adults and Dementia (MHOAD.

2. Name of **Lead** person responsible for carrying out the assessment? (where there is a service change, this should be the individual with responsibility for implementing the change)
[The EIA should, wherever possible, be completed and considered in a group]

Lead: David Norman/Cha Power

Others involved:
e.g. staff, service users / service user consultants / carers / carers consultants:

This EIA draws on the views of staff, service users, carers and those who work with older people in Lambeth and Southwark.3. Describe the main aim, objective and intended outcomes of the service change?

Aim
SLAM is seeking to *redesign* services in order to avoid unnecessary admissions to hospital based services. The primary motivation in doing so is the need to provide more appropriate, effective, efficient and patient centred 'crisis' care.
There is significant evidence (see elsewhere in this assessment) to suggest that
1) the majority of patients would prefer to be supported and 'treated' in their own home;
2) prolonged periods spent in hospital can have a detrimental impact on an individual's ability to recover from a 'crisis'.

Objective –
These proposals will enable the MHOAD to better meet the needs of those who experience 'crisis' incidents, provide quicker, more effective interventions within the home. It is important to underline that reference to 'home' include all relevant types of residence, including an individual's house or flat, or sheltered accommodation.

The basic proposal is for MHOAD develop a new Home Treatment Team (HTT) to provide early interventions for people experiencing or at risk of 'crisis' in their own homes. As a result of reduced admissions over time there may be a reduction in bed numbers.

The Lambeth and Southwark Older Adults Home Treatment Team will provide comprehensive and accessible crisis resolution and home-based care and treatment to people in the acute phase of mental illness which, in the absence of the team, would result in admission to hospital. It will be a multidisciplinary service offering crisis assessment , home treatment and onward referral for the residents of Lambeth and Southwark

The team will:

- Gatekeep all Lambeth and Southwark admissions to the MHOA&D CAG inpatient beds.
- Oversee the allocation of the MHOA&D CAG inpatient beds.
- Offer an assessment service for residents of Lambeth and Southwark who, immediately prior to the team's involvement; have been assessed as requiring admission to hospital.
- Provide intensive home-based treatment to patients in the acute phase of mental illness, thus diminishing the need for hospital admission.
- Facilitate early discharge from hospital
- Secure appropriate follow-up care for the patient once the alleviation of the acute phase of mental illness has occurred.
- Be fully integrated into the Lambeth and Southwark mental health systems and the community as a whole.

Principles of the Service

The team will:

- Provide a safe and effective home based alternative to hospital admission for residents of the area defined as Lambeth and Southwark.
- Provide rapid assessment and intensive planned care 7 days a week.
- Oversee the allocation of inpatient beds for the MHOA&D CAG. All patients living in Lambeth and Southwark who are deemed to require more intensive input will be assessed by the HTT prior to any allocation of an inpatient bed. All patients living in Lewisham and Croydon will not be assessed by the HTT.
- Act as gatekeeper to all Lambeth and Southwark MHOA & D beds by ensuring that each patient referred for inpatient care receives a

comprehensive assessment before a final decision is reached as to eventual treatment location.

- Facilitate early discharge for inpatients and providing high intensity support in the community.

- Work co-operatively and collaboratively with patients, their families and carers, primarily in their place of residence, and encourage them to take an active part in the decision-making process regarding the care they receive.

- Recognise the pivotal role of family and carers and aim to provide them with or signpost them to the relevant support.

- Acknowledge the importance of a patient's current and potential support system which can include the community as a whole as well as voluntary and statutory agencies. The team will engage and work within the patient's support system when conducting assessments, providing ongoing care and when planning a patient's discharge and aftercare from the service.

- Recognise that Lambeth and Southwark have a richly diverse population. The Team's aim will be to provide care that is constantly sensitive and appropriate to the patients' circumstances, gender, ethnicity, language and culture. Patients will be assisted in accessing specific services relevant to themselves and their individual needs.

- Remain relevant to both patients of the service and the Lambeth and Southwark mental health system for older adults as a whole. For this reason, the team will encourage ongoing dialogue and feedback with individuals and organisations which will assist in shaping the team's operation and activity.

4 (a). What evidence do you have and how has this been collected? *[Please list the main sources of data, research and other sources of evidence reviewed to determine the impact on the equality groups, sometimes referred to as protected characteristics. Your data can include demographic data, access data, national research, surveys, reports; focus groups; information from your service?]*

Evidence suggests that SLAM currently provides a greater number of hospital beds per head of the local population(s) as compared with the national average and has higher admission rates than other similar urban areas, including other London boroughs (see main assessment). There is also emerging internal evidence which suggests that patients experience longer stays on existing SLAM wards that those in other similar units. The proposed service development of Home Treatment Team as part of the wider Mental Health of Older Adults and Dementia Clinical Academic Group, (MHOAD) is an attempt to redress a historical over reliance upon in-hospital services. This will achieved by developing and delivering improved home based interventions, including during periods outside current service hours.

We have used data relating to local population, service use and service evaluations from both the Trust and other MH units. This data covers a number of the equality protected

grounds, however there are gaps in terms of current data collection (for example in relation to disability) and these are addressed in the action plan which accompanies this EIA.

4 (b). Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups?

YES

Which equality groups may be disadvantaged / experience negative impact? *[please base your answers on available evidence which can include for example key themes from the general feedback you receive via patient experience data (such as patient surveys; PEDIC); carer experience; complaints; PALS; comments; audits; specialist information - your personal knowledge and experience]*

Age	YES
Disability	YES
Gender reassignment	YES
Pregnancy and maternity	NO
Race	YES
Religion / Belief	NO
Sex (?)	YES
Sexual orientation	YES
Marriage and civil partnership	YES

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)
Group NO

5. Have you explained your policy / function / service development to people who might be affected by it? *(Please let us know who you have spoken to and the results of these conversations and what actions/ developments/ changes have come out of them)*

Yes

If 'yes' please give details of who you involved and what happened as a result.

- Staff consultation - Staff consultations were held in February 2012. Staff were given the opportunity to be seconded into the Home Treatment Team for the duration of the pilot.
- User consultation – The "Being Involved" Group – which is effectively our current Service user and Carer Advisory Group in MHOAD CAG, received three presentations on the proposals to develop the Home Treatment Service – they gave constructive and useful

feedback which shaped the development of the service. This group is made up of service users, carers and ex-carers. Many ex-carers expressed the view that they would have welcomed the existence of a HTT when they were caring for their loved ones.
The start of the pilot in June 2012 will see managers increasingly consulting with local agencies, discussing ways in which the service can be delivered and improved. A Service user and carer participation group has been established which will also guide the development of the pilot in the coming months.

- Carers consultation - Carers groups supported by the Alzheimers Society were consulted on the development of the Home Treatment Service. The proposal received a positive response. The CAG has Advisory Groups in each of the four boroughs it serves. Notification of the development of the Home Treatment Team was brought to both Southwark and Lambeth meetings. Both have asked to be kept informed. Feedback from these meetings informed the development of the pilot.

6. If the policy / function / service development positively promotes equality please explain how?
The proposals will lead to the provision of enhanced 'out of hours' services, which will effectively ensure that older people can access the same levels of service currently available to working age adults.
Community Mental Health Teams currently operate Monday to Friday (office hours). The new service would represent a significant extension of provision, with the Home Treatment Team (HTT) operating seven day a week, 365 days a year between the hours of 9am and 8pm. This means that the proportion of the week during which the HTT can provide 'crisis' care will be significantly increased. The following EIA includes proposed measures to enable MHOAD to cover the remaining periods (outside HTT's operating hours).

Disability – Our service users include people with dementia, learning disability, physical disability/health issues. Our service will support them by treating them in their own home, thus preventing hospital admission, unless the crisis cannot be treated at home. The emphasis in the work of the HTT will be to keep people in their lives, and in their communities as far as possible.
Age – this change brings services for older people into line with those for people in other age ranges.
Ethnicity – opportunity to ensure services are culturally appropriate and responsive to the needs of services users from different ethnic groups. The HTT will liaise with local BME groups to ensure they know about their service and can receive referrals – links will also be established with the BME volunteer programme in SLAM to seek support from BME volunteers to support people – such as accompanying people to lunch clubs, or church.

7. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

Positive:	High (highly likely to promote equality of opportunity and good relations)	Medium (moderately likely to promote equality of opportunity and good relations)	Low (unlikely to promote equality of opportunity and good relations)
Negative:	High (highly likely to have a	Medium (moderately likely to have a	Low (probably will not

	negative impact)	negative impact)	have a negative impact)

Neutral: High (highly likely)

Reason for your decision: The nature of the services which are provided means that this development is clearly relevant to the equality duty. It is important therefore to ensure that the service development does not lead to any unintended consequences for particular groups and communities and that these service changes are properly assessed so that we can identify any potential problems at the earliest possible stage and put in place measures to remove any potential discriminatory or inequality of access and outcome.

Date completed: ……..

Signed ……. Print name ……..

If the screening process has shown potential for a high negative impact you will need to carry out a full equality impact assessment

Given that there is the potential for this policy to affect different groups differentially, it has been decided that the policy would benefit from a full equality impact assessment. This will enable us to identify gaps in current approach/systems and identify additional support for particular groups and communities. This will ultimately strengthen the policy overall.

South London and Maudsley NHS
NHS Foundation Trust

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

1. Name of the policy / function / service development?

Establishment of a Home Treatment Team as part of the Mental Health Older Adults and Dementia (MHOAD).

2. From the initial screening process, which groups may experience negative impact?

Age	YES
Disability	YES
Gender reassignment	YES
Pregnancy and maternity	NO
Race	YES
Religion / Belief	NO
Sex	NO
Sexual orientation	YES
Marriage and Civil partnership	YES

Others [that your service / policy is specifically aimed at (e.g. refugees, behavioural difficulties)

Group:…… NO

It is important to underscore that as we are dealing with mental health services (which clearly fall within the definition of disability for the purposes of the Equality Act 2010, thus all significant changes to these services are deemed relevant to the duty.

Introduction
This proposal is in line with significant policy and academic thinking regarding the most effective interventions for older people with mental health issues.

This now substantial literature underscores the importance of
1) early, community and home based interventions which avoid unnecessary admissions,
2) early, appropriate and non-delayed discharge.

The literature is explored in greater detail below. This literature includes JRF, 2011, Older People and High Support http://www.jrf.org.uk/sites/files/jrf/older-people-and-high-support-needs-full.pdf), McGlynn, P (ed) (2006) **Crisis Resolution and Home Treatment: A practical guide, The Sainsbury Centre for Mental Health 2006** http://www.centreformentalhealth.org.uk/pdfs/Crisis_resolution_and_home_treatment_guide.pdf and http://www.centreformentalhealth.org.uk/pdfs/crisis_resolution_mh_topics.pdf and Pinner, G et al (2011), In-patient care for older people within mental health services, Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists. The latter notes that:

'Significant numbers of mental health beds have been reportedly occupied by people whose discharge has been delayed: 13.3% of functional mental illness beds and 28.6% of organic assessment beds in a national survey by the Faculty of Psychiatry of Old Age (Barker & Bullock, 2005). More recent findings by the Mental Welfare Commission for Scotland (2010) show very similar results, reporting that on average 2.5 patients on dementia assessment wards and 0.75 patients on functional assessment wards are there because of delayed discharges at any one time, the main delay being patients waiting to move into a care home.'

It concludes:

'Community services must be developed to allow proper alternatives to in-patient care to avoid unnecessary admission. Services such as crisis intervention and home treatment are all too often exclusive to adult mental health services, but arrangements should be made within trusts to provide equally relevant services for older people. This is an area which is clearly age discriminating and contravenes the Age Discrimination Act that will be enforceable by 2012.'

The proposed service change will enhance access and therefore improve service provision for groups across the broad equality agenda. Key improvements will include:

(i) Extending service provision
(ii) Equalising services for all age groups
(iii) Greater opportunities to develop and deliver integrated care packages.
(iv) More bespoke support for individual service users, their families and carers.
(v) Reducing disruption for individuals, their families and carers.

Current provision
MHOAD currently provides 81 acute beds across the trust. This is significantly higher than for other comparable parts of London. The pilot will demonstrate if there is a possibility of reducing bed numbers in order to reconfigure services to be more bespoke and cost effective.

Bed numbers in Neighbouring Trusts

June 7th 2012

TRUST	BED NUMBERS	AGE GROUP	HOME SERVICE	FUNCTIONAL/ORGANIC SPLIT
Oxleas	73	65	No	Yes
South West and St Georges	41	75	Yes	No
CNWL	31	65	Yes	No
East London and City	70	65	No but specialist Dementia Teams	Yes
West London NHS Trust	48	65	No	No

3) What evidence do you have? Please give details.

a) Strong evidence

There is a strong national and local evidence base for the proposed changes. This draws on local service level data, service reviews and audit, DH/NICE guidance and advice and independent research by think tanks and academics. This has been supplemented with findings from recent consultation exercises with MHOAD patients, carers and staff (2010 and 2011/2012

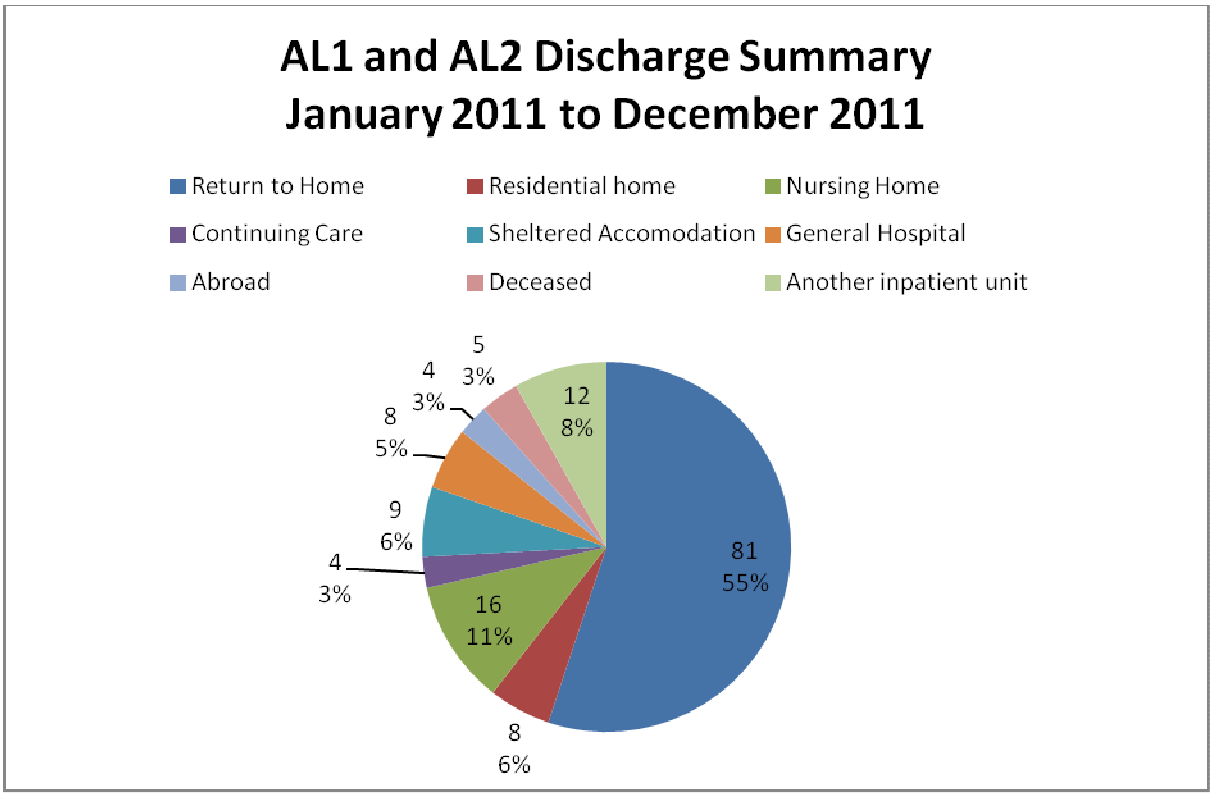
In addition, the Home Treatment pilot will be evaluated through a Programme Board consisting of representatives from NHS and Social Services commissioners, Social Services managers, clinicians from the MHOA service, and representatives from Kings and St Thomas's hospitals and the voluntary sector.
There will be a separate service user and carers reference group which will provide input into the development of the pilot and any subsequent recommendations. The draft terms of reference for these groups are attached. This group will support further engagement exercises between August 2012 – March 2013.

Action: A draft version of this EIA and/or a summary version will be circulated to both stakeholder groups.

MHOAD in-Patient activity
(i) Historic and current over provision of in-hospital services within SLAM
There is evidence to suggest that SLAM has historically retained and used a greater number of beds (per head of the population) than other comparable (location, social mix and population size) areas/boroughs. Internal records show the following:

	MAY 2011	JUN 2011	JUL 2011	AUG 2011	SEP 2011	OCT 2011	NOV 2011	DEC 2011	JAN 2012	FEB 2012	MAR 2012	APR 2012
AL1	33	28	24	40	49	34	51	47	45	39	46	0
AL2	45	46	33	60	27	65	39	23	35	35	34	28
Chelsham	66	40	51	35	33	49	32	45	42	29	32	20
Hayworth	45	43	27	59	46	21	43	45	44	34	73	62

(ii) A substantial proportion of those leaving AL1 and AL2 'go home'
Table two shows that 81% of those discharged (or leaving AL1 & AL2) during 2011 returned 'home' (using the broad definition outlined above of home being a person's residence). Just 8% went directly to another inpatient mental health service, with a further 5% entering into general hospital care.



This data underlines the importance of continuity of care and importance of the 'home' environment in the provision of on-going long-term care. It also prompts the question of whether it would be more appropriate to try and keep people in their own homes and provide on-going interventions in these and other community based settings.

Academic and policy evidence to support a move towards home based care
There is now a considerable body of evidence to support a shift away from traditional hospital based care for older people with mental health diagnosis. This literature which dates back to 2001 and beyond, argues that more effective outcomes can be achieved by a combination of early, home based interventions and a focus on

ensuring timely, non-delayed discharge from hospital settings (in appropriate cases). This literature includes academic, think tank and service provider evidence.

Commission for Social Care Inspection (2006) stated that service users who have made the transition to older people's service noted the inequality of provision

Kings Fund and Centre for Mental Health (2010) : to meet current financial challenges strengthen home treatment and crisis especially in older adults where provision is "patchy"

"Mental Health and the Productivity Challenge: Improving quality and value for money" (Naylor, C. & Bell, A (2010), Mental health and the productivity challenge Improving quality and value for money, Kings Fund, London http://www.kingsfund.org.uk/publications/mental_health_and.html) which says that improving value for money can often be achieved by also improving the quality of services.

The report's three key messages about the way that older people's mental health services can contribute to improving productivity are that:

- *Delivering services to care homes can reduce the use of primary and secondary health services, and can also reduce unnecessary prescribing of antipsychotic drugs, which are currently estimated to be overprescribed to the value of £14 million per year*
- *Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates*

Perhaps most importantly in the context of this assessment, the Kings Fund report quotes Anderson et al (2009) which suggests that:

Provision of specialist older people's CRHT services can reduce hospital admission rates by up to 31 per cent, as well as reducing length of stay and admission to care homes (Anderson et al 2009).

This forms a major part of the rationale for the current service proposal. It is not simply that more effective home based interventions can reduce hospital stays and readmissions, but rather it can wholly avoid unnecessary admissions in the first place by facilitating earlier interventions, which prevent individuals entering full blown crisis.

The most exhaustive analysis of the evidence base for home based interventions has been provided by Dr Sara Turner (2011). The following section provides an overview of this analysis.

The notion of introducing models of crisis intervention which is built around home treatment teams is not a new one. The NHS National Service Framework for Mental Health (published in 1999) proposed that such arrangements should be at the heart of future mental health provision.

However, take up and implementation during the intervening period has been somewhat patchy, although by 2005, 243 CRHTTs had been established (Turner, S, Reviewing models of crisis and home treatment teams to aid planning a better community service). In relation to provision for older people the picture was much starker – just 9% of areas had introduced specialist services for older people, and in many of these the services were available for shorter periods than comparable services for the wider population (Turner & Healthcare Commission). An earlier Healthcare Commission review of older people's services found that:

The out-of-hours services for psychiatric advice and crisis management for older people were much less developed, and older people who had made the transition between these services when they reached age 65 said there were noticeable differences such as poorer quality, fewer services and less support. (Healthcare Commission)

Action: It is clearly important that the service provision offered by HTT matches that of comparable services for other age groups, in order to ensure equality of service and provision under the Equality Act 2010.

Hospital stays can have a longer term detrimental impact on an individual's longer term health prospects. As Turner underlines:

The main reasons that people with functional problems are admitted to hospital are because of risk of suicide or self-harm (may be psychotic or non-psychotic) or because of an acute psychotic episode. The unintended consequence of admission to hospital is that there is a loss of independence and there can be difficulties for both the person and the support system in re-establishing the previous level of acceptable/adaptive functioning. The loss of confidence from an admission can often make it difficult to achieve discharge without substantial packages of support. The philosophy behind crisis and home treatment teams has been to put short term intensive treatment and support into the community setting to maintain all of the links that the person has. When admission is unavoidable, such a team can also provide intensive input to promote earlier discharge and rebuild confidence.

As Turner shows a number of localities have already adopted the home based care model and there are further examples which underline the growing importance of this approach for the care of older people with mental health diagnoses. The proposed approach has already been explored and adopted in other London boroughs. Islington is pursuing this approach having identified that ineffective community based interventions have historically led to an over reliance on hospital based services. It noted:

'weaknesses in community based services can lead to avoidable admissions to acute hospital care, while over reliance on residential care diverts money away from community services, reducing their capacity.' (Islington, Joint Commissioning Strategy - http://www.ncl.nhs.uk/media/43939/120511-joint-commissioning-strategy.pdf)

The current proposal will allow SLAM to redress this imbalance.

A further example is provided by West Sussex NHS which recently commissioned a review of its acute bed provision for older people which recommended a move toward home based care (NHS West Sussex, (http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media//publications/consultations/improving-mental-health-services/Sussex_Older_Peoples_Mental_Health_Services_Review_of_Acute_Bed_Provision.pdf)

The proposals for the establishment of a HTT is clearly in line with the wider national agenda of a move away from traditional hospital based treatment to more responsive, individualised and effective home based care services.

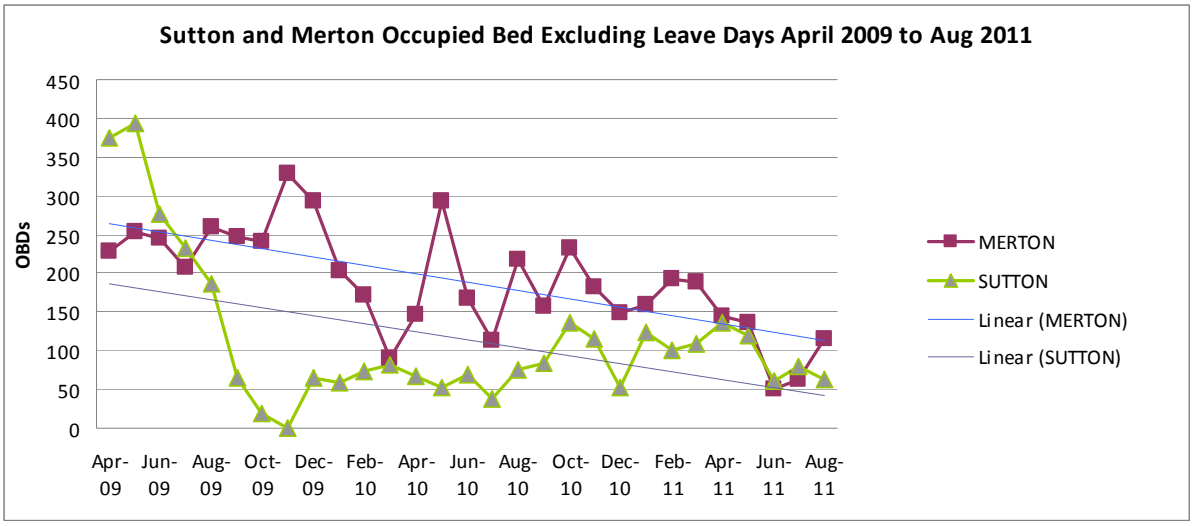
Evidence of more effective interventions

Turner's review of a range of older people's HTTs found that their development led to improved outcomes for service users and a reduced reliance on in-hospital services. A review of a HTT in Sheffield found *'no re-admissions within 28 days and a reduced rate of re-admissions over a period up to a year'* (Turner, 2011). Turner notes that there are *'clear suggestions that the establishment of Specialist Older People's Teams has had an effect on admissions and discharges however the evaluations have again not been robust so results also have to be treated with caution'* (Turner, 2011).

Turner concludes:

'The evidence presented so far in this report supports the view that older people can frequently be maintained in their own homes if timely, intensive input is offered to them. Those services which previously reported pressure on beds no longer report this and those which have reduced bed numbers have reported success. The evidence is not hard research evidence from controlled research trials but it is consistent. The reports of service users, carers and professionals have been almost universally positive with any concerns about having several people involved in the care of an individual not being borne out in practice' (Turner, 2011)

A review of Sutton's Intensive Home Treatment Team (pilot) which was established in 2009 found that a significant decrease in the number of hospital beds used (comparison with neighbouring Merton) following the establishment of the IHTT.



Sutton OPMH services have seen fewer inpatient admissions over this period than the other Borough Services:
As a result, Sutton had far lower hospital admissions compared to its neighbouring boroughs –

In developing the pilot the following questions were considered.

Do we have the correct hours of service?
The establishment of the HTT would see some service users move from 24/7 to home based services. This raises the question of whether the HTT should operate 24/7. Evidence from other similar HTTs suggests that 24/7 is not the norm. Turner's review found that no existing service provides an around the clock service and just one providing telephone support at night. Most services appear to operate extended hours, usually 7am – 10-11pm (Turner, 2011).

One review paper wrote of night time admissions found:

"Overnight presentations requiring immediate admission are rare in the over-65 age group. The Generic Home Treatment Team was the only service we visited that was fully operational on a 24/7 basis and saw an average of just two older people presenting at night per month. Our own local audit of acute psychiatric admissions found that fewer than 8% of older adults admitted over a one-year period had presented in crisis overnight (between 8pm and 8am), and three quarters of these night time admissions were under the Mental Health Act, suggesting that home treatment was probably inappropriate at that point in time."

It is important that we think about this gap and consider the options on the basis that HTT will provide a core between 9am and 8pm.

As outlined above, the Home Treatment pilot will be evaluated through a Programme Board consisting of representatives from NHS and Social Services commissioners, Social Services managers, clinicians from the MHOA service, and representatives from Kings and St Thomas's hospitals and the voluntary sector. In addition, there will be a separate service user and carers reference group which will provide input into the development of the pilot

and any subsequent recommendations. They will support the managers to consider gaps throughout 2012/13.

Service user, relative and carer feedback will be obtained.

Complete and reliable information and outcome measures will be obtained from
HoNOS65+/MHCT: at assessment and discharge
Zarit Burden Interview: at assessment and discharge

Staff and team well-being will be assessed.

It is hoped that the development of the HTT will inform the evidence base for home treatment for older people.

Role of the HTT

It is proposed that the HTT will provide a range of services and interventions:

- Handle staged discharge of those leaving hospital and establish care packages to help avoid readmissions
- Provide home visits
- Work with relevant providers to identify service users at risk of crisis
- Be the first point of contact for services experiencing or on the verge of a crisis.
- Act as 'gatekeepers' to relevant key services
- Work with hospital based colleagues to ensure continuity of treatment and wider provision
- Facilitate access to psychological services.
- Ensure continuity of provision between services.
- Signpost service users and carers to other relevant services

Currently the team is co-located on the MHOAD CAG Aubrey Lewis 2 Ward. The team operates from 9am-9pm Monday- Friday and 10.am-6pm at weekends and will be available 365 days a year. Current staffing is provided by existing ward and community staff with one new appointee (HTT Manager) on secondment. This is in order to see if the HTT model is effective, efficient and provides good value for money.

It is important to note that the establishment of HTT does not mean that those service users who use the HTT will not be able to access in-hospital services if they are required. HTT members will be able to fast-track those service users who need in-hospital treatment and will have the skills and capacity required to handle the most complex cases.

Continued availability of hospital provision for those who need it
It is also important to underline that in-hospital and other residential alternatives will still be available to those for require, including those for whom their home circumstances are at the root of their mental ill health.

Action: Set out protocols for admission to in-hospital services.

Action: Training for HTT members on hospital referrals. This is already being implemented as in the current pilot the team is located on the ward, working directly with ward staff on admissions and discharge. This is being explored as a model for future work.

Analysis of equality data

(1) Ethnicity breakdown of crisis patients

Detailed data is provided in the following table.

	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	Z	Not Recorded	Total
Croydon	1062	60	180	4		2	5	61	18	1	32	86	15	14		15		20	1575
Lambeth	286	76	234	4			1	22	7	1	25	185	42	13	3	27	1	19	946
Lewisham	477	38	137	3	2			6	1		13	140	26	7	2	9	1	9	871
Other Borough	6		2								2								10
Southwark	296	50	120	4	1	1	3	4	1	1	7	84	24	10	4	19	2	3	634
Total	2127	224	673	15	3	3	9	93	27	3	79	495	107	44	9	70	4	51	4036

A	White British
B	White Irish
C	White Other
D	White & Black Caribbean
E	White & Black African
F	White & Asian
G	Mixed Other
H	Indian/British Indian
J	Pakistani/British Pakistani
K	Bangladeshi/British Bangladeshi
L	Asian Other
M	Black Caribbean
N	Black African
P	Black Other
R	Chinese
S	Other Ethnic Groups
Z	Not Stated

This data shows a significant difference in the proportions of white British and other Black and ethnic minority communities across the different boroughs, with higher numbers of BME service users in Lambeth and Southwark. It will be important that as the policy is developed, the resulting services deliver improved outcomes for different communities. The previously mentioned review by NHS Islington argued that a greater emphasis on community based interventions can help improve services and outcomes for particular groups and communities:

'With poor experiences and outcomes obtained in psychiatric hospitals, alternative services for the black and ethnic minority population present a new and innovative way of providing acute mental health care. Such services have taken due consideration of cultural needs and the problems experienced by these communities. Our indications are that such considerations are welcome but that the problems of working with marginalised communities may lie not singularly in providing culturally specific services but in working with staff to enhance cultural understanding and further consideration of patient-centred care provision.' (Islington, Joint Commissioning Strategy - http://www.ncl.nhs.uk/media/43939/120511-joint-commissioning-strategy.pdf)

Action: Map all relevant service use by ethnicity.
Action: Review service user records to determine whether any service users require language support or other additional needs.
Action: Ensure that all HTT members receive comprehensive equalities training.
Action: HTT to make contact and build working relationships with local community organisations which work in particular
Action: HTT management should consider diversity profile

2) Disability

We are aware that most service users accessing our services have long term mental health conditions and therefore meet the definition of disabled. We believe that the number of service users with additional identified disabilities is higher than recorded as the disability will be detailed in the case notes narrative.

In relation to mobility, all the buildings have full physical disability access. Where disabilities are disclosed, the service will work to put in place reasonable adjustments to enable it to be accessible.

The decision as to who receives our service is principally based on the severity and complexity of the mental health condition, which could be a depressive illness, an anxiety disorder, a personality disorder, dementia, or any other mental disorder such as bi-polar affective disorder, but diagnosis per se is not a criterion for acceptance or exclusion from services.

All of those using wards AL1 and AL2 are for the purposes of this EIA covered by the Equality Duty by virtue of their disability mental health. It is clearly important that this is considered in the development of the HTT. It is also important to consider the wider disability needs of service users.

However, MHOAD currently only collects disability data as part of the narrative recording of the 'patient journey', it does not routinely collect wider disability monitoring data.
This is a significant gap which we will develop address as outlined in the action plan

Action: Introduce routine data collection of disability related data. Consult local disability organisations in order to ensure the most appropriate approach to collection.
Action: Undertake an assessment of the disability needs of existing service users.
Action: Once meaningful data has been collected, undertake detailed analysis of the wider disability impact and implement appropriate remedial measures and service adaptations.
Action: Ensure that all communication (verbal and written) is delivered in appropriate formats. Identify appropriate sources of communication support.

3) Gender
The following table shows current service use by gender and borough for the last twelve months

	Female	Male	Total
Croydon	1007	568	1575
Lambeth	573	373	946
Lewisham	548	323	871
Other Borough	6	4	10
Southwark	399	235	634

As the above table demonstrates there is significantly greater service use by women. This is in line with the national picture which demonstrates that there is a clear gender dimension to mental ill health in the UK (NHS Confederation (2011) Key facts and trends in mental health, London - http://www.nhsconfed.org/Publications/Documents/Key_facts_mental_health_080911.pdf)
Such patterns mean that the majority of those affected by the proposed changes are likely to be women. It is therefore important that as the policy is developed that those responsible are aware of the needs of both men and women.

Action: Consultation and discussions with service users and carers should seek to determine whether female and male users have different service needs.

4) Sexual Orientation/ Gender re-assignment/transgender
We do not currently collect this data. It is not clear that it would be appropriate to collect systematic data relating to sexual orientation. MHOAD will seek advice from local LGBT organisations and/or Stonewall as there may be steps which MHOAD can take to make sure that the service is inclusive and accessible – for example, ensuring recognition of same sex partners. The service is available to this group should they require it. We do not believe there is any disproportionate impact.

In recognition that staff attitudes and organisational culture need to support transgender people, the Trust regularly runs a training day on 'gender concerns in mental health and anti-discriminatory practice'. This programme is co-presented by the Trust's Equality and Diversity trainer and a transgender member of staff.

4.8 Marriage and civil partnerships
Mental Health Older Adults services are available to all people irrespective of their marital or civil status. We do not believe there is any disproportionate impact.

Action: Consider whether to introduce data and record rationale for decision (either way).
Action: Undertake a quick review of key systems (information recording – civil partnerships, next of kin policies et al) to ensure that they are inclusive and appropriate.
Action: Ensure that staff equality training includes a sexual orientation and age component.

5) Age
The following table shows the age profile of service users by borough.

	0-15	16-18	19-35	36-65	65+	Not Specified	Total
Croydon			3	112	1460		1575
Lambeth			3	35	908		946
Lewisham			2	70	793	6	871
Other Borough					10		10
Southwark				22	612		634

6) Religion and belief
We collect information on the religion/ beliefs of people using our services however in common with sexual orientation this is information that many service users are reluctant to share with us. Supervision of staff provides a focus for the delivery of a service that is sensitive to religious beliefs. Clients are able to access the Trust multi-faith spiritual and pastoral care service.

We are aware that staff record the details of religion and belief within clinical case records. Part of the action plan we are developing will ensure this data is entered into our data set to enable monitoring.

We will review to review to identify potential impacts and barriers

Good relations
Need to consider how the service development will be perceived by wider communities. Need to ensure that the changes are communicated clearly in order to avoid any misconceptions (as in earlier media coverage of 'Care in the Community' in the 1980s).

Action: We are developing a communications plan with the team implementing the pilot, explaining rationale and evidence for changes and we are ensuring transparency about plans. We have informed local stakeholders about the development. MHOAD is developing a new website that will hold information on the pilot and our findings.

4.. Please outline steps taken during the EIA process to raise awareness and consult/involve interested parties and those who may be affected by the policy / function / service development

Staff consultation- Staff consultations were held in February 2012. Staff were given the opportunity to be seconded into the Home Treatment Team for the duration of the pilot.
User consultation – The "Being Involved" Group – which is effectively our current Service user and Carer Advisory Group in MHOAD CAG, received three presentations on the proposals to develop the Home Treatment Service – they gave constructive and useful feedback which shaped the development of the service. This group is made up of service users, carers and ex-carers. Many ex-carers expressed the view that they would have welcomed the existence of a HTT when they were caring for their loved ones.
The start of the pilot in June 2012 will see managers increasingly consulting with local agencies, discussing ways in which the service can be delivered and improved. A Service user and carer participation group has been established which will also guide the development of the pilot in the coming months.
Carers consultation - Carers groups supported by the Alzheimers Society were consulted in the development of the Home Treatment Service. The proposal received a positive response. The CAG has Advisory Groups in each of the four boroughs it serves. Notification of the development of the Home Treatment Team was brought to both Southwark and Lambeth meetings. Both have asked to be kept informed. Feedback from these meetings informed the development of the pilot.

5. What does available evidence / results of consultation show?
The results of the engagement exercises to date indicate that local communities are interested in the development of the HTT and wish to remain informed and involved. This is why a Programme Board for the pilot as well as the user and carer Reference Group have been established. As outlined above the pilot is an important contribution to national knowledge on the effectiveness or otherwise of a Home Treatment Service for older adults.

6. If you have not been able to conduct consultation how do you intend to test out your findings and recommended actions?
This is a pilot. Consultation and engagement has commenced and will continue throughout the period of the pilot.

7. What changes or practical measures would reduce the negative impact on particular groups? (Think what a successful outcome would look like and what can be done to bring about this outcome)

See attached action plan.

If changes are required please complete the action plan template overleaf

8. What are the main conclusions of the assessment?
The main conclusions of the assessment are that it is correct to have a pilot phase of the Home Treatment Service in order to be sure that it meets the requirements of our local communities.
It is necessary and important to seek the support and partnership of our local stakeholders in this programme of work.

9. Has a monitoring process been established to measure/review the effects of the policy, function or service development? (This may include statistical analysis of monitoring data, satisfaction surveys or use of networks)

A senior psychologist is leading on measuring the effects of the pilot.

Yes (if yes, please include details in the action plan overleaf)

Date completed: ……..

Signed ……. Print name ……..

Please send an electronic copy of the completed assessment, action plan (if required), any relevant monitoring reports used and a summary of replies received from people you have consulted, to:

1. Kay.harwood@slam.nhs.uk
2. Your CAG Equality Lead

ACTION PLANNING

Agree actions and insert into action plan

The following action plan should summarise the proposed actions, setting out the timescale, lead individual and include details of any monitoring needed in the future to check that desired outcomes are reached.

Issue / Adverse impact identified	Proposed actions	Responsible/ lead person	Timescale	Progress
Important to ensure service users and stakeholders are aware of considerations and thinking in terms of the development of the HTT.	A draft version of this EIA and/or a summary version will be circulated to stakeholders as part of this process.	Nuala Conlan	June 2012- June 2013	Draft EIA being developed.
Important that the service provision offered by HTT matches that of comparable services for other age groups, in order to ensure equality of service and provision under the Equality Act 2010).	Establishment of the HTT will help ensure that the Trust ensure equality of service delivery for people of all age groups.	Cha Power	June 2012	Pilot to begin
How do we know that the HTT service hours are the rights ones?	Review service hours.	Cha Power	October 2012	
How will we cover those periods outside HTT operating hours?	Produce clear communication resources explaining out of hours arrangements.	Cha Power	July 2012	Operational policy developed
How can we be sure that the service will improve outcomes for service users?	Put in place data collection systems to monitor outcomes for HTT service users and monitor admissions.	Cha Power Alice Mills	July 2012	Currently in discussion
Will the HTT have strong enough relationships with local organisations which provide residential care for service users?	Continue to develop links and contacts with residential care providers, housing associations specialising in supported housing and mainstream health and social care providers.	Nuala Conlan Cha Power		Ongoing
Some service users, carers and other stakeholders may be concerned that service users will not be referred to in-hospital services, when and where	Set out protocols for admission to in-hospital services and provide reassurances regarding access to appropriate services.	Cha Power	July 2012	Operational Policy

appropriate. This is particularly important for service users for whom their home environment is a contributory factor in their condition.				
Will staff know when services should be referred for in-hospital treatment?	Training for HTT members on hospital referrals.	Cha Power	July 2012	Training programme
Ensure current ethnic monitoring categories are comparable with the Census 2011 categories.	Review ethnic monitoring categories to ensure comparability with Census 2011.	Cha Power Nuala Conlan	March 2013	
Do we have a complete picture of the ethnic profile of all service users?	Map all relevant service use by ethnicity.	Cha Power	December 2012	To be discussed with business managers
Do individual service users have particular language support needs?	Review service user records to determine whether any service users require language support or other additional needs.	Cha Power	July 2012	Part of the operational policy
Will staff have the knowledge and skills needed to deliver services to a range of communities?	Ensure that all HTT members receive comprehensive equalities training.	Cha Power	July 2012	
How can the HTT ensure that it provides appropriate services, interventions and solutions for different communities – including signposting to wider services?	HTT to make contact and build working relationships with local community organisations which work in particular	Nuala Conlan	Sept - 2012	Discussions happening on how to do this.
How will the HTT ensure that it can provides services which are appropriate to different communities and groups?	HTT management should consider diversity profile of the team and ensure that all staff are properly trained to deal with different communities and groups.	Cha Power	Recruitment policy Training programme	
It is not yet clear whether female and male services have different expectations and needs.	Consultation and discussions with service users and carers should seek to determine	Nuala Conlan	During the pilot	

	whether female and male users have different service needs.			
There is currently insufficient disability data.	Introduce routine collection of disability related data. Consult local disability organisations in order to agree suitable categories and ensure the most appropriate approach to collection.	Cha Power Nuala Conlan	During the pilot	
We do not currently possess a clear picture of the wider disability profile and needs of service users.	Undertake an immediate, swift assessment of the disability needs of existing service users.	Nuala Conlan	By December 2012	
Ensure that all disability data that is collected is regularly analysed to plot the disability impact of the service.	Once meaningful data has been collected, undertake detailed analysis of the wider disability impact and implement appropriate remedial measures and service adaptations.	Cha Power	By December 2012	
Is information available and delivered in different formats (disability)?	Ensure that all communication (verbal and written) is available and delivered in appropriate formats. Identify appropriate sources of communication support. Ensure consistency across all related services.	Cha Power Laura Broadley	Ongoing	
Should the HTT service collect and analyse data relating to the sexual orientation of service users?	Consider whether to introduce data and record rationale for decision (either way).	Nuala Conlan		Discussions planned with LGBT groups
Are all relevant, current policies and practices appropriate in terms of sexual orientation?	Undertake a quick review of key systems (information recording – civil partnerships, next of kin policies et al) to ensure that they are inclusive and appropriate.	Nuala Conlan Cha Power	Ongoing	
Do staff and managers have the knowledge and skills to deal with service	Ensure that staff equality training includes a sexual orientation and age	Cha Power		Training to be arranged

users on issues relating to sexual orientation?	component.			
Need to consider how the service development will be perceived by wider communities. Need to ensure that the changes are communicated clearly in order to avoid any misconceptions.	Develop communications strategy explaining rationale and evidence for changes and ensure transparency about plans.	Nuala Conlan Team Leader	Ongoing	
How will we ensure that the projected impacts are correct and that the policy does not have any unintended consequences?	In addition to on-going monitoring and appropriate remedial action, there will be further review of all equality data and assessment of impact of the work of the HTT after twelve months.	Cha Power	Autumn 2013	

Please send an electronic copy of your completed assessment to:

1. Kay.harwood@slam.nhs.uk

2. Your Service Equality Lead

The national annual admission rate thus derived is 343/100,000 people aged 65+. The admission rate for Sussex overall 2008/09
FYE based upon Q1-Q3 admissions) was calculated to be 426/100,000 based on the ONS population .

http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1304-075_V01.pdf

1. Risk management

4.1 Risk assessment

Risks have been assessed using a traffic light system:

		Impact		
		Low	**Medium**	**High**
Probability	**Low**	Green	Green	Amber
	Medium	Green	Amber	Red
	High	Amber	Red	Red

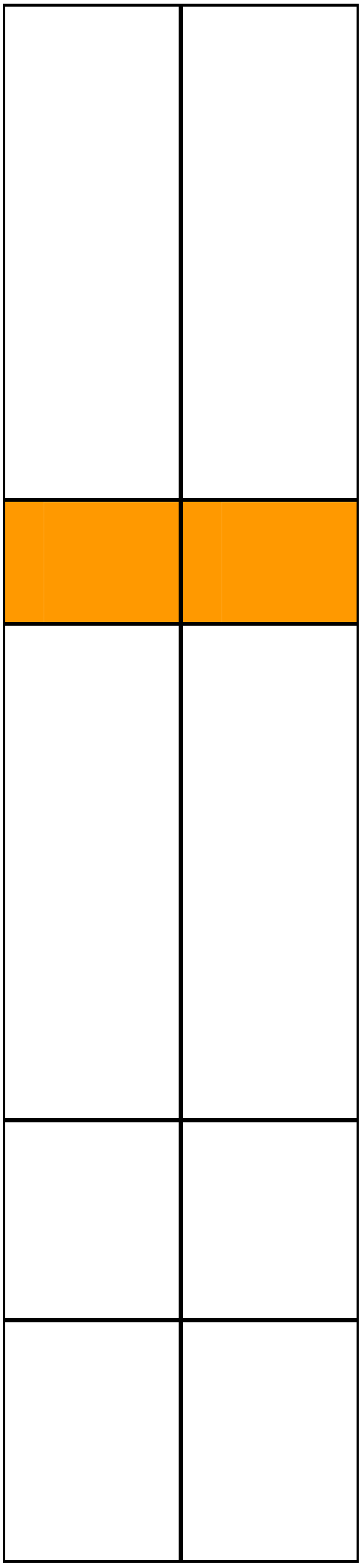
4.2 Risk Response

Risks can be managed using the following risk responses:
Acceptance: Project Tolerance, how much risk is the Trust prepared to take
Prevention: End the risk by doing things differently or stop the threat occurring
Transference: Pass the risk on to a third party e.g. by using an insurance policy
Reduction: Take action before to reduce the risk or limit its impact.
Contingency: Prepare a contingency plan to come into force if the risk occurs

4.3 Risk Register

Risk Title	Risk Owner	Risk Description	Score	Risk Response
Financial	SLaM NHS Trust	Unable to identify appropriate patients to discharge or prevent admission		**Have discussed with both community and inpatient clinicians who have recognized patients that would benefit from this approach.** **Quarterly meetings to insure the service is meeting its objectives**
Financial	SLaM NHS Trust	Unable to get agreement from Joint Commissioners on setting up the service or delay in its implementation		**Currently in discussion with commissioners**
Financial	SLaM NHS Trust	Without redesign of inpatient services SLAM MHOA&D will not be able to make cost savings which will have a major impact on savings plan 12/13		**Currently in discussions with commissioners**
Clinical`	SLaM NHS Trust	Unable to recruit staff suitably qualified to work in Home treatment Model		**Able to provide comprehensive training from with in the CAG and other directorates In Slam**

Clinical Patient Safety	SLaM NHS Trust	Incident with patient or relative putting their Health or others at risk		**Comprehensive risk management and assessment to prevent this happening Crisis Plan and emergency numbers given. Intensive support when the person is initially taken on**
Clinical Staff safety	SLaM NHS Trust	Safety for staff working out of hours and visiting patients in acute distress		**Lone working policy to be instigated. Risk assessment to include visits whether two staff are needed in some circumstances. Training to be provided to staff**
Clinical	SLaM NHS Trust	Service is not running between 9pm and 8am		**Accepted risk. There would be phone cover by the ward who would be familiar with all the patients and have access to their clinical records electronically**
Clinical Ineffective service	SLaM NHS Trust	Service not found to be affective and not having the impact in reduction in admissions and no patients treated at home		**Accepted risk . Full evaluation of the service after 12 months with possibility of linking it with the Integrated Care Pathway in Southwark and Lambeth**



Agenda Item 6

Lambeth

Southwark Council

Cllr Mark Williams
Southwark Council, 160 Tooley Street, SE1 2TZ.
Cllr Ed Davie
Lambeth Town Hall, Brixton Hill, SW2 1RW.

Date 8 August 2012

Dear Gwen Kennedy and Denis O'Rourke

Psychological Therapy Services

The 16 May 2012 joint meeting of Lambeth and Southwark health overview and scrutiny committees decided to seek the views of Southwark and Lambeth Clinical Commissioning Committees on changes to Psychological Therapy Services.

The respective committees would like your views on the service reorganization. We would like to know if you are satisfied with proposed structure and outcomes for the service. A particular concern is the potential drop in psychodynamic psychotherapy in Southwark, and this was highlighted in evidence received. We would like commissioners' views on if they would like to invest more of their budget on this and less in other areas.

SlaM have also been asked to provide details on the availability of different modalities in the different boroughs and how a high level of service can be guaranteed in both boroughs. A copy of a letter sent to SLaM on the 27 June 2012 is enclosed.

Psychological Therapy Services will be placed on the agenda of the next Southwark Health, Adult Social Care, and Communities & Citizenship Scrutiny Sub-Committee, which takes place on 18 September 2012. We would appreciate a response to this letter by **7 September 2012** and for a representative to attend the next Southwark scrutiny meeting in order to contribute to the committee's deliberations. Please get in touch with the respective lead scrutiny officers, in the first instance, if you have any queries.

Yours sincerely

Councillor Mark Williams
Chair, Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

Councillor Ed Davie
Chair, Lambeth Health and Adult Services Scrutiny Sub Committee

Please copy your response to Julie Timbrell Julie.Timbrell@southwark.gov.uk and Elaine Carter Ecarter@lambeth.gov.uk

CC Zoe Reed, SLaM Director of Strategy and Business Development
Steve Davidson, SLaM, Service Director , Mood Anxiety & Personality CAG
Andrew Bland, Managing Director, SCCC BSU NHS Southwark
Dr Amr Zeineldine, Chair of Southwark Clinical Commissioning consortia
Andrew Eyres, Managing Director , LCCC BSU NHS Lambeth
Adrian McLachlan, Chair Lambeth Clinical Commissioning consortia

NHS
Lambeth Southwark Clinical Commissioning Group

Lambeth and Southwark Clinical Commissioning Groups

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Councillor Mark Williams
Chair Southwark Council's
Health, Adult Social Care,
Communities and
Citizenship Scrutiny Sub
Committee

And

Councillor Ed Davie
Chair, Lambeth Health and
Adult Services Scrutiny Sub

3rd September 2012

Dear Councillors Williams and Davie,

Psychological Therapy Service

Thank you for your letter of 8th August following the joint meeting of Lambeth and Southwark Health overview and scrutiny committees on changes to the Psychological Therapy Service.
.
Lambeth and Southwark are currently satisfied with the proposed structures and clinical outcomes designed by SLaM. However as Commissioners we intend to continually review services commissioned to ensure that our commissioning plans are evidence based and able to appropriately respond to our local resident's needs. Lambeth and Southwark are also satisfied that the new structure will improve equity of access for all people to all treatments and interventions available.

The remodelled service will enable Commissioners to systematically review the service through the timely collection of data; this will include information on waiting times, choice of treatment, outcomes delivered, patient experience of those services, impact on the different populations' needs of both boroughs.

NHS Lambeth Southwark Clinical Commissioning Group

Commissioners have agreed with SLaM that an on-going service evaluation using a continuous service improvement approach will inform commissioners as part of the commissioning cycle. Contracted activity will be monitored monthly by Commissioners with a more in-depth presentation by SLaM to Commissioners on a quarterly basis. The Mental Health Programme Management Group in Southwark and the Mental Health Improvement Programme in Lambeth, will receive reports on the activity, quality and access to the service providing a health overview that will help inform our future commissioning plans and contribute to the continual service improvement process adopted by SLaM.

We have been formally assured by SLaM that the capacity for psychodynamic psychotherapy in the redesigned service will continue to be provided at the same level. We will continually review this element of therapy choice and reflect this in our future commissioning plans.

Southwark CCG will be represented at the next Southwark Health, Adult Social care, Communities and Citizenship Scrutiny Sub Committee

Yours sincerely

Gwen Kennedy
Director of Client Group Commissioning
Southwark Clinical Commissioning Group

Adrian McLachlan
LCCCB Chair
Lambeth Clinical Commissioning Group

cc. Zoe Reed, SLaM Director of Strategy and Business Development
Steve Davidson, SLaM Service Director, Mood Anxiety and Personality CAG
Andrew Bland, Managing Director, SCCCG NHS

South London and Maudsley NHS
NHS Foundation Trust

Zoe Reed
Executive Director Strategy and Business Development
South London and Maudsley NHS Foundation Trust
Trust Headquarters, Maudsley Hospital
London
SE5 8AZ
Tele: 020 3228 2435
3rd September 2012

By email only

Cllr Mark Williams
Southwark Council, 160 Tooley Street, London SE1 2TZ
Cllr Ed Davie
Lambeth Town Hall, Brixton Hill, London SW2 1RW

Dear Cllr Mark Williams and Cllr Ed Davie

Changes to Psychological Therapy Services – Progress Update

Further to your letter dated 27th June 2012, I am pleased to set out below a progress update on the recommendations and queries that you requested for 3rd September 2012, about the service changes to psychological therapy services in Lambeth and Southwark.

1. Evaluation Framework

The development of the evaluation framework has started and is near completion. A workshop took place on 31st July 2012, which was well attended by interested stakeholder s and both LINks to look at three specific areas of the framework, these being:

- Outcomes - both in terms of evidence based clinical outcomes as well as patient reported outcomes
- productivity - which includes activity levels, waiting times, clinical work plans
- patient experience – which includes monitoring levels of communication and information etc

Two working groups have been organised by our PPI lead initially meeting on the 12th and 14th of September 2012 to look further at the patient experience and information needs. This information will be used to finalise the framework ready to use in October, with a review of the new services to take place in April 2013. All of this is being closely monitored by the MAP service user Advisory Board that meets monthly.

2. Building links with the Council

Effective links are continuing to be built between the council services and the psychological therapy services. Community mental health services in Lambeth and Southwark currently are fully integrated health and social care services with social workers and psychiatric nurses, medics and other clinicians such as psychological therapist working within the same community system. Indeed it is our responsibility to ensure that the Personalisation agenda is realised and becomes a great success with community mental health services and we are committed to the idea of a continuation of this integrated model. In terms of housing, it has been recognised that further work is needed in improving communication between us. The new head of social care in Southwark has made a commitment to support improved communication between mental health services and housing and we are currently exploring how this can be facilitated in Lambeth.

3. Access and information to service users

The previously mentioned information sub group has been set up to look at information needs and our communication standards for people accessing therapy, which will include information about waiting times and access to other support systems such as developing peer support networks etc. We have now developed the Single Point of Access meetings that take place on a weekly basis, where referrals from community teams or Improving Access to Psychological Therapy Teams will be discussed by senior clinicians representing each clinical area and plans will be agreed across the system. We believe this transparency will improve access for hard to reach patients in community mental health teams.

4. Honorary Therapists

There are currently 246 honorary therapists within the new IPTTs, of these:

- 63 are supervised to deliver CAT
- 9 are supervised to deliver family / systemic therapy
- 13 are supervised to deliver group therapy
- 35 are supervised to deliver CBT
- 126 are supervised to deliver psychodynamic therapy

They are currently seeing 341 patients, 297 individually and 44 in a group setting and providing 360 hours of therapy a week.

It would be difficult to have an accurate figure for the number of therapeutic hours honorary therapists have provided over the last two years as the number fluctuates in response to the number of people needing training places for their courses. This data was also not systematically collected by the various services involved in the past nor has the process of engaging and supervising honoraries been consistently managed or subject to Trust Management oversight. However, we are confident that the number of honorary therapists has remained relatively stable over the last two years and therefore believe that the number of therapeutic hours provided is in the region of 29,000 hours.

Our clinicians have worked hard to ensure continuity and our honorary therapists have been reassigned to our existing qualified supervisors as part of the restructure. We will closely monitor both the numbers of therapists and their supervision arrangements as part of the evaluation framework.

All supervisors of honorary therapists are accredited with the British Psychoanalytical Council (BPC) or the United Kingdom Council for Psychotherapy (UKCP) and are clear about the standards and expectations of a supervisor as set out in the UKCP Supervision Policy 2012 and the BPC code of Ethics and CPD policy.

5. Unequal provision between Southwark and Lambeth

Historically, commissioning of psychological therapies has always been higher in Lambeth than in Southwark and continues to be so with the new configuration. As part of the restructure we have ensured that all modalities are provided in both boroughs and are working across boroughs to look at how colleagues can support each other and provide reciprocal and / or joint arrangements for supervision, especially when developing group programmes.

I hope you have found this progress update informative and I am of course happy to clarify further if that would be helpful.

Yours Sincerely

Zoe Reed
Executive Director Strategy and Business Development

Cc Julie Timbrell; Elaine Carter
Steve Davidson

Agenda Item 7

Southwark Clinical Commissioning Group

The best possible outcomes for Southwark people

Southwark CCG
Report to HASC Overview & Scrutiny Committee

18 September 2012

4 September 2012

The report addresses the request of the Chair of the Southwark HACS Overview & Scrutiny Committee for updates on the following areas of CCG business:

1. Copy of the CCG Draft Constitution
2. Information on the recruitment of CCG Governing Body Members
3. Information about how GPs respond to patients with mental health needs out of hours
4. A report of the development of the CCG's QIPP programme for 2013/14

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1. CCG Constitution

1.1. The CCG Constitution has been developed in collaboration with member practices, discussions and input from the London-wide and local LMC representatives and has been approved at the Southwark Clinical Commissioning Committee in August 2012.

1.2. The draft Constitution is the result of work over the last five months, during which practices provided over 50 pages of comments and suggestions. The CCG has run a Southwark-wide forum in July which over 100 GPs and practice managers attended to discuss and refine the Constitution document.

1.3. It is attached as Appendix 1

2. Southwark Clinical Commissioning Committee / CCG Governing Body Members

2.1. Over the last 18 months the CCG has worked with its members to define the composition of the Governing Body and the senior management team.

2.2. The CCG has ensured that clinical leadership is drawn from across all borough localities, represents a mix of partners and sessional clinicians and includes a local general practice nurse.

2.3. The Governing Body will be chaired by a clinician and its membership includes a registered nurse and a secondary care clinician, recruited in line with national guidance. All Governing Body members have a clear role outline, job description and objectives aligned to national guidance and local priorities.

2.4. Our Governing Body brings together a cohesive team of clinicians, senior managers (including the Chief Officer and Chief Financial Officer) and Lay Members as outlined below. In addition the CCG has placed importance on the representation of the Local Authority, Southwark LINK (*Healthwatch* in future) and Public Health on the Governing Body.

2.5. Details of members of the Governing Body and the recruitment process they completed ahead of their appointment are included in the section below. The roles and portfolios held by CCG clinical members are summarised as table 1.

Clinical Leadership

2.6. Commissioning in Southwark has drawn upon the leadership of local clinicians for many years adopting a model of involvement with clinical representatives for a number of Southwark localities. This representative model has been retained by the CCG and in April 2012 the management team engaged practices in the

development of a process for appointing a clinical leadership team to become members of the CCG's Governing Body post-authorisation (and throughout the remainder of the transition).

2.7. As a result of our engagement the CCG commissioned the Electoral Reform Society to independently administer a selection/election process in the months of May and June 2012 for the eight GP members and the local Practice Nurse member of the Governing Body (this process is outlined in the Constitution).

2.8. The selection/election process has resulted in the appointment of eight GP members (drawn from across the localities and containing a mix of partners and sessional GPs) and a local Practice Nurse member. Each clinical member of the Governing Body holds and provides leadership for a clinical portfolio (see table 1, below).

2.9. As part of the CCG's selection / election process the appointed clinical Governing Body members elected a Chair, Dr. Amr Zeineldine.

Table 1: Southwark CCG Clinical Leadership Team

Clinical Lead	Tenure	Clinical Portfolio	Corporate Portfolio
Dr Zeineldine	*2 years*	Chair - Leadership	Governance
Dr Bradford	*3 years*	Staying Healthy	Information Governance
Dr Holden*	*2 years*	Unplanned Care	Health & Wellbeing
Dr Heaversedge	*3 years*	Engagement & Quality	Health & Wellbeing / Public Health
Dr Durston**	*2 years*	Planned Care	Information Technology
Dr Fradd**	*2 years*	Finance	Safeguarding Adults
Dr Bhatia***	*3 years*	Mental Health	Integrated Care
Dr Howell*	*3 years*	Medicines Management	Safeguarding Children
Linda Drake (Practice Nurse)		Community Services	Nursing

* Dr Holden and Dr Howell will share a joint role for the commissioning of Guys and St Thomas' Hospital NHSFT

** Dr Durston and Dr Fradd will share a joint role for the commissioning of Kings College Hospital NHSFT

*** Dr Bhatia will undertake the role for the commissioning of South London & The Maudsley NHSFT

2.10. The recruitment process for the registered nurse and secondary care clinician positions on the Governing Body commenced, via national advert, in July 2012 and the process will be completed by October 2012.

Lay Membership

2.11. The CCG has undertaken a recruitment process in line with national guidance to appoint Lay Members to the Governing Body of the CCG. In addition to the two roles prescribed for governing bodies, the CCG took the decision to appoint a third Lay Member with a lead role for quality and standards in commissioned services.

2.12. Our recruitment process was undertaken against a national advertisement and clearly defined role outline and job description and was delivered in two parts. The first was undertaken independently of the CCG to shortlist and interview potential candidates to determine their competencies and skills for the roles. The second was conducted by the CCG leadership team and involved a further local interview.

2.13. Lay members will play a pivotal role in the Governing Body and the CCG more widely undertaking the following roles and sitting on each of the CCGs key committees:

- Lay member with a lead role in overseeing key elements of governance: Dr Richard Gibbs, who will also be the Vice-Chair of the Governing Body
- Lay member with a lead role in championing quality: Robert Park, who will also Chair the Integrated Governance and Performance Committee
- Lay member with a lead role in championing patient and public involvement: Diane French, who will be a member of the Engagement and Patient Experience Committee.

All Lay Members will engage in the Commissioning Strategy Committee of the CCG.

Senior Management Team

2.14. The CCG has also recruited a senior management team, including the recruitment of the Accountable Officer (May 2012) and the Chief Financial Officer (July 2012) following a local and the national processes for recruitment.

2.15. A CCG management leadership team has been in place throughout the transition and following the appointment of the Accountable Officer (Chief Officer Designate) the CCG has begun the process of appointment to the CCG directly employed team including a Director of Service Redesign and a Director of Client Group Commissioning. The CCG will also share a clinical director post with NHS Lewisham CCG in future.

3. Information on how GPs respond to patients at weekends and evenings, who are experiencing mental distress and are in need of support

3.1. Southwark Patients that are experiencing mental distress during the evenings or weekends are able to contact their GP out of hour service. At present this is provided by SELDOC (South East London Doctors). GPs will undertake a clinical assessment to establish how to support the patient presenting. Depending on the nature of the crisis the GP may either conduct a telephone or surgery consultation or a home visit.

3.2. Once this assessment has taken place the GP will decide with the patient how best to support them. If the person is already a patient of South London and Maudsly Trust, this may mean supporting the person to access specialist support or treatment from those services out of hours or by re- referral. In some circumstances – depending on the nature of the crisis – the GP may refer the patient to A&E. If the patient consulting the GP is not receiving any medical treatment or social support the GP will assess the patient and decide on the most appropriate support. This may include:

- A direct referral to A&E where specialist Mental Health liaison teams are place
- A next day consultation and potential referral to a SLaM service
- Treatment from the GP on call with a follow up consultation from their own GP practice.

4. CCG QIPP in 2013/14

4.1. The level of financial challenge facing the NHS over the next few years is unprecedented, especially when compared to the significant levels of financial growth experienced over the last decade. The challenge is therefore to secure significant efficiency and productivity savings over the course of the next three years to provide the financial resource to support delivery of our strategic goals and to make improvement in each of the CCG's seven priority areas.

QIPP Forward Planning

4.2. To close the forecast funding gap over the next three years, the CCG has developed a QIPP programme, which it is currently implementing in 2012/13. This plan has been shared with the Overview & Scrutiny Committee as a part of previous CCG reports.

4.3. The CCG begins its annual planning round for the year ahead in October. It is important for members to note that the **CCG will develop a final QIPP Plan for the year 2013/14 from October2012**, with further detailed modelling, risk-mapping and equality analysis completed between this month and March 2013.

4.4. In advance of the 13/14 planning round, the CCG has identified the size of the financial challenge based on a series of assumptions about rates of growth in our allocation, demographic change, growth in use of healthcare and inflation. Table 2 sets out the size of the QIPP challenge in future years based on these assumptions. Members will note the size of the QIPP challenge is larger in 2012/13 than it is projected to be in the following two years.

4.5. Our modelling shows a cumulative projected deficit in 2014/15 of £16.230m, so in order to achieve the statutory 1% surplus in 2014/15, QIPP savings totalling £22.087m will need to be delivered over the three year period, £11.04m of these are targeted in the current year.

Table 2: The Three Year Financial Challenge 2012/13 – 14/15 (draft model, August 2012)

	£'000
Forecast Surplus/ (Deficit) 2011/12	**5,857**
QIPP savings requirement 2012/13	(11,043)
QIPP savings requirement 2013/14	(5,865)
QIPP savings requirement 2014/15	(5,179)
Total QIPP savings requirement	**(22,087)**
"No Change" Forecast Surplus/ (Deficit) 2014/15	**(16,230)**

4.6. In advance of the 13/14 planning round beginning CCG officers have worked with clinicians to scope the QIPP opportunity available over the planning period and to establish a simple model to determine how the QIPP challenge can be addressed.

4.7. Part of the scoping exercise has been to review the likely financial impact of planned programmes of service redesign (e.g. programme for admissions avoidance or Integrated Care Programme) and also to assess the potential opportunity for contractually-secured efficiency programmes with providers. Details of these programmes are included in the CCG's *Integrated Plan*.

4.8. Table 3 below is the high-level summary of potential QIPP initiatives for the period to 14/15. This model has been included in the CCG's financial and strategic commissioning plans (*CCG Integrated Plan*).

4.9. Further detail on QIPP initiatives planned for 13/14 and 14/15 included as table 4.

Table 3: Draft QIPP Savings Opportunity by Expenditure Area 2012/13 – 2014/15

Planned QIPP Savings After Risk Rating	2012/13	2013/14	2014/15	Total 2012/13 - 2014/15
Acute and Specialist Budgets	5,429	4,136	3,788	13,353
Corporate Budgets	1,503	400		1,903
Health Client Groups	899	1,000	1,000	2,899
Prescribing	600	329	390	1,319
Primary Care	2,613			2,613
Grand Total	**11,043**	**5,865**	**5,178**	**22,087**

4.10. The majority of the CCG's annual QIPP programme are secured as efficiency savings in provider contracts, with the basis of this comparative benchmarking indicators that situate local provider trusts with others in London. These QIPP targets are agreed with local trusts as a mechanism to incentivise them to work towards delivering optimal local processes comparable to the most efficient trusts in London.

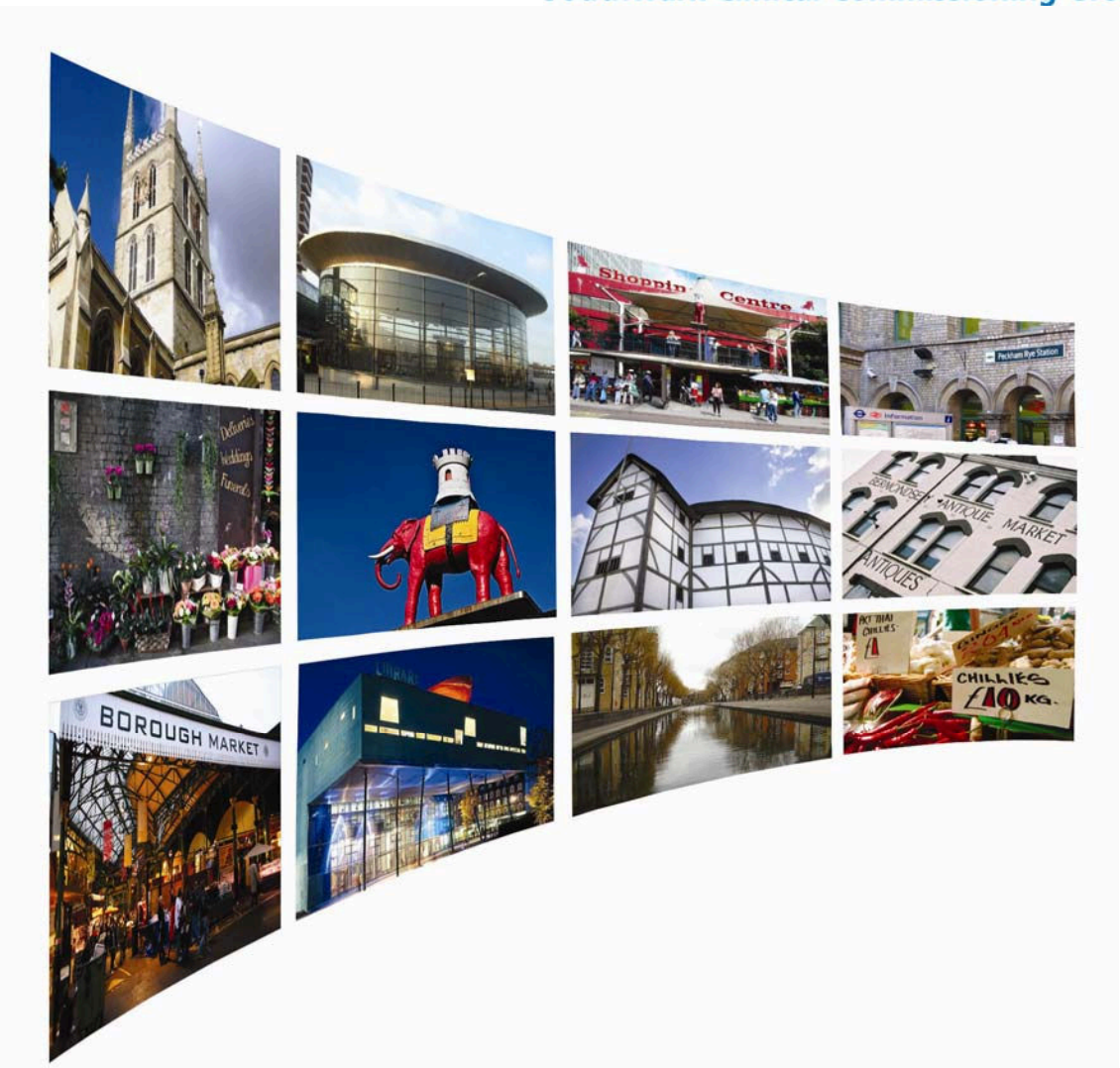
4.11. The CCG's commissioning intentions have been developed in partnership with member practices and local patients and partner organisations. These are included in the CCG *Integrated Plan*. The commissioning intentions will be agreed by the Southwark Clinical Commissioning Committee and developed into comprehensive work programmes (with risk registers, detailed investment and savings plans and equality impact analyses) before January 2013. Initiatives included in the draft CCG commissioning intentions section of the Integrated Plan will make up both the contractually-secured and pathway redesign initiatives that make up the QIPP programme for the year ahead.

Table 4: Southwark CCG QIPP Opportunity 12/13-14/15

	QIPP SAVINGS OPPORTUNITY				
QIPP Initiative	Area of spend	Type of QIPP	2012/13 Plan	2013/14 Opportunity	2014/15 Opportunity
			£'000	£'000	£'000
New GP-initiated Outpatient Attendances	Acute	Pathway Improvement	1,193		
New GP-initiated Outpatient - Practice performance improvement	Acute	Pathway Improvement	150		
Reduce A&E Attendance and UCC front end	Acute	Pathway Improvement	355	425	78
Emergency Admissions / Reablement Programme	Acute	Pathway Improvement	665	399	399
PoLCE	Acute	Contractual Efficiency	113		
Reduction in Outpatient Follow Ups	Acute	Contractual Efficiency	1,552	1,035	1,034
Consultant to Consultant referrals	Acute	Contractual Efficiency	200	133	133
Emergency Admissions (A&E conversion rates)	Acute	Contractual Efficiency	636	532	532
Excess bed Days per spell	Acute	Contractual Efficiency	423	282	282
Acute Prescribing and Medicines Management	Acute	Contractual Efficiency	293	293	293
Other Productivity & Efficiency Measures	Acute	Contractual Efficiency	250	250	250
Primary Care Productivity Programme/ Procurement	Primary Care	Contractual Efficiency	50		
Primary Care Performance Management	Primary Care	Contractual Efficiency	38		
Primary Care Prescribing	Primary Care	Contractual Efficiency	600	329	390
PMS review	Primary Care	Contractual Efficiency	1,250		
SLaM Provider Efficiencies	Client Groups	Pathway Improvement	1,561	1,000	1,000
Estates Optimisation Programme	Corporate Budgets	Contractual Efficiency	234		
Corporate Budget reviews and efficiency project	Corporate Budgets	Contractual Efficiency	250	400	
GP Outpatient Shift Investment	Client Groups	Investment Fund	(956)		
Urgent Care Investment	Acute	Investment Fund	(191)		
Admission Avoidance Investment	Acute	Investment Fund	(412)		
APMS Review	Primary Care	Contractual Efficiency	200		
End of Life/Patient Participation Group Incentive Scheme	Client Groups	Contractual Efficiency	94		
PMS Review - Best Case Scenario	Primary Care	Contractual Efficiency	1,075		
UCC Front End of A&E - Enhanced Savings	Acute	Pathway Improvement	200		
Estates Optimisation - St Olaves	Corporate Budgets	Contractual Efficiency	188		
Running Cost Efficiencies Target	Corporate Budgets	Contractual Efficiency	832		
Community Services Productivity Target	Client Groups	Contractual Efficiency	200		
Integrated Care	Acute	Pathway Improvement		788	788
Total			**11,043**	**5,866**	**5,179**

NHS

Southwark Clinical Commissioning Group



The best possible outcomes for Southwark people

NHS SOUTHWARK CLINICAL COMMISSIONING GROUP: CONSTITUTION

Authorisation Submission September 2012

[Draft 15 : 29 Aug 2012]

CONTENTS

Foreword

Southwark's clinicians have a tradition of being involved in planning and co designing services for the long term benefit of patients and their carers, and being committed to working with partners for the common good of patients and residents of Southwark.

This constitution sets out formally the operations and governance structures that build upon our current significant clinical involvement in commissioning, and to ensure that these principles of broad involvement, both within
the CCG and between the CCG and other related organisations, are supported and developed further.

We recognise that the CCG is a new type of commissioning organisation, with different responsibilities to preceding NHS organisations. The constitution reflects this and seeks to ensure that not only are the views of all local clinicians heard and represented, but importantly, the views of local residents and users of the commissioned services are also heard and responded to.

The coming years represent a time of significant change, both in terms of the ways in which services are delivered and limitations in resources. It is in everyone's interests to ensure that resources are spent effectively, allocated fairly, and that services are of the highest possible quality and produce the outcomes that professionals seek and the population both needs and deserves.

The constitution sets out our responsibilities for commissioning care for the residents of Southwark. It describes the governing principles, rules and procedures that we have established to ensure probity and accountability in the day to day running of the CCG; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to our goals.

Southwark CCG is a membership organisation. The engagement of our member practices will be critical to our success. Our member practices will be involved in our decision making, reserving key strategic decisions to themselves (to be voted upon at our Council of Members meetings), delegating other decisions to our governing body and working in their respective Localities on Locality specific plans and projects. There will be two way accountability between Member Practices and the Governing Body.

The constitution applies to all of the member practices, the CCG's employees, individuals working on behalf of the CCG, anyone who is a member of the CCG's governing body, representatives on the council of members, and any other committee(s) established by the CCG or its governing body.
All such people are responsible for knowing, complying with, and upholding the arrangements for the governance and operation of the group as described in this constitution.

Dr Amr Zeineldine
Chair, Southwark CCG
August 2012

GLOSSARY OF KEY TERMS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006;
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act);

Chief Officer	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the CCG:
	• complies with its obligations under:
	  ○ sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),
	  ○ sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),
	  ○ paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and
	  ○ any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;
	• exercises its functions in a way which provides good value for money;

Area Covered	the geographical area that the CCG has responsibility for, as defined in Clause 2 of this constitution;
CCG	NHS Southwark Clinical Commissioning Group, whose constitution this is;
CCG's Website	For 2013 this will be: www.southwarkccg.nhs.uk;[1] our current website is as follows: http://www.southwarkpct.nhs.uk/about_us/nhs_southwark_clinical_commissioning_group/nhs_sccg_constitution
Chair of the Governing Body	the individual appointed to act as chair of the Governing Body. The eight GP Representatives on the Governing Body shall elect one of their number to this role;
Chief Financial Officer	the qualified accountant employed by the CCG with responsibility for financial strategy, financial management and financial governance;
clinical commissioning group	a body corporate established by the NHS Commissioning Board in accordance with Clause A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act);
Council of Members	the representative group through which the CCG acts to fulfil its duties to (a) decide those matters reserved to the Member Practices under the Scheme of Reservation and Delegation, and (b) through which the Member Practices hold the Governing Body and a its committees and sub-committees to account;
Deputy Practice Representative	a clinician or practice manager employed by or contracted to work for his/her Member Practice, who will act on behalf of his/her Member Practice as deputy to the Practice Representative when required;
EPEC	engagement and patient experience committee;
Financial Year	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March;
Good Governance Standard for Public Services	the report published by the Independent Commission on Good Governance in Public Services, Office of Public Management and the Chartered Institute of Public Finance and Accountability in 2004 available at http://www.cipfa.org.uk/pt/download/governance_standard.pdf

[1] Subject to registration of domain name

Governing Body	the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it;
Governing Body member	any member appointed to the Governing Body of the CCG;
GP	a general practitioner;
GP Representative	one of the eight GPs who are appointed to the Governing Body;
Health and Wellbeing Board	the body established by Southwark Council pursuant to section 194 of the 2012 Act;
LMC	the local medical committee for Southwark as recognised by the NHS Act 1977;
Lay Member	a lay member of the Governing Body, appointed by the CCG. A lay member is an individual who is not a member of the CCG or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations;
Locality(ies)	groups of Member Practices organised on a geographical basis as determined by the CCG from time to time, the function of which is to facilitate communication between the Governing Body and the Member Practices;
Local Authority	Southwark Council;
Member Practice	each of the 47 holders of General Medical Services, Personal Medical Services or Alternative Provider Medical Services contracts that is listed as a member of this CCG in Appendix B and referred to in paragraph 3.1 of this constitution;
NHS CCG Regulations	statutory instrument 2012 number 1631, The National Health Service (Clinical Commissioning Groups) Regulations 2012;
Practice Representative	a GP appointed by his/her Member Practice to act on behalf of his/her Member Practice in all matters reserved to the Council of Members under the Scheme of Reservation and Delegation;
Registers of interests	registers a CCG is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the CCG; • the members of its Governing Body; • the members of its committees or sub-committees and committees or sub-committees of its Governing Body; and • its employees;
Scheme of Reservation and Delegation	The scheme set out in Appendix D.

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Southwark Clinical Commissioning Group (the "CCG").

1.1.2. The CCG is a statutory public body established by the NHS Commissioning Board in accordance with the 2006 Act (as amended by the 2012 Act).

1.2. Status of this Constitution

1.2.1. This constitution is made between the members of the CCG and takes effect from the [1st of April 2013][2], when the NHS Commissioning Board established the CCG. The constitution is published on the CCG's Website and complies with the requirements of Part 1 of Schedule 1A of the 2012 Act, the NHS CCG Regulations regarding CCGs and takes account of guidance from the NHS Commissioning Board.

1.3. Amendment and Variation of this Constitution

1.3.1. This constitution can only be varied in two circumstances:

a) Where the CCG applies to the NHS Commissioning Board and that application is granted;
b) Where in the circumstances set out in legislation the NHS Commissioning Board varies the CCG's constitution other than on application by the CCG.

2. AREA COVERED

2.1. The geographical area covered by the CCG is the London Borough of Southwark as shown in part 1 of Appendix A.

3. MEMBERSHIP

3.1. Membership of the CCG

3.1.1. The practices that comprise the Member Practices of the CCG are listed at Appendix B, together with the signatures of each of their authorised signatories confirming their agreement to this constitution.

3.2. Eligibility

3.2.1. Providers of primary medical services to a registered list of Southwark patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract may be members of the CCG.

4. MISSION, VALUES AND VISION

4.1. Mission

4.1.1. The CCG's mission is to commission high quality services that improve the physical and mental health and wellbeing of our population and result in reduction of health inequalities. Our commissioning will be:

a) Evidence based;
b) Focused on clinical outcomes;
c) Led by local frontline healthcare professionals;
d) Determined by local need;
e) Informed by genuine patient and public engagement, and;

[2] Subject to authorisation

f) Result in more information and choice for patients.

4.2. Values

4.2.1. The CCG will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

4.2.2. The values that lie at the heart of the CCG's work are:

a) We continue to be guided by the founding principle of the NHS – that good healthcare should be available to all, free at the point of delivery;
b) We place patients, health improvement and quality at the heart of everything we do;
c) We are honest and open about the actions and decisions we take;
d) We are accountable to the public and recognise our responsibility to act in the best interests of the population we serve;
e) Our decisions are evidence based, fair and make the best use of the resources we have available to us;
f) We act responsibly as a public sector organisation and are committed to working in partnership with local government, voluntary organisations and the wider community to ensure a united approach to tackling the wider determinants of poor health in Southwark.

4.3. Vision

4.3.1. We want the best possible health outcomes for our population and will achieve this by aiming to ensure that:

a) People live longer, healthier, happier lives no matter what their situation in life;
b) The gap in life expectancy between the richest and the poorest in our population continues to narrow;
c) The care local people receive is high quality, safe and accessible;
d) The services the CCG commissions are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy, and;
e) We make effective use of the resources available to us and always act to secure the best deal for Southwark.

4.4. Principles of Good Governance

4.4.1. In accordance with section 14L(2)(b) of the 2006 Act, the CCG will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

a) The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
b) *The Good Governance Standard for Public Services* (see link to report in glossary);
c) The standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles' (Appendix F);
d) The seven key principles of the *NHS Constitution* (Appendix G);
e) The Equality Act 2010.

4.5. Accountability

4.5.1. The CCG will demonstrate its accountability to its members, local people, stakeholders and the NHS Commissioning Board in a number of ways, including by:

a) Publishing its constitution;
b) Appointing independent Lay Members and non GP clinicians to its Governing Body;
c) Holding meetings of its Governing Body in public (except where the CCG considers that it would not be in the public interest in relation to all or part of a meeting);

d) Holding meetings of its Council of Members in public (except where the CCG considers that it would not be in the public interest in relation to all or part of a meeting) at least three times per annum;
e) Publishing annually a commissioning plan;
f) Complying with Local Authority health overview and scrutiny requirements;
g) Meeting annually in public to publish and present its annual report;
h) Producing annual accounts in respect of each Financial Year which must be externally audited;
i) Having a published and clear complaints process;
j) Complying with the Freedom of Information Act 2000;
k) Providing information to the NHS Commissioning Board as required.

4.5.2. In addition to these statutory requirements, the CCG will demonstrate its accountability through its Governing Body's Engagement and Patient Experience Committee ("EPEC") working within the Localities to engage with patients and the public and form Locality Public and Patient Engagement Groups in each Locality ("Locality PPGs") whose members will be drawn from the patient and public engagement groups of each Member Practice.

4.5.3. The CCG's Governing Body will also be a full member of the Health and Wellbeing Board established by the Local Authority.

4.5.4. In discharging its functions, the CCG will through its Governing Body, committees and sub-committees consult the LMC on decisions that impact on Member Practices in their delivery of primary care services and individual GPs in their professional roles. This shall be effected, for example, by holding and attending regular standing joint consultative meetings between the Governing Body and the LMC in accordance with an accountability framework to be agreed between the CCG and the LMC.

4.5.5. The Council of Members and Governing Body of the CCG will throughout each year have an ongoing role in reviewing the CCG's governance arrangements to ensure that the CCG continues to reflect the principles of good governance.

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

5.1.1. The functions that the CCG is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health's *Functions of clinical commissioning groups: a working document*. They relate to:

a) Commissioning certain health services (where the NHS Commissioning Board is not under a duty to do so) that meet the reasonable needs of:

   i) All people registered with Member Practices within the Area Covered, and
   ii) People who are usually resident within the Area Covered and are not registered with a member of any clinical commissioning group;

b) Commissioning emergency care for anyone present in the Area Covered;
c) Paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body (via its Remuneration Committee) and determining any other terms and conditions of service of the CCG's employees;
d) Determining the remuneration and other allowances of members of its Governing Body (via its Remuneration Committee).

5.1.2. In discharging its functions the CCG will:

a) Act, when exercising its functions to commission health services, consistently with the discharge by the Secretary of State for Health for Health and the NHS Commissioning Board of their duty to ***promote a comprehensive health service*** and with the objectives and requirements placed on the NHS Commissioning Board through the mandate published by the Secretary of State for Health before the start of each financial year by:

i) Reserving certain matters to the Member Practices and delegating responsibility for other matters to the Governing Body (in accordance with the Scheme of Reservation and Delegation as set out in Appendix D). The Governing Body shall discharge its functions either directly or by delegation to its committees;
ii) The Member Practices, acting through a Council of Members, agreeing the CCG's vision, values and overall strategic direction and approving its commissioning strategy;
iii) The Governing Body recommending the CCG's commissioning plan to the Council of Members and the Council of Members considering and approving it;
iv) The Governing Body preparing operational plans and operational budgets and implementing the commissioning plan through those operational plans and operational budgets;
v) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account;
vi) Facilitating two way communications between the Governing Body and the Member Practices through Localities.

b) ***Meet the public sector equality duty*** by:

i) Delegating responsibility to its Governing Body (in accordance with the Scheme of Reservation and Delegation as set out in Appendix D), which shall discharge such functions either directly or by delegation to its committees;
ii) Working with the Governing Body and its committees to implement plans;
iii) Through the Council of Members, monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account;
iv) Publishing information at least annually to demonstrate compliance with this duty;
v) Producing an annual update on the equality and diversity strategy and an annual work plan.

c) ***Promote integration*** of *both* health services with other health services *and* health services with health-related and social care services, where the CCG considers that this would improve the quality of services or reduce inequalities, and work in partnership with the Local Authority to develop ***joint strategic needs assessments*** and ***joint health and wellbeing strategies*** by:

i) Requiring the Chief Officer, Chair of the Governing Body and up to two further GP Representatives to be full and active members of the Southwark Health and Wellbeing Board;
ii) Inviting a representative from Southwark Local Authority to participate as a non-voting member of the Governing Body;
iii) Requiring the Governing Body to provide assurance to the Council of Members that the CCG's commissioning plans take into account the joint strategic needs assessments and joint health and wellbeing strategies;
iv) Require the Governing Body to work within the Localities to implement plans;
v) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees, and holding the Governing Body to account.

5.2. **General Duties** - in discharging its functions the CCG will:

5.2.1. Make arrangements to ***secure patient and public engagement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements, ***promote the engagement of patients, their carers and representatives in decisions about their healthcare*** and ***enable patients to make choices*** by:

a) The Governing Body delegating responsibility for engagement to the EPEC, monitoring the progress of the EPEC's work and holding the EPEC to account for delivery of the communications and engagement strategy, implementation plan and annual refresh;
b) The EPEC working within the Localities to form Locality PPGs;
c) Inviting a member of Southwark Health Watch to become a voting member of the Governing Body and to become a member of the EPEC;
d) Ensuring all Quality, Innovation, Productivity and Prevention ("QIPP") plans include detailed engagement plans;
e) Ensuring best practice in engagement activities to meet the needs of a wide range of communities, including those with unmet needs;
f) Publishing information about health services on the CCG's Website and through other media;
g) Encouraging and acting on feedback received from patients and the public;
h) The Integrated Governance and Performance Committee implementing a complaints procedure that is compliant with the relevant statutory framework and investigating and acting on complaints and concerns;
i) The Integrated Governance and Performance Committee monitoring and providing assurance on patient safety and reporting regularly to the national reporting and learning system;
j) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account.

5.2.2. ***Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution*** by:

a) The Member Practices, acting through a Council of Members, agreeing the CCG's vision, values and overall strategic direction and setting its commissioning strategy so that it reflects the NHS Constitution;
b) The Governing Body recommending the CCG's commissioning plan to the Council of Members and the Council of Members considering it, ensuring it reflects the NHS Constitution and approving it;
c) The Governing Body implementing the commissioning plan;
d) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account.

5.2.3. ***Secure continuous improvement to the quality of services*** and act ***effectively, efficiently and economically*** by:

a) Reserving certain matters to the Member Practices and delegating responsibility for other matters to the Governing Body (in accordance with the Scheme of Reservation and Delegation as set out in Appendix D). The Governing Body shall discharge its functions either directly or by delegation to its committees;
b) The Member Practices, acting through a Council of Members, agreeing the CCG's vision, values and overall strategic direction and setting its commissioning strategy;
c) The Governing Body recommending the CCG's commissioning plan to the Council of Members and the Council of Members considering and approving it;
d) The Governing Body preparing operational plans and operational budgets and implementing the commissioning plan through those operational plans and operational budgets;
e) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account;
f) Facilitating two way communications between the Governing Body and the Member Practices through Localities;
g) Appointing internal and external auditors;
h) Acting on patient feedback and in particular identifying and tackling quality and safety issues through the EPEC and the Integrated Governance and Performance Committee;
i) Put arrangements in place to deal with and learn from serious untoward incidents and never events through the Integrated Governance and Performance Committee and EPEC.

5.2.4. ***Assist and support the NHS Commissioning Board*** in relation to the Board's duty to improve the quality of commissioned services by:

a) The CCG monitoring, benchmarking and improving the quality of all services through clinical governance and clinical audit in particular, this being a key role of the Integrated Governance and Performance Committee;
b) The CCG working collaboratively with the NHS Commissioning Board to address variability and service improvements and to engage patients and the public;
c) The CCG working in partnership with NHS Commissioning Board to improve the quality of specialised services;
d) Member Practices in their Localities sharing data and benchmarking primary care outcome indicators across Member Practices;
e) Working in a joint advisory group with other clinical commissioning groups across South East London (as described in clause 6.7 below) to examine system-wide care pathway performance of primary care.

5.2.5. Have regard to the need to ***reduce inequalities*** by:

a) Reserving certain matters to the Member Practices and delegating responsibility for other matters to the Governing Body (in accordance with the Scheme of Reservation and Delegation as set out in Appendix D). The Governing Body shall discharge its functions either directly or by delegation to its committees;
b) The Member Practices, acting through a Council of Members, agreeing the CCG's vision, values and overall strategic direction and setting its commissioning strategy;
c) The Governing Body recommending the CCG's commissioning plan to the Council of Members and the Council of Members considering and approving it, ensuring that it includes measures to reduce inequalities in its content;
d) The Governing Body preparing operational plans and operational budgets and implementing the commissioning plan through those operational plans and operational budgets;
e) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account;
f) Facilitating two way communications between the Governing Body and the Member Practices through Localities;
g) Ensuring best practice in engagement activities to meet a wide range of communities and to reach these with unmet needs and unexpressed demands.

5.2.6. ***Obtain appropriate advice*** from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) Delegating responsibility to its Governing Body (in accordance with the Scheme of Reservation and Delegation as set out in Appendix D), which shall discharge such functions either directly or by delegation to its committees;
b) Assisting the Governing Body to develop strategy and implementation plans and working with the Governing Body and its committees to implement plans;
c) Monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account.

5.2.7. ***Promote innovation*** and ***promote research and the use of research*** and by:

a) The Member Practices, acting through a Council of Members, agreeing the CCG's vision, values and overall strategic direction and setting its commissioning strategy, taking into account relevant findings from research;
b) The Governing Body recommending the CCG's commissioning plan to the Council of Members and the Council of Members considering it, ensuring that it promotes innovation, research and the use of research, and approving it;
c) The committees of the Governing Body (including, in particular, the Integrated Governance and Performance Committee and the Commissioning Strategy Committee) being tasked in their terms of reference with the promotion of innovation, research and the use of research;

d) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account.

5.2.8. Have regard to the need to ***promote education and training*** for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty by:

a) Reserving certain matters to the Member Practices and delegating responsibility for other matters to the Governing Body (in accordance with the Scheme of Reservation and Delegation as set out in Appendix D). The Governing Body shall discharge its functions either directly or by delegation to its committees;
b) The Member Practices, acting through a Council of Members, agreeing the CCG's vision, values and overall strategic direction and setting its commissioning strategy;
c) The Governing Body recommending the CCG's commissioning plan to the Council of Members and the Council of Members considering it, ensuring that it promotes education and training, and approving it;
d) The Governing Body preparing operational plans and operational budgets and implementing the commissioning plan through those operational plans and operational budgets;
e) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account;
f) Facilitating two way communications between the Governing Body and the Member Practices through Localities.

5.3. **General Financial Duties** – the CCG will perform its functions so as to:

a) ***Ensure its expenditure does not exceed the aggregate of its allotments for the Financial Year;***
b) ***Ensure its use of resources*** *(both its capital resource use and revenue resource use)* ***does not exceed the amount specified by the NHS Commissioning Board for the Financial Year;***
c) ***Take account of any directions issued by the NHS Commissioning Board, in respect of specified types of resource use in a financial year, to ensure the CCG does not exceed an amount specified by the NHS Commissioning Board, and;***
d) ***Publish an explanation of how the CCG spent any payment in respect of quality*** made to it by the NHS Commissioning Board

By:

i) Appointing appropriately qualified Chief Officer and Chief Financial Officer;
ii) Reserving certain matters to the Member Practices and delegating responsibility for other matters to the Governing Body and to the Chief Officer and Chief Financial Officer (in accordance with the Scheme of Reservation and Delegation as set out in Appendix D);
iii) The Member Practices, acting through the Council of Members, agreeing the CCG's vision, values and overall strategic direction and setting its commissioning strategy;
iv) The Governing Body recommending the CCG's commissioning plan to the Council of Members and the Council of Members considering it, ensuring that it promotes innovation, research and the use of research, and approving it;
v) The Chief Financial Officer and the Chief Officer preparing the CCG's operational scheme of delegation;
vi) The Chief Financial Officer preparing the detailed financial policies and the Governing Body considering and approving them;
vii) The Governing Body preparing operational plans and operational budgets and implementing the commissioning plan through those operational plans and operational budgets;
viii) The Council of Members monitoring progress through performance reports and minutes of meetings of the Governing Body and its committees and holding the Governing Body to account;
ix) Facilitating two way communications between the Governing Body and the Member Practices through Localities;

x) Publishing an annual report which will include annual accounts and a remuneration report;
xi) Submitting to audit.

5.4. Other Relevant Regulations, Directions and Documents

5.4.1. The CCG will:

a) Comply with all relevant regulations;
b) Comply with directions issued by the Secretary of State for Health or the NHS Commissioning Board, and;
c) Take account, as appropriate, of documents issued by the NHS Commissioning Board.

5.4.2. The CCG will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its Scheme of Reservation and Delegation (as set out in Appendix D) and other relevant CCG policies and procedures.

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

6.1.1. The CCG is a membership organisation and the Member Practices are accountable for exercising its statutory functions.

6.1.2. The CCG may grant authority to act on its behalf to:

a) Its Council of Members;
b) Its Governing Body;
c) Its employees;
d) Any committee or sub-committee of the Governing Body;
e) Any of its Member Practices in their Localities.

6.1.3. The CCG remains accountable for all of its functions, including those that it has delegated.

6.1.4. A diagram of the CCG's governance structure is attached at part 2 of Appendix A.

6.2. Scheme of Reservation and Delegation

6.2.1. The extent of the authority to act of the various bodies mentioned at 6.1.2 depends on the powers delegated to them by the CCG as expressed through:

a) The CCG's Scheme of Reservation and Delegation (as set out in Appendix D); and
b) For committees, their terms of reference (included in Appendix C).

6.2.2. The Scheme of Reservation and Delegation sets out the key functions of the CCG and to whom the CCG has delegated responsibility for fulfilling these. The Member Practices are involved in decision making by:

a) Reserving to themselves key strategic functions, which they shall exercise through the Council of Members;
b) Delegating other strategic functions and all operational functions to the Governing Body (which it may exercise either directly or by delegation to its committees), the Chief Officer and the Chief Financial Officer;
c) Each appointing a Practice Representative (and a Deputy Practice Representative) to attend meetings of the Council of Members;
d) Working in their Localities to:
    i) Discuss Locality priorities and inform the Governing Body of these, so that the Governing Body can take them into account in its preparation of commissioning plans

and budgets for the CCG, prior to submitting them to the Council of Members for approval;

ii) Facilitate communications between Member Practices within the Localities and between the Member Practices and the Governing Body.

6.3. General

6.3.1. In discharging functions of the CCG that have been delegated to its Governing Body (and its committees), committees and individuals must:

a) Comply with the CCG's principles of good governance;
b) Operate in accordance with the CCG's Scheme of Reservation and Delegation;
c) Comply with the CCG's standing orders;
d) Comply with the CCG's arrangements for discharging its statutory duties;
e) Ensure that Member Practices have had the opportunity to contribute to the CCG's decision making process.

6.3.2. When discharging their delegated functions, committees must also operate in accordance with their approved terms of reference.

6.4. The Localities

6.4.1. Member Practices are organised in three Localities: South Southwark; Bermondsey and Rotherhithe, and; Borough and Walworth.

6.4.2. The Localities do not have delegated strategic or CCG wide operational decision making powers. They have the following functions, to:

a) Discuss Locality priorities and inform the Governing Body of these, so that the Governing Body can take them into account in its preparation of commissioning plans and budgets for the CCG, prior to submitting them to the Council of Members for approval;
b) Facilitate communications between Member Practices within the Localities and between the Member Practices and the Governing Body;
c) Implement any project specific operational plans delegated to the Localities by the Governing Body, Chief Officer, Chief Financial Officer or any committee;
d) Facilitate Member Practices working together and supporting one another to achieve improvements in services.

There shall be no restrictions on who from Member Practices may attend Locality meetings. Specifically, practice nurses, allied health professionals and practice managers from Member Practices shall be encouraged to attend Locality meetings.

6.5. The Council of Members

6.5.1. ***Functions*** – To exercise the key strategic functions the Member Practices have reserved to themselves and to hold the Governing Body and the officers of the CCG to account for fulfilling their duties and to be held to account by the Governing Body and officers of the CCG in respect of their contribution to the success of the CCG.

6.5.2. ***Composition*** - Each Member Practice shall appoint a Practice Representative to the Council of Members. Each Member Practice may change its Practice Representative from time to time, on prior written notice to the Governing Body. The Practice Representatives shall elect a chair of the Council of Members from amongst their number.

Where a Practice Representative is unavailable for any reason, Member Practices shall have a Deputy Practice Representative to deputise for the Practice Representative, as set out in clause 7.1 below.

6.5.3. ***Voting rights*** – Each Member Practice shall have one vote which shall be exercised on its behalf by its Practice Representative.

6.6. The Governing Body

6.6.1. ***Functions*** - the Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with the other functions connected with its main functions as may be specified in regulations or in this constitution. The Governing Body functions and responsibilities shall include:

a) Ensuring that the CCG has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the CCG's *principles of good governance* (its main function);
b) Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act as advised by the Remuneration Committee;
c) Approving any functions of the CCG that are specified in regulations;
d) Assessing capacity requirements and quality assuring internal capabilities, shared services and commissioning support services;
e) All other functions of the CCG, as set out at paragraph 5 above.

6.6.2. ***Composition*** - the Governing Body shall be clinically led and include no fewer than eleven clinical members. It shall comprise:

a) Eight GP Representatives of Member Practices (all voting), one of whom shall be the Chair of the Governing Body (who shall not have a casting vote);
b) Three lay members (all voting), one of whom shall be appointed by the Governing Body to be Deputy Chair of the Governing Body;
    i) one to lead on audit, remuneration and conflict of interest matters;
    ii) one to lead on patient and public engagement matters;
    iii) one to lead on quality of commissioned services;
c) Two registered nurses (both voting);
    i) one from secondary care or community care; and
    ii) one practice nurse from a Member Practice;
d) One secondary care specialist doctor (voting);
e) The Chief Officer (voting);
f) The Chief Financial Officer (voting);
g) A Public Health representative (voting);
h) A Health Watch representative (voting);
i) One Local Authority employee (non-voting);
j) The CCG Director of service redesign (non-voting);
k) The CCG Director of client groups and partnerships (non-voting);
l) A representative of the LMC (non-voting).

6.6.3. From time to time, up to two other non-voting members may be co-opted as additional members of the Governing Body.

6.6.4. There will always be a voting majority of clinical professionals on the Governing Body. Voting status may be changed by agreement of the Council of Members.

6.6.5. ***Committees of the Governing Body*** - the Governing Body has appointed the following committees and sub-committees, all of whom have delegated authority to form committees and sub-committees to assist them in the discharge of their duties:

a) **Audit Committee** –provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance, and assurance on risk and fraud issues;

b) **Remuneration Committee** –makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide

services to the CCG and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme;

c) **Integrated Governance and Performance Committee** – monitors and provides the Governing Body with assurance on finance, QIPP, performance, quality and safety; will proactively identify and notify the Governing Body of early warning signs of a failing community or secondary care service (as set out in the National Quality Board's document "Review of Early Warning Systems in the NHS" published February 2010, a copy of which will be available on the CCG's Website); maintains the CCG's assurance framework and risk registers; monitors, investigates and acts on complaints and concerns; works with Member Practices to implement plans and undertake designated actions in the Localities; provides the Governing Body with assurance on legal compliance and effectiveness of the CCG's policies and activities on safeguarding, information governance, equality and diversity;

d) **Commissioning Strategy Committee** - oversees the development and implementation of the CCG's strategic plans and commissioning intentions, taking into account information received from Localities and the Council of Members on commissioning strategy and priorities; scrutinises the ongoing efficacy of commissioned services where service developments are identified; works with Member Practices to implement plans and undertake designated actions in the Localities; receives reports from strategic programme boards charged with overseeing major commissioning programmes;

e) **Engagement and Patient Experience Committee** – is responsible for ensuring that a range of patient experience data is captured and acted upon and informs commissioning decisions, and; to monitor patient engagement and advise the Governing Body on the subject, ensuring account is taken to reach those with unexpressed demands and needs.

All of the committees set out above are accountable to the Governing Body and the Governing Body has approved and keeps under review the terms of reference for the committees, which includes information on the membership of the committees.

6.7. **Joint Arrangements**

6.7.1. The CCG has entered into joint advisory arrangements with clinical commissioning groups across South East London. These arrangements include arrangements for informal cross CCG working, to plan pan CCG wide approaches and to make recommendations to the Governing Body and the Governing Body's committees on issues such as:

a) Collaborative contracting with providers;
b) System-wide pathways commissioned with primary care;
c) Implementation of shared programmes and cross-clinical commissioning group QIPP initiatives;
d) Sharing thinking and learning in relation to clinical commissioning and develop joint strategies and plans.

6.7.2. The CCG works with the Local Authority on the Safeguarding Adults Board, Local Safeguarding Children Board and the Health and Wellbeing Board.

6.7.3. The CCG has joint arrangements with the Local Authority, including:

a) arrangements made pursuant to s256 of the National Health Service Act 2006;
b) Plans to collaborate on public health matters, integrated care pathways, reducing health inequalities and other areas through a joint advisory group, the "Southwark Joint Commissioning Group".

7. ROLES AND RESPONSIBILITIES

7.1. Practice Representatives on the Council of Members

7.1.1. Practice Representatives shall represent their Member Practice's views and act on behalf of their Member Practice in matters relating to the CCG. The role of each Practice Representative is to:

a) Represent his/her Member Practice at meetings of the Council of Members;
b) Act as the contact and communications lead for his/her Member Practice partners and staff in respect of all matters concerning the CCG, acting as the channel for two-way communications between the CCG and the Member Practice;
c) Be committed to upholding the NHS Constitution and the Nolan Principles;
d) Develop a sound understanding of clinical commissioning, the CCG and the wider interests of the health community;
e) Vote on proposals when required to do so (or a Deputy Practice Representative in accordance with paragraph 3.6.2 of Appendix C (Standing Orders));
f) Represent the majority view of the Council of Members within his/her Member Practice;
g) Foster engagement of his/her Member Practice in Locality wide and CCG wide initiatives and the implementation of the CCG's mission, values and aims through its operational plans;
h) Ensure delivery of operational plans in his/her Member Practice.

7.1.2. Member Practices shall also have a Deputy Practice Representative to deputise for the Practice Representative when he/she is unavailable for any reason.

7.2. Chair of Council Members

7.2.1. The Chair of the Council of Members will:

a) Lead the Council of Members, ensuring that it remains able to discharge its duties and responsibilities set out in this constitution;
b) Lead the Practice Representatives and help the Member Practices to influence the work of the CCG;
c) Contribute to building a shared vision of the mission, values, vision and culture of the CCG;
d) Ensure Member Practices, patients and the public's views are heard and understood, and insofar as possible, met;
e) Support the Member Practices to implement through the Localities the commissioning plans approved by the Council of Members in accordance with the corporate budgets approved by the Council of Members;
f) Hold the Governing Body and its members to account for performance of their roles as set out in this constitution and in their job descriptions.

7.3. GP Representatives on the Governing Body and other Primary Care Health Professionals

7.3.1. In addition to the Practice Representatives identified in section 7.1 above, the CCG has identified a role for eight GP Representatives on the Governing Body and may identify a number of other GPs / primary care health professionals from Member Practices to either support the work of the CCG and / or represent the CCG rather than represent their own individual practices. All of these GP Representatives, GPs and primary care health professional undertake the following roles on behalf of the CCG:

a) Participate in working groups and committees;
b) Become involved in clinical training events, and;
c) Provide professional advice on particular projects and commissioned services.

7.4. All Members of the CCG's Governing Body

7.4.1. Guidance on the roles of members of the Governing Body is set out in a separate document by the NHS Commissioning Board "Clinical Commissioning Group Governing Body Members – Roles, Attributes and Skills".

7.4.2. Each member of the Governing Body will share responsibility as part of a team to ensure that the CCG exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.5. The Chair of the Governing Body

7.5.1. The role of Chair of the Governing Body is fully defined in a job description available on the CCG's Website. It has been summarised in a national document as:

a) Leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
b) Building and developing the Governing Body and its individual members;
c) Ensuring that the CCG has proper constitutional and governance arrangements in place;
d) Ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;
e) Supporting the Chief Officer in discharging the responsibilities of the organisation;
f) Contributing to building a shared vision of the aims, values and culture of the organisation;
g) Leading and influencing to achieve clinical and organisational change to enable the CCG to deliver its commissioning responsibilities;
h) Overseeing governance and particularly ensuring that the Governing Body and the wider CCG behaves with the utmost transparency and responsiveness at all times;
i) Ensuring that public and patients' views are heard and their expectations understood and, where appropriate, these views and expectations are met as far as is possible;
j) Ensuring that the organisation is able to account to its local patients, stakeholders and the NHS Commissioning Board;
k) Ensuring that the CCG builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority(ies);
l) Being the senior clinical voice of the CCG and taking the lead in interactions with stakeholders, including the NHS Commissioning Board.

7.6. The Deputy Chair of the Governing Body

7.6.1. The Deputy Chair of the Governing Body will be one of the three lay members on the Governing Body, appointed by the Governing Body. He/she will deputise for the Chair of the Governing Body where the Chair of the Governing Body has a conflict of interest or is otherwise unable to act.

7.7. Role of the Chief Officer

7.7.1. The Chief Officer of the CCG is a member of the Governing Body.

7.7.2. This role of Chief Officer is fully defined in a job description available from the CCG's Website. It has been summarised in a national document as:

a) Being responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;
b) At all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems;
c) Working closely with the chair of the Governing Body, the Chief Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the Member Practices (through the Governing Body) of the CCG's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.

7.8. Role of the Chief Financial Officer

7.8.1. The Chief Financial Officer is a member of the Governing Body and is responsible for providing financial advice to the CCG and for supervising financial control and accounting systems.

7.8.2. This role of Chief Financial Officer is fully defined in a job description available from the CCG's Website. It has been summarised in a national document as:

a) Being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
b) Making appropriate arrangements to support, monitor on the CCG's finances;
c) Overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources;
d) Being able to advise the Governing Body on the effective, efficient and economic use of the CCG's allocation to remain within that allocation and deliver required financial targets and duties; and
e) Producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to the NHS Commissioning Board.

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. Standards of Business Conduct

8.1.1. Member Practices, members of the Governing Body (and its committees and sub-committees) and employees will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the CCG and should follow the *Seven Principles of Public Life*, set out by the Committee on Standards in Public Life (the Nolan Principles). The Nolan Principles are incorporated into this constitution at Appendix F.

8.1.2. Employees, members, committee and sub-committee members of the CCG and members of the Governing Body (and its committees) must comply with the CCG's policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the CCG's Website.

8.1.3. Individuals contracted to work on behalf of the CCG or otherwise providing services or facilities to the CCG will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

8.1.4. Employees, members, committee and sub-committee members of the CCG, members of the Governing Body (and its committees), individuals contracted to work on behalf of the CCG or otherwise providing services or facilities to the CCG must comply with provisions of the Bribery Act 2010.

8.2. Conflicts of Interest

8.2.1. As required by section 14O of the 2006 Act, as inserted by Section 25 of the 2012 Act, the CCG will make arrangements to manage conflicts and potential conflicts of interests to ensure that decisions made by the CCG will be taken and seen to be taken without any possibility of the influence of external or private interest.

8.2.2. Where an individual employee, Member Practice, member of the Governing Body, member of a committee or a sub-committee has an interest, or becomes aware of an interest which could lead to a conflict of interests, that must be considered a potential conflict of interests, and is subject to the provisions of this constitution.

8.2.3. A conflict of interest will include:

a) A direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);
b) An indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;
c) A non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);
d) A non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for

example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

e) Where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

8.2.4. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

8.3. Declaring and Registering Interests

8.3.1. The CCG will maintain one or more registers of the interests of:

a) The Member Practices of the CCG;
b) The members of its Governing Body;
c) The members of its committees or sub-committees and the committees or sub-committees of its Governing Body; and
d) Its employees.

8.3.2. The registers will be published on the CCG's Website.

8.3.3. The Chief Officer will hold and maintain the registers.

8.3.4. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the CCG, in writing to the Governing Body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

8.3.5. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

8.3.6. The Audit Committee will ensure that the register of interests is reviewed regularly, and updated as necessary.

8.4. **Managing Conflicts of Interest: general**

8.4.1. The CCG's policy for management of conflicts of interest, at Appendix H, shall apply and conflicts shall be managed accordingly. This includes holding a panel to consider issues of conflict for members, chaired by the lay member of the Governing Body with responsibility for audit, remuneration and conflict of interest matters (who is referred to in the policy as the "guardian for CoI"). The results of any such panel will be reported in the CCG meetings, and ratified there.

8.5. Managing Conflicts of Interest: contractors and people who provide services to the CCG

8.5.1. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the CCG in relation to the potential provision of services or facilities to the CCG, will be required to make a declaration of any relevant conflict / potential conflict of interest.

8.5.2. Anyone contracted to provide services or facilities directly to the CCG will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.6. Transparency in Procuring Services

8.6.1. The CCG recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The CCG will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

8.6.2. The CCG will publish a Procurement Strategy approved by its Governing Body which will ensure that:

a) all relevant clinicians (not just members of the CCG) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services, and;
b) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way

8.6.3. Copies of this Procurement Strategy will be available on the CCG's Website.

9. THE CCG AS EMPLOYER

9.1. The CCG recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the CCG, whatever their role or status in the CCG.

9.2. The CCG will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.

9.3. The CCG will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the CCG. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.

9.4. The CCG will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The CCG will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters

9.5. The CCG will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.

9.6. The CCG will ensure that employees' behaviour reflects the values, aims and principles set out above.

9.7. The CCG will ensure that it complies with all aspects of employment law.

9.8. The CCG will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.

9.9. The CCG will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned staff have the means through which their concerns can be voiced.

9.10. Copies of this Code of Conduct, together with the other policies and procedures outlined in this clause, will be available on the CCG's Website.

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. General

10.1.1. The CCG will publish annually a commissioning plan and an annual report, presenting the CCG's annual report to a public meeting.

10.1.2. Key communications issued by the CCG, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues and certain papers will be published on the CCG's Website.

10.1.3. The CCG may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

10.2. Supporting Governance Documents

10.2.1. This constitution is also informed by a number of documents which provide further details on how the CCG will operate. They are the CCG's:

a) ***Standing Orders (Appendix C)*** – which sets out the arrangements for meetings and the appointment processes to elect the CCG's representatives and appoint to the CCG's committees (including the Governing Body) and annexed to Appendix C are the terms of reference for the Governing Body's committees which are as follows:
   i) Audit Committee;
   ii) Remuneration Committee;
   iii) Integrated Governance and Performance Committee (which has the following sub-committees:
      - Finance and QIPP
      - Safeguarding Executive);
   iv) Commissioning Strategy Committee and;
   v) Engagement and Patient Experience Committee;

b) ***Scheme of Reservation and Delegation (Appendix D)*** – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the Governing Body, the Governing Body's committees and sub-committees, the CCG's committees and sub-committees, individual members and employees;

c) ***Prime Financial Policies (Appendix E)*** – which sets out the arrangements for managing the CCG's financial affairs;

d) ***Nolan Principles in Public Life (Appendix F)–*** which sets out standards for public office;

e) ***NHS Constitution (Appendix G)–*** which details the key standards that the National Health Service should maintain and improve for its population;

f) ***Management of Conflicts of Interests (Appendix H)*** – which sets out the manner in which the CCG will deal with conflicts of interests;

g) ***Joint Arrangements with Other Clinical Commissioning Groups (Appendix I)–*** as detailed in section 6.7 above;

h) ***Procurement Strategy(Appendix J)-*** as referenced in the Constitution, Standing Orders and Prime Financial Policies;

i) ***Whistle blowing policy (Appendix K)–*** as referenced in the Conflict of Interest Policy;

j) ***List of Current Clinical and Corporate Policies (Appendix L)*** – as referred to in this Constitution, and its appendices.

10.2.2. In a situation of conflict between the provisions of this constitution and its appendices, the provisions of this constitution shall prevail.

EMBARGOED UNTIL 10:00 FRIDAY 27 JULY 2012

Health merger moves a step closer

Three leading NHS foundation trusts have today moved a step closer to merging to create a single academic healthcare organisation, closely integrated with their university partner. The new organisation would build on the existing partnership between the organisations to deliver benefits for patients, staff and students.

The Boards of Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS foundation trusts have each agreed to continue exploring plans for an organisational merger and a strengthened partnership with King's College London, their joint academic partner. The proposal is set out in a Strategic Outline Case which was approved by each of the Boards and King's College London, although the university would not be a legal partner in any merger.

Professor Sir Robert Lechler, Executive Director, King's Health Partners said:

"The new organisation would mean better care for our patients, a faster translation of research into treatments and an integration of mental and physical health rarely seen elsewhere. It would give us the opportunity to create a world leading institution, capable of attracting the best clinicians, that our patients, communities and staff can be proud of."

If a full business case for this proposal is approved by the boards of the partner organisations and the regulators, it is hoped that the merger could take legal effect in 2014. The partners, however, recognise that there are uncertainties around the timeline to the new organisation. The regulatory process under the new Health and Social Care Act 2012 is unclear and the implications of a trust special administrator being appointed to resolve the future of South London Healthcare Trust (SLHT) are unknown. The NHS partners are keen to play a constructive part in the SLHT solution and will actively engage with the Department of Health, Monitor and competition authorities to better understand the time scales, while making preparations for a full business case.

The new organisation would have a turnover of about £2.6 billion and around 29,000 staff, but would be structured so that decisions were taken locally, giving staff greater autonomy and making the organisation more accountable to its patients and commissioners.

The four organisations have collaborated for many years and were accredited by the Department of Health as an academic health sciences centre, King's Health Partners in 2009. Working together has led to good examples of better care for patients across the three trusts and better research being undertaken and translated into treatments. The proposal to merge is based on accelerating these benefits and removing some of the structural and cultural obstacles to greater collaboration.

The full business case would test rigorously that the benefits this proposal is based on can be realised and that the risks can be properly managed. There will also be thorough engagement with everyone who might be interested or concerned, including local people and their representatives, our staff, the organisations that provide funding, regulators and other stakeholders. By bringing together three leading NHS organisations with mental health at the core, with a leading university, King's Health Partners will be positioned to make real

improvements to the health of one of the most diverse and challenged communities in the country.

ENDS

The Strategic Outline Case can be downloaded at: www.kingshealthpartners.org. For interview requests please contact Sarah Crack, Communications Manager, King's Health Partners sarah.crack@kcl.ac.uk 020 7188 4058.

King's Health Partners Academic Health Sciences Centre (AHSC) is a pioneering collaboration between King's College London, and Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts.

King's Health Partners is one of only five AHSCs in the UK and brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health. Our combined strengths will drive improvements in care for patients, allowing them to benefit from breakthroughs in medical science and receive leading edge treatment at the earliest possible opportunity.

For more information, visit www.kingshealthpartners.org

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

King's Health Partners

Strategic Outline Case:
creating a single academic healthcare organisation

July 2012

CONTENTS

EXECUTIVE SUMMARY

1. King's Health Partners, accredited by the Department of Health as an Academic Health Sciences Centre (AHSC) in 2009, is a partnership between King's College London (KCL) and three NHS Foundation Trusts: Guy's and St Thomas' (GStT), King's College Hospital (KCH) and South London and Maudsley (SLaM). In February 2012 the four partners agreed to look at the case for creating a single academic healthcare organisation. The partners are in a position of strength but the proposition is that the new organisation could achieve more and at greater pace, allowing King's Health Partners to respond to a changing world and the future needs of patients.

2. If the health challenge of the last century was the treatment of infectious disease, this century's challenge is dealing with long-term conditions. Diabetes rates, for example, are expected to grow by 60% over the next 20 years. Many more people have both physical and mental health challenges. This is particularly the case in the kind of deprived and diverse communities that King's Health Partners serves across south London, where levels of health inequalities are high.

3. But the health system has not kept up with these changes. It remains focussed on disease and illness rather than promoting health and wellbeing. The mind and the body are treated separately. Services are fragmented and not always patient-centred. Research and education can appear quite distant from the reality of healthcare problems. As an integrated organisation, King's Health Partners would be better able to develop a new model of healthcare to help meet this challenge and improve the quality of life for our patients.

4. The academic world is also changing. Global competition for the best students, research talent and resources is increasing. At the same time, medical research is becoming increasingly complex, which requires organisational scale and a broad range of expertise.

5. The wider economic context presents a further serious challenge. While demand for healthcare and the costs of healthcare are rising, NHS funding may, at best, be held steady for the next decade. This means the NHS needs innovative new models of healthcare that radically improve value for the patients and the system.

6. So although King's Health Partners has achieved a great deal in its current form, we believe we could respond better to this changing environment if we created a more integrated organisation. This would enable us to align our priorities, give us greater financial flexibility, make it easier to work with local partners, and give us the organisational scale to transform how we work. As a result, we could more effectively achieve our vision.

7. **Our vision for the new organisation is to be a leader, locally and globally, in improving health and wellbeing**. **We aspire to be one of the top ten global academic healthcare organisations and to bring these benefits to our local communities, patients and students.**

8. King's Health Partners is uniquely positioned to do this because it brings together three successful trusts, with mental health at the core, with a leading university, all serving one of the most diverse and challenged communities in the country.

9. Working closely with partners across the health and care system and beyond, we have six goals for the new organisation:

   - **Provide care around people's needs.** We will aim to work in partnership across the health and care system to integrate care around the patient, and to overcome traditional distinctions between mind and body (for example, through routine screening for depression, alcohol and dementia). Better understanding people's full care needs will enable us to provide better value care in more appropriate settings.
   - **Keep people well.** Intervening earlier and working with our partners, including patients themselves, we hope to develop new approaches to the main health challenges of our local population, such as alcohol and childhood obesity.
   - **Provide the best specialist care when it is needed.** By bringing together our specialist services we aim to improve patient outcomes for the most pressing health challenges our communities face and to enhance our research.
   - **Train the workforce of today and tomorrow.** Through better teaching and facilities, we hope to produce the highest quality graduates and develop our staff to their full potential. To help shape the healthcare workforce of the future, we will develop new ways of learning and new professional roles.
   - **Turn world-leading research into treatments as quickly as possible.** We aim to speed up translational research to create new drugs and treatments that benefit our local patients first. We will seek to develop new research opportunities by working with our diverse local population and by using the strengths across our university.
   - **Build prosperity for our local communities and the UK.** We aim to attract new commercial, fundraising and grant income, which will help contribute to the local economy through new jobs and investment. We will seek to improve the productivity of all our services, and reinvest these savings in better care.

10. **To achieve this vision we propose creating a single organisation through the merger of the three NHS Foundation Trusts (with mental health at its core), enhanced by closer integration with KCL and a stronger academic ethos**. **This would create the UK's most integrated and innovative academic healthcare organisation.**

11. We envisage that the new organisation would deliver benefits for our patients, public, staff, students, commissioners and other providers, including:

    Better health

    - **More integrated care**. Integrating care across the new organisation would help ensure patients' full mental and physical needs are met, for example by addressing the physical health needs of patients with serious mental illness, and through earlier identification and treatment of the 40% of hospital inpatients with dementia.
    - **Better patient experience**. A shared electronic patient record across the new organisation could help engage patients in their own care, avoid them having to repeat information unnecessarily, and improve patient safety.
    - **Better patient outcomes**. Consolidating certain specialist services could lead to better patient outcomes, because of the close relationship between quality and numbers of patients treated.

Better research and education

- **Higher quality research**. Locating academic and clinical staff and services together would encourage innovation in research and new medical breakthroughs that can swiftly be turned into improved patient care.
- **Better educational experience**. Better teaching, facilities and career opportunities would improve the educational experience and help King's Health Partners attract the best students and staff.

Better value

- **Better use of physical space**. Working more closely with community and mental health services would enable services to be brought closer to patients, and help the new organisation to make more efficient and creative use of its estate, which is made up of more than 225 locations across south London and beyond.
- **More efficient services.** The new organisation would enable us to improve value for money for patients and taxpayers across the health and care system. Estimates suggest 3-5% savings in non-clinical support functions alone could be achieved in the new organisation, which could be reinvested in better care for patients.
- **New jobs and investment**. The new organisation would help to attract new investment in our local communities from industry, fundraising, and grant-makers, helping create new jobs and encourage regeneration.

12. We recognise that an organisational change of this scale is a significant undertaking and that people will have a number concerns and questions, some of which are set out below.

- **Would merger lead to local services closing?** Core local health services would continue to be provided on multiple sites, for example, the two Accident and Emergency departments and two maternity units would remain in their current locations.
- **Would mental health issues be less prominent?** Mental health is central to the vision of the new organisation. We would aim to lead the UK in demonstrating equal treatment for mental and physical health at every level of the new organisation, and develop new ways of caring for patients with both mental and physical health needs.
- **Would academic issues be neglected?** A defining characteristic of King's Health Partners is academic excellence. This would be reflected in the organisational model at every level.
- **Would this change affect organisational performance?** We would put measures in place to try and minimise disruption to business as usual, including a dedicated transition team to oversee the merger planning and implementation.
- **Would the new organisation be too inflexible?** Organisational scale gives us the opportunity to transform the business, for example by developing delivery arms organised around patient pathways or population groups, which could be more autonomous and flexible in how they work.
- **How would cultural and staff issues of integration be handled?** If we proceed to the next stage of the process, engaging with staff to understand their priorities and concerns would be a high priority. We would work with them to build the culture and values of the new organisation, drawing on the best of the existing institutions.

13. Further detailed work would need to be undertaken at the next stage, but on the basis of the preliminary assessment undertaken in this paper we believe that the benefits of the new organisation outweigh the costs and risks. If the partner organisations decide to proceed on the path to establishing this new organisation, the next step would be to create a Full Business Case by early 2013. We estimate that the new organisation could be in place at the earliest by late 2014.

1. BACKGROUND AND PURPOSE

1.1 King's Health Partners Academic Health Sciences Centre (AHSC) is a pioneering collaboration between King's College London (KCL) and three NHS Foundation Trusts (FTs): Guy's and St Thomas' (GStT), King's College Hospital (KCH) and South London and Maudsley (SLaM). King's Health Partners is one of only five accredited AHSCs in the UK and brings together an unrivalled range and depth of clinical and academic expertise, spanning both physical and mental health.

1.2 In February 2012 the four partner organisations unanimously endorsed a recommendation from the King's Health Partners Board to prepare a Strategic Outline Case (SOC) to assess the case for establishing a single academic healthcare organisation.

1.3 This recommendation followed two reviews commissioned by the King's Health Partners Board last year.[1] These reviews explored a number of organisational options for how King's Health Partners might accelerate its progress but concluded that creating a single academic healthcare organisation (i.e. merger of the three FTs and closer integration with KCL) was most likely to help us achieve our goals.

1.4 The partners, three successful Trusts and a leading university, are in a position of strength. Unlike many mergers this discussion is not being driven by the need for financial savings, although this could be a significant benefit. The proposition is that an integrated organisation could achieve more and at greater pace and that these benefits would translate directly into greater social value for the communities and patients that we serve.

1.5 This SOC is seeking to answer four questions:

- **What is the rationale for organisational integration?** (Sections 2 and 3)
- **What is the preferred organisational model?** (Section 4)
- **Do the benefits outweigh the costs and risks?** (Sections 5, 6 and 7)
- **What is the forward plan to achieve organisational integration?** (Section 8)

1.6 In the process of developing this SOC we have engaged a wide variety of groups and individuals to seek their views and to understand their concerns. They included staff, governors, commissioners, local authorities, MPs and other stakeholder groups. All have engaged in a thoughtful and constructive way. We hope this has helped us write a document that is clear about the benefits and addresses some of the concerns that have been voiced.

1.7 The next stage of the process would be accompanied by a broader and deeper engagement with all of our stakeholders, alongside a full public consultation at the appropriate stage. We hope to work in particular with our local partners in the health and care system to develop innovative ideas about how we might most effectively achieve our goals around integrated care and population health.

1.8 If the four partners agree to the recommendation of the SOC, we will proceed to the development of a Full Business Case. We recognise that further detailed work will need to be done at this stage, including quantifying the benefits and costs of the new organisation, and a detailed analysis and testing of the proposed organisational model.

2. CASE FOR CHANGE

Health needs are changing but healthcare systems are not keeping pace

2.1 If the health challenge of the last century was the treatment of infectious disease, this century's challenge is the prevention and management of long-term conditions. More than 15 million people in England have one or more such condition.[2] Rates of diabetes, for instance, are expected to grow by over 60% in the next 20 years. This challenge is particularly stark in the local communities that King's Health Partners serves, where one in four school children is already obese.[3]

2.2 The numbers of people with multiple long-term conditions ('multi-morbidity') is high and rising. More than one in three of this group have both physical and mental health challenges. New evidence suggests that the rates of people with multiple long-term conditions are highest in populations that are economically deprived such as Lambeth and Southwark.[4]

2.3 Multi-morbidity is particularly common amongst older people – and this population is growing fast. The number of people over 65 in the UK is set to increase to 20% by 2030 and the proportion of 85 year olds will double by 2032.[5]

2.4 Left unchecked, the likely cost to the system of these trends is extremely high – estimates suggest that around 70% of healthcare costs are already spent on people with long-term conditions.[6]

2.5 But healthcare systems around the world are not keeping pace. Health services are focussed on disease and illness rather than promoting health and wellbeing. They tend to be reactive and poor at planning ahead. The mind and the body are still treated quite separately.[7] In most healthcare systems, it often appears that the hospital rather than the patient is at the centre. One result of this is that care is not always provided in the best settings for patients. Services can be fragmented leading to worse outcomes and poorer experience for patients. This can have a particular impact on older people and those with long-term conditions who have to navigate this complex system.[8] Finally, research and education can appear quite distant from the reality of healthcare problems.

2.6 All of this points to the need for new models of healthcare delivery, including more integrated care, a new relationship between the patient and the system, changes to how the workforce is educated and trained (for example, considering the balance between generalist and specialist skills), and a more productive relationship between research and healthcare delivery. As an integrated organisation, King's Health Partners would be better able to develop a new model of healthcare to meet this challenge.

The academic world is becoming increasingly competitive

2.7 Competition for the best students and research talent is rising, as academia becomes a global market. The UK used to undertake 6% of clinical trial activity; the figure now stands at just 2%.[9] This has consequences for the country's overall economy and international standing in healthcare.

2.8 Universities increasingly need to demonstrate excellence to be able to compete. The upcoming Research Excellence Framework reinforces this trend – only the highest quality research will attract funding. It will also need to be able to demonstrate impact for social benefit. This offers a clear opportunity to organisations committed to translational research – as King's Health Partners is.

2.9 Meanwhile medical research is becoming more complex, as medicine continues to sub-specialise. One result of this is that is has become more difficult to sustain clinician-led research in traditional teaching hospitals.[10] This implies a need for greater organisational scale with larger academic facilities co-located with clinical services, supported by large scale specialist teams. It also raises the question of how organisations can undertake research in very different ways, including, for example, undertaking more research embedded in the communities we serve.

2.10 The demise of higher education block funding and the introduction of a new fees regime will further encourage competition for the best students. This is likely to raise student expectations about their experience which may take many forms – including demand for better teaching and better integration between academic learning and clinical placements. Successful universities will need to concentrate on delivering distinctive education and the best student experience.

2.11 Trends in teaching and courses suggest students are attracted to new ways of learning. This includes a greater number of inter-disciplinary courses, a greater emphasis on team working, problem solving and other general skills. AHSCs are well placed to benefit from these changes, by enhancing multi-professional elements within existing courses, and by developing new courses altogether that reflect emerging healthcare needs (for example, with management, humanities and informatics).

Economic and social pressures pose questions about how we work

2.12 The economic situation in the UK is an important part of the backdrop to the discussion about King's Health Partners' integration. Firstly, economic factors are closely related to health outcomes and health inequalities. In Lambeth and Southwark nearly 40% of children live in poverty, and the unemployment rate is above the national average.[11]

2.13 Second, with public finances under pressure, funding sources for health, education and research will inevitably be constrained. In particular, whilst the demand for and the costs of healthcare continue to rise significantly, NHS funding is likely to be, at best, held steady for the next ten years. This means the NHS needs innovative new ways of providing healthcare that radically improve productivity.[12] Organisations working in isolation will struggle to respond to this challenge.

2.14 Finally, the UK as a whole needs to find new sources of economic growth. As education, health and life sciences are among those industries in which the UK has a comparative advantage, there is a clear opportunity for King's Health Partners to contribute further to overall economic growth by realising the commercial potential of its business.[13] This in turn would contribute social value and employment opportunities to the south London economy (from which the majority of our workforce is drawn).

2.15 Alongside changes in the economy we will see significant social changes. In the future, we can expect a more informed and less deferential population. This offers healthcare providers the opportunity to develop a new, less paternalistic relationship with patients and service users. Technology could play a significant role in enabling this change. Technological advance in the last 20 years has been extraordinarily rapid, influencing many aspects of our lives. The rate of advance looks set to continue - with continuing growth in computing power and social media and a move towards ubiquitous access. Yet healthcare has been slow to benefit from these advances. King's Health Partners has the opportunity to tap into new technological opportunities to transform the care it provides (for example tele-medical monitoring for cardiac patients after surgery) and to encourage new research opportunities.

King's Health Partners has achieved much but there are further opportunities

2.16 King's Health Partners has achieved a lot in its current organisational form, for example:

- We have established 21 Clinical Academic Groups (CAGs) to help integrate patient care, research and education across the partners. The CAGs are driving service and academic improvement in a range of areas, including consolidating Bone Marrow Transplantation, Vascular Surgery and Stroke services.
- We are making progress on finding new ways to tackle local health challenges. In partnership with our local health and social care partners, the Lambeth and Southwark Integrated Care Programme is redesigning local systems of care to fit around the needs of patients, starting with care for older people.
- We are innovating in 'whole person care'. For example, the Psychological Medicine CAG is working with the Cardiovascular CAG implementing joint clinics for patients with chest pain as part of the King's Health Partners IMPARTS (Integrating Mental and Physical Healthcare: Research, Training and Services) programme.
- King's Health Partners is at the forefront of pioneering new medical techniques; for example, we host one of the largest Transcatheter Aortic Valve Implantation (TAVI) programmes in the world.
- We have put in place the building blocks for groundbreaking research. For example, the Department of Heath reaccredited our two National Institute for Health Research (NIHR) Biomedical Research Centres (BRCs) and established a new Biomedical Research Unit for Dementia, pledging over £112 million of funding over five years.
- King's Health Partners has established an Education Academy which successfully oversees the education and training activities of the four organisations to ensure consistent standards of excellence. In April 2012, all three Trusts were appointed lead providers to deliver £77 million worth of postgraduate training programmes to higher speciality trainees across south London in 15 different specialties, from renal medicine to forensic psychiatry. With local partners, we are leading the development of the South London Local Education and Training Board.
- We have created a single King's Health Partners fundraising team to join up the efforts across the four organisations.

2.17 However, current organisational arrangements are not allowing us to make progress towards achieving our vision at sufficient pace, not least because the financial incentives are not fully aligned.

2.18 The result is that we are slowed down or in some cases missing opportunities altogether. This has affected the Clinical Academic Groups, progress on bringing together corporate functions such as IT, and in some instances hindered the development of external partnerships.

2.19 Our Clinical Academic Groups are now telling us that a more integrated organisation would allow them to achieve more and at greater pace.

An integrated King's Health Partners would make it easier to achieve our goals

2.20 A more integrated organisation would offer a number of advantages that would help King's Health Partners overcome current organisational barriers, respond more effectively to the external opportunities described above, and help achieve our academic and healthcare goals.

- **Align priorities and decision-making.** A single organisation would help align organisational priorities. For example, King's Health Partners would be able to articulate a clearer set of healthcare and academic priorities to potential philanthropic donors.
- **More financial flexibility.** An organisation with a single balance sheet would enable greater resource flexibility, for example investing more in mental health interventions such as liaison psychiatry that can help reduce hospital length of stay. As a single organisation we could also make better use of our combined assets (£1.3billion across the three FTs) to release funds for investment in new models of healthcare.
- **Make it easier to work with external partners.** An integrated organisation would simplify relationships with external partners. For example, we could streamline our processes to reduce bureaucracy for referring GPs. With our external partners, King's Health Partners could help develop a shared electronic patient record that covered the whole health and care system.
- **Organisational scale to transform how we work and improve efficiency.** An integrated organisation would offer economies of scope and scale. For example, we might consider consolidating elective care for a number of specialties in a single centre, thereby improving patient experience, outcomes and efficiency.

3. VISION FOR THE NEW ORGANISATION

3.1 An integrated organisation would allow us to extend our vision – in particular to achieve a greater focus on physical and mental health integration; on prevention and population health; and on the academic opportunities associated with these two major challenges.

3.2 **Our vision for the new organisation is to be a leader, locally and globally, in improving health and wellbeing**. **We aspire to be one of the top ten global academic healthcare organisations and to bring these benefits to our local communities, patients and students.**

3.3 In pursuit of this vision, we aim to overcome some traditional distinctions. We hope that our local and global ambitions can reinforce each other: our large and diverse local population can help us make a global impact, and our global reach can help us improve the health of our local population. We hope to excel academically and provide consistently high quality care for all our patients. We hope that we can address both the mental and physical health needs of our patients. We hope we can provide system leadership, not just provide services.

3.4 King's Health Partners is uniquely positioned to do this because it brings together three successful Trusts, with mental health at the core, with a leading university, all serving one of the most diverse and challenged communities in the country.

3.5 Working in partnership with others in the health and care system and beyond, we have six goals for the new organisation:

i) Provide care around people's needs

3.6 By bringing together acute, community and mental health services the new organisation can provide more integrated care for our patients. But to be most effective we will need to work in partnership across the health and care system with providers and commissioners. Building on the work of the Integrated Care Programme, we hope to develop a new relationship with primary care and social care, overcoming the barriers that have existed since the NHS was formed. A key enabler of this will be developing a shared electronic patient record - helping King's Health Partners, our partners and our patients to work in fundamentally new ways with each other.

3.7 Providing more integrated care also has implications for how we educate and conduct research. We will consider what the future workforce might look like and what its educational needs might be, for example the balance between generalists and specialists in hospitals.[14] We will also look at how we can use our partnerships with others in the health and care system to change how we do research, for example by extending more trials into the community, and by investing more in understanding how to improve the delivery of healthcare. Our recent creation of King's Improvement Science, which seeks to find new solutions to real world problems in healthcare, is a key step in this direction.

3.8 By bringing together a mental health Trust with two acute care Trusts and community services in Lambeth and Southwark, the new organisation will help us

overcome traditional distinctions between mind and body, helping position King's Health Partners as a world leader on whole person care.

3.9 At present, patients with mental illness, particularly those with serious mental illness do not receive adequate physical care – these patients live on average 10 to 15 years less than expected – often rivalling the years of life lost to many major medical illnesses (such as breast cancer or heart disease).[15] Improving the physical health of the seriously mentally ill will require a joined-up approach across the healthcare spectrum and specific programmes, clinics and professional development to deal with this issue. King's Health Partners aims to be the national leader in the development, implementation and evaluation of these programmes.

3.10 At the same time, patients with long-term physical conditions receive sub-optimal mental health care: nearly 30% of people with long-term conditions have depression; half of all referrals to specialist services have 'medically unexplained symptoms' many of which are linked to psychiatric diagnoses.[16] King's Health Partners will seek to lead the way in developing innovative services and models of care (such as routine depression, alcohol and dementia screening) which lead to improved outcomes and lower costs of care.[17]

3.11 We recognise that the physical-mental integration is often held back by the lack of appropriate funding incentives. By bringing all these services within a single organisation, King's Health Partners will develop internal incentives to drive this integration.

ii) Keep people well

3.12 Through the scale of the new organisation and its academic strengths we will seek to develop new approaches to population health to address the stark healthcare challenges our populations face, such as alcohol and childhood obesity. We will do this in partnership with others in the healthcare system, local government, industry and the voluntary sector. We will aim to intervene earlier and avoid unplanned care where possible, for example through earlier interventions for people with long-term conditions such as Chronic Obstructive Pulmonary Disease (COPD) to avoid unnecessary hospital admissions.

3.13 We will seek to support people to manage their own health, for example by using telehealth to support self-care at home rather than in the hospital.[18] By offering patients greater access to their own health records we hope to empower them to better manage their own health. To this end, we will build on SLaM's MyHealthLocker, which is the first patient-held electronic health record in the field of mental health. Opening up a two-way flow of information between patients and their clinicians this represents a shift in the status of the patient from a passive recipient to active participant in their care.

3.14 To find new ways of addressing these public health challenges, we will draw on the strengths across the university. For example, cultural anthropologists and social geographers can shed light on 'lifestyle diseases' by better understanding the cultural context of people's lives. KCL's recent creation of a new Department of Social Science, Health and Medicine demonstrates our commitment to this issue.

3.15 We aim to do more to help our staff improve their own health. This is because they represent a significant proportion of the local population in their own right, and because we know that healthier staff provide better care. We are putting in place a range of measures to help our staff become healthier, for example through smoking cessation classes and mental health interventions to support their wellbeing. Through this and other measures we would like to support and encourage our staff to be effective advocates for health and wellbeing in the local community.

iii) Provide the best specialist care when it is needed

3.16 Our patients deserve excellent local services, but we believe that they also deserve excellent specialist services. We know that treating higher numbers of patients is associated with better outcomes in certain specialist services. So to improve the quality of care we provide, we will consider consolidating some of our specialist services across our sites. Our proposals may include co-locating these services with academic facilities to accelerate the translation of research into new drugs and treatments and to encourage further research innovation. This is relevant for some of the most pressing health challenges in our area, such as HIV and sexual health, sickle cell disease and alcohol-related liver disease.

3.17 In those specialist areas where we excel, we will continue to strengthen and expand our clinical networks. Based on clear protocols, data and pathways, these networks will help us to improve the quality of care across the country. We will consider how the greater use of technology can support our specialist networks, thereby enabling patients to be cared for safely and effectively closer to home.

iv) Train the workforce of today and tomorrow

3.18 Our ranking in the National Student Survey suggests we need to do more to improve student experience.[19] Closer integration between the university and the Trusts should help us improve teaching, student experience and the quality of graduates. Our ambition is that all King's Health Partners award-bearing education will be consistently high quality, and should take a common approach to quality assurance, training of teachers, performance management and student feedback. We will seek to improve the quality of our teaching through more efficient use of clinical time and better recognition of clinicians who make an academic contribution.

3.19 Greater flexibility in investment decisions will allow us to improve educational facilities across the King's Health Partners campuses, for example by creating a 'virtual learning environment' that enables students and staff to access all learning resources from all King's Health Partners sites.

3.20 Healthcare is changing and the new organisation will prepare the current and future workforce accordingly. We aim to do this by offering students and healthcare professionals a greater diversity of applied educational and research opportunities (including primary, community and mental health settings). Alongside this, we will extend the opportunity for students to undertake more joint or intercalated degrees with other academic disciplines. We will consider how to support new professional roles, such as integrated care practitioners, who work across physical and mental health, and social care. We will also offer more 'inter-professional' education (between doctors, nurses, mental health professionals) – professionals who work together should have the opportunity to train together.

3.21 Through the new organisation, we hope to offer enhanced career opportunities to our students and staff. Currently only about 20% of our clinical students end up working at King's Health Partners' healthcare providers. This is inefficient and a poor way of managing talent. We will work towards a point where the majority of our students are employed in King's Health Partners and see us as their natural employer. This will have benefits for the quality of healthcare that we provide by ensuring a more consistent level of training to future employees.

v) Turn world leading research into treatments as quickly as possible

3.22 Bringing together clinical and academic services will increase sub-specialisation in research, and encourage innovation between clinicians and academics. This should help speed up translational research. We will also aim to make research easier to conduct by improving the research infrastructure (such as bio-banking). An important dimension of this will be encouraging a greater number and range of healthcare professionals to get involved in research. This will both improve the quality of the research itself and help encourage a culture of improvement across King's Health Partners.

3.23 As a single organisation we will seek to make the most of our large and diverse local population with its global research implications. We will aim to make better use of patient data for research through a new electronic record. Leveraging our scale, we will seek to establish a larger number of patient trials addressing the health issues that matter to our local population. We will do this in partnership with others through the Academic Health Science Network we hope to develop across south London.

3.24 Closer working with the university can help us draw on the academic strengths across KCL's Schools. For example, researchers in the humanities and health might collaborate to better understand the different cultural experiences of pain.

vi) Build prosperity for our local communities and the UK

3.25 A single organisation will help us to generate new income through our own business and attract new commercial, fundraising and grant income. For example, closer integration with the university would allow us to commercialise better the value of our research and create more commercial spin-outs.

3.26 Attracting new income and investment will enable us to contribute to the local economy, helping regenerate some of the most deprived areas of the country. This will occur directly (e.g. by creating new jobs and developing new products) and indirectly (e.g. through building new facilities and offering new training opportunities to local people).

3.27 Our new organisation will also accelerate efforts to position the UK and London as one of the top global centres for life sciences, competing with places like Boston, San Francisco and Singapore.[20] Our organisational scale, increased patient base and improved administrative systems will make King's Health Partners an attractive partner to commercial and other research organisations.

4. ORGANISATIONAL MODEL

4.1 We are proposing that King's Health Partners AHSC should be embodied as the partnership of a single NHSFT formed through the merger of the three FTs, and closer integration with KCL. Full integration between an NHS organisation and a university is not feasible under the current statutory arrangements. Nevertheless, a partnership on the lines we envisage would enable us to create the UK's most integrated and innovative academic healthcare organisation. In taking it forward, we would:

- Honour and build on the strength and depth of the heritage and prestige of our current institutions and the strategic advantages of our current main hospital sites.
- Strengthen the links between KCL and the clinical-service delivery arms of the NHS organisation, so that all clinical services are supported by the strength in teaching and research that only an AHSC can provide.
- Put mental health at the centre of the mission and practice of the new partnership at all levels, and reflect this in the leadership (executive and non-executive) of the AHSC and its delivery arms.

Governance

4.2 In this form, King's Health Partners would consist of a partnership of two legal entities – KCL and the new NHSFT – which would nevertheless present to the world as a unified entity. This would be expressed through:

- **Merger of the three FTs**. We propose bringing together physical and mental healthcare in equal partnership in a single FT, with specific provisions to ensure adherence to the guiding principle that there should be parity between mental and physical healthcare. This should enhance the distinct national standing of SLaM and the Institute of Psychiatry (IoP), which is part of KCL. Such provisions should include ensuring that the overall balance of the Board and leadership of the new organisation appropriately reflect the parity between mental and physical health. This might include non-executive (for example, chair / vice chair), executive, clinical and academic leadership. Similarly, attention to the prominence and approach of mental health services should be reflected in the wider corporate structure.
- **Establishing a new King's Health Partners Board**. The Board would focus on the strategy and investment in order to deliver the AHSC vision. It would seek to embody the partnership values that have characterised King's Health Partners to date, including the parity accorded to mental and physical health. Membership would be drawn from the executives and non-executives of the NHSFT and KCL. Additional non-executives would be appointed to the Board, in order to bring in external perspectives and enhance the academic ethos of the organisation.
- **Establishing a new King's Health Partners Executive**. The objective of the Executive would be to ensure delivery of the King's Health Partners strategy and to reconcile any competing priorities between NHSFT and KCL. It would be led by the Executive Director of King's Health Partners, comprise key executives from the two partners (including the CEO of the NHSFT), and reflect the parity between mental and physical health.

4.3 Other governance arrangements would be considered to help cement the partnership, for example, reciprocal executive and non-executive representation between the NHSFT, KCL and the King's Health Partners Boards.

Organisation and operating model

4.4 We are conscious that in following this model of partnership, we would be proposing the creation of an NHSFT twice as big as any that exists at present. Indeed, Guy's and St Thomas' is already the largest FT by turnover in England. The relationship with KCL creates an even larger entity. We have been clear from the outset that this undertaking would be unacceptable – and would fail – if it resulted in a remote, centralised organisation which attempted to replicate the conventional NHS Trust governance, management and service arrangements at this scale. It would have to operate in a very different way to be effective.

Clinical academic delivery arms

4.5 Our proposed model for the organisation of the new NHSFT is that it would operate in a group structure, in which responsibility for delivery of the objectives of the AHSC would be devolved to a small number of clinical academic delivery arms which would:

- be of sufficient scale to have their own character, leadership and devolved budgets;
- nevertheless represent an opportunity to bring delivery of clinical services even closer to the patients and communities that they serve;
- be accountable for the quality of services for which they are responsible, and take responsibility for engaging with regulators, commissioners and other stakeholders;
- be coterminous with the relevant KCL Schools to more effectively support the AHSC goals; and
- take responsibility for progressing the research and teaching objectives of the AHSC within their area to support and enhance the clinical services that they lead.

4.6 These clinical academic delivery arms would be directly accountable to the NHSFT Board for NHS performance issues, for which the FT would be statutorily accountable. They would also have accountability to KCL through the relevant academic Schools for performance on academic issues, for which KCL is statutorily accountable, in a manner comparable to the way the IoP and SLaM currently interact. This will ensure that the operational issues have a clear line of accountability and can be swiftly resolved. Finally, the clinical academic delivery arms would report to the King's Health Partners Board for the shared agenda of the tripartite mission. This dialogue would focus on setting strategy and agreeing an integrated business plan, including budgets, against which they would be monitored. The SLaM-IoP relationship is the nearest existing analogue to how we envisage the clinical academic delivery arms working.

4.7 Each of these clinical academic delivery arms would have a management board, which would involve non-executive representation and a role for FT Governors. The

Board's leadership structure would respect the shared academic and healthcare goals of King's Health Partners, including the commitment to reflect the central role of mental health across the leadership of the organisation.

4.8 The number and composition of these clinical academic delivery arms have yet to be decided; and of course, they would evolve over time as the health system changes and new models of care drive different service delivery arrangements. However, the aim would be to begin building the new structure on the foundation of the current CAGs. So for example, at the point of launch of the merged organisation, it is possible to envisage cancer services, children's services and dentistry all operating as separate, single service delivery arms with their own character, leadership and budgets. Over time, other clinical service areas might also be grouped to a greater extent around patient pathways and population groups than they are under our current arrangements. However, we also recognise the importance of continuity over the transition period, in particular to ensure operational performance is maintained.

4.9 As part of our commitment to encourage a greater academic ethos, we would look in particular at how we develop our workforce. For example, the majority of future consultant appointments to the new NHSFT will simultaneously be given honorary academic appointments at KCL, helping support the development of an 'integrated faculty' across King's Health Partners.

Cross-cutting functions

4.10 The NHSFT Board will bring together the management of a number of central and support functions that appropriately sit at the corporate level. These functions might include, for example, finance, estates, human resources, IT and facilities management. While each of the separate clinical academic delivery arms may have some of its own support functions, these would operate under clear rules of discretion established by the FT Board.

4.11 There is also scope for establishing a number of cross-cutting functions across both the NHSFT and KCL, as is already the case with fundraising which is run by KCL. For example, we would leverage KCL's expertise in education and research management to lead the development of comprehensive frameworks for education and for research; and to coordinate our activities in these two areas, most urgently in relation to medical education.

Benefits of the new organisation

4.12 The new organisational model would help King's Health Partners deliver the vision in a number of ways, in particular by:

- aligning the interests of the separate organisations;
- bringing physical and mental health services together into a single organisation;
- simplifying the academic and healthcare relationship – KCL will have only one FT to work with;
- creating the organisational scale to help deliver the vision.

Transition to the new organisation

4.13 The full details of the operating model would be developed as part of the Full Business Case. While that is being compiled, we would also carry out further reviews of the ambitions of the current CAGs – particularly those in priority areas for the AHSC – which might impact on the emerging operating model for the AHSC.

4.14 Our transition to the new organisation would be evolutionary where possible, in order to ensure that performance against key operational measures is maintained where appropriate and improved wherever necessary. This will be essential for ensuring that we maintain the confidence and support of patients as well as the wider population and stakeholders.

4.15 As we develop the new organisation, we would like to engage further with our local commissioners, and our partners in primary care, to discuss how we might most effectively achieve our goals around encouraging more integrated care and strengthening community services. We genuinely believe that there is scope for innovation in this area, to the benefit of patients. But we recognise that if there is to be further integration involving primary care, it has to be on the basis of real partnership.

5. BENEFITS

Improving health

5.1 **Improving care outcomes.** The special emphasis on linking physical and mental healthcare would lead to an immediate improvement of care provided to patients – and would in time lead to better long-term outcomes (for example by decreasing years of life lost to schizophrenia). Consolidating our specialist services would lead to better patient outcomes because for many specialties quality is directly related to how many cases a centre does. For example, specialist endovascular aneurysm repair has lower mortality and shorter length of stay than open surgery but requires doctors to be doing a large number of cases to be proficient. Creating integrated clinical services could also help 'level up' performance across different services by putting in place the most effective practice.[21]

5.2 **Quicker access to new drugs and therapeutics.** We would be able to speed up access to new drugs and treatments through more effective research, supported by clinical and academic co-location; through more opportunities for patients to take part in trials as commercial partners are attracted to our larger patient base; and through investment in cutting edge technologies (for example, robotic surgery for complex mitral valve surgery), which may be unaffordable as separate organisations.

5.3 **Less wasted time for patients.** Greater separation of acute and elective services could prevent the admission of emergency patients from disrupting planned activity – reducing inconvenience for patients and improving efficiency of services.[22] For example, consolidation of fractured neck of femur surgery for elderly patients could reduce waiting times for theatres. Likewise, creating a single elective joint replacement centre would reduce cancelled operations and the length of stay in hospital.

5.4 **More integrated care.** More joined up working across acute, community and mental health services could improve patient care and experience. For example, an estimated 40% of inpatients in King's, Guy's and St. Thomas' hospitals have dementia, but recognition of dementia in secondary care is poor. The inclusion of dementia specialists in Accident & Emergency departments could lead to earlier diagnosis and more effective treatment.

5.5 **More convenient care**. A large proportion of King's Health Partners' 225 sites are based in the community. These could be used more effectively and creatively to support care closer to home.

5.6 **Better use of information technology**. Creating shared platforms such as a shared electronic patient record across King's Health Partners and our local partners could lower the risk of medical error, reduce outpatient appointment time, and improve patient experience by avoiding asking people to repeat basic information. At Brigham & Women's hospital (Boston, USA), e-prescribing and access to an electronic patient record including medical history decreased the incidence of preventable adverse drug events by more than 17%.[23]

Better research

5.7 **Quality of research.** First, bringing together academic and clinical services in specialties would encourage innovation and improve access to clinical trials. Second, the integrated organisation could improve access to and data about the vast patient population that the three healthcare providers serve, by developing a shared electronic record that is accessible to research, building on existing models like the Clinical Record Interactive Search (CRIS). For researchers aspiring to generate research with global applicability this is particularly important. Third, the scale and reach of the new organisation would offer new research opportunities, such as finding solutions to the problems of healthcare delivery through 'Improvement Science', or by linking physical and mental health research to better understand 'medically unexplained symptoms'.

5.8 **Making research easier**. The new organisation would be able to improve research infrastructure (including laboratories, IT, trial co-ordination, bioinformatics, data management and bio-banking). This would make it easier to conduct major clinical trials either for our own research or in conjunction with the pharmaceutical industry. New processes would encourage clinical and patient participation in research (for example by taking a consistent approach to obtaining patient consent) and reduce bureaucracy (such as by creating a single research approvals process).

5.9 **Attracting research talent and funding.** Closer links to the new NHSFT would help KCL demonstrate impact (a critical factor in how university research is assessed). New funding partners (whether commercial, not-for-profit or government) would find it more attractive and easier to do business with the new organisation. The enhanced scale, performance, and reputation of the organisation would help attract the best talent and resources, competing against the world-leading AHSCs.

Better education and training

5.10 **Improved student experience.** The new organisation would be able to improve the student experience (particularly for clinical undergraduates), for example through better coordination of clinical teaching, co-location of clinical and academic facilities, and improved student services.

5.11 **Greater opportunities for applied learning**. The new organisation would offer a wide range of applied educational opportunities for health and non-health students. It could do this through joint degrees, a wide range of real world learning opportunities (for example across community and mental health settings), and greater employment opportunities upon graduation. This would give students a more rounded education and KCL a comparative advantage in attracting the best students.

5.12 **Improved resources and facilities for students and staff**. Greater flexibility in investment decisions would allow us to improve educational and training facilities across the King's Health Partners campuses. All King's Health Partners students and staff would have access to common support services and facilities, such as the libraries.

5.13 **Attract the best students**. Enhanced experience, facilities, learning and employment opportunities would help King's Health Partners attract the best students in the UK and internationally.

Better value

5.14 **More efficient healthcare economy.** The new organisation would enable us to improve value for money for patients and taxpayers across the health and care system. Estimates suggest 3-5% of savings could be achieved from savings in non-clinical support functions alone in the new organisation.[24] We think significant further savings could be achieved through improved productivity across much of our business which will have benefits for the whole healthcare economy. For example, we could consolidate services where they are duplicated. A single heart attack centre could enable all patients to receive 24/7 care by combining the workforce and implementing a single on call rota. Likewise, a single diabetes service would enable King's Health Partners to reduce the number of specialist services and move more care closer to home. The Full Business Case will examine in detail the full range of productivity opportunities.

5.15 **Better use of assets.** The new organisation has the potential to make better use of its extensive estate, which comprises 225 sites with a combined value of over £1.8 billion. An integrated organisation could unlock more value from this estate, for example by rationalising facilities, freeing up space for re-use or reinvesting the capital in front line services. The Charitable Trusts associated with our organisations have combined assets of well over £600 million which could be used to greater effect if joined up.

5.16 **New jobs and prosperity.** The new organisation has the potential to generate new income by extending the geographic reach of its specialist services and by attracting new investment (commercial and not for profit). For example, we would aim to develop further initiatives such as the Cell Therapy Catapult centre at Guy's Hospital, the objective of which is to bridge the gap between academic invention and real life commercial products. This kind of development has the potential to create new employment opportunities and prosperity in the local economy.

6. FINANCIALS

The four partners are in financial good health but have challenging future plans

6.1 The finances of the three NHS Foundation Trusts reveal a combined organisation with an income of £2.1 billion and expenditure of £2.0 billion. KCL has total income of £532 million and expenditure of £507 million, of which around 45% is King's Health Partners related.

6.2 In their most recent annual accounts, each of the three FTs and KCL reported a financial surplus. Over the next three years, growth projections for both income and expenditure are approximately 1% across the three FTs. KCL is projecting around 5% growth in both income and expenditure. Collectively the FTs plan to find annual cost savings of approximately £200 million by 2015. Of this approximately half will be from pay costs, reflecting about 8% of the pay cost base.

6.3 Capital investment plans for each partner are significant. The FTs are planning approximately £480 million of capital expenditure over the next three years. KCL is midway through a £635 million ten-year capital programme (of which ca. 30% is at the three health campuses). The FTs' funding plans for their capital programmes are derived from a combination of existing cash reserves, additional borrowing and from future surpluses. Shortfalls in projected levels of cost savings or margin from income growth would threaten the ability to fund these capital plans in full. The projected drawdown on loans at the FTs will total £207 million over the next three years.

6.4 The combined property footprint of all four organisations comprises over 800,000 square metres across more than 225 sites, at a value of around £1.8 billion. Of the health sites, around one quarter is leasehold. The majority of KCL property is freehold.

6.5 The Charitable Trusts associated with our organisations have combined net assets of approximately £636 million. Whilst they will not be directly integrated with the FTs, a full merger of the FTs might necessitate a merger of the three Charitable Trusts.

The benefits of integration could be significant but are not fully quantified

6.6 We recognise that savings anticipated in advance of mergers are not always realised post-merger. Accordingly, we need to ensure that any merger savings identified are supported by robust and detailed plans in order to ensure the anticipated value of savings is realised. These detailed plans will be drawn up as part of the Full Business Case process. With this caveat in mind, our assessment is that across the FTs there is opportunity to achieve between 3-5% of cost savings from organisational synergies in some non-clinical support functions. These benchmark estimates will need to be supported by bottom-up analysis before being confirmed.

6.7 It is expected that there are further financial benefits, still to be assessed, which would only be realised through more transformational changes arising from integration. For example, the Integrated Care Programme is implementing a new model of healthcare delivery for older adults which could free up 16,000 bed days per annum (about 2% of the King's Health Partners' total).

6.8 A detailed analysis of the asset base would determine the extent to which capital could be released. To give an illustration of the order-of-magnitude, land and building assets across the FTs have a value of £1.3 billion. Increasing utilisation to release 5% would therefore free up £65 million of additional capital. Alternatively, the freed-up estate could be used for additional sources of rental income.

The costs are not yet fully assessed – particularly longer term restructuring costs

6.9 The detailed cost estimates of transition would be developed alongside the integration plans as part of the Full Business Case process. The main cost categories are described below.

- *Transitional costs.* The Full Business Case itself would require investment funding from the partners. A separate paper will develop robust costings including the cost of the project team and other costs (such as legal advice). In addition, project management resources would be required to both plan transition to the new organisation and subsequently to run post merger integration.
- *Restructuring costs*. There would be a need for both short-term and longer-term restructuring costs. For example, investment in systems would be required to help integrate the organisations. This might include short- term investment such as common payroll platforms, or longer term investment in IT systems such as e-prescribing.
- *Transformational costs*. The SOC has not sought to calculate longer term transformational costs such as the development of entirely new clinical or academic facilities. Where these developments are integral to the new organisation, they would be included in the Full Business Case.

The financial dynamics of the new organisation may need to adapt

6.10 The new organisation would need to build capability to succeed in a changing environment, including the possibility of new funding models in the future, such as capitation payments or personal health budgets. These new funding models may pose financial challenges but could also deliver significant productivity by stimulating innovation in healthcare delivery.

7. CONCERNS AND QUESTIONS

7.1 A number of concerns and questions associated with the proposed organisational change have emerged as we have developed the SOC, in part through discussions with our staff and stakeholders. We seek to address these below.

Would merger lead to closure of local services?

7.2 Core local services would continue to be provided on multiple sites. For example, the two Accident and Emergency departments and two maternity units would remain in their current locations. Rather than closing existing local services, the new organisation would seek to develop new local models of care with our partners to deliver more services, closer to patients' homes.

Would mental health issues be less prominent in the new organisation?

7.3 Mental health is key to the vision of the new organisation and would have a central place in it. The unique place of mental health and its parity of esteem would be enshrined in the principles of the new NHSFT. Specific provisions would be made in the Council of Governors of the NHSFT so that those with mental illnesses could be involved and engaged in this new organisation. In addition, specific provisions would be made to the governance and management model to reflect the centrality of mental health to the new organisation. This might include the creation of specific non-executive, executive and professional leadership roles in the new organisation. The experience of mental health systems would significantly inform the overall model of care of the new organisation, as mental health systems have pioneered the move from hospitalised care to the community. In addition, there is a body of evidence that suggests investment in mental health interventions can reduce demand for acute services.[25]

Would academic issues be neglected in the new organisation?

7.4 A defining characteristic of King's Health Partners is academic excellence. This would be reflected in the new organisational model at every level. A range of mechanisms would be considered to cement the partnership between the NHSFT and KCL, including joint appointments and reciprocal non-executive representation between NHSFT and KCL. The new organisation would commit to flourishing academic campuses at Guy's, St Thomas', King's College Hospital and SLaM/IoP. The new organisation would seek to make the most of the university's wide range of academic strengths (across culture, security, health and beyond), reinforcing KCL's position as a world leading centre for translational research in these areas.

How would operational performance be maintained during this process?

7.5 We recognise that a merger of this scale is a significant undertaking with many associated risks, particularly in the transitional period. To help ensure merger causes little disruption to business as usual, or result in a loss of operational focus, a dedicated transition team would be put in place to operate in parallel to everyday business. This team would ensure robust programme management of the pre- and post-merger activities as well as the active management of both internal and external stakeholders. We would structure and manage our new organisation so there is clear accountability for achieving NHS performance standards (such as

access times) and KCL's key performance measures (such as the National Student Survey and the Research Excellence Framework).

How would the cultural and staff challenges of integration be handled?

7.6 We recognise we would need to put significant investment into developing a strong organisational culture for the new organisation. This would draw on the best of each of the existing organisations. Working with staff to develop this culture and values would be a high priority if we proceed to the next stage of the process.

7.7 There would be significant career and development opportunities for staff in the new organisation. For example, we plan to develop new professional roles as we develop new models of healthcare that cut across existing boundaries. We would support staff with appropriate training as required, for example to better understand the needs of mental health patients in hospital settings.

7.8 In addition, we hope the new organisation would be able to offer better facilities and support services (such as ICT, library access and leisure facilities). Where it is necessary, we would make it easy for staff to work across locations, through improved transport, ICT, and through new ways of working.

Would merger create an inflexible or remote organisation?

7.9 Organisational scale gives us the opportunity to transform the organisation altogether, and make it more responsive, for example by developing new pathway or population based delivery arms. The NHSFT would devolve significant decision-making powers to these delivery arms, creating more autonomous and flexible units that allow the organisation to maintain its agility.

Would merger undermine local accountability through Governors?

7.10 The Council of Governors is a key part of the accountability structure of a Foundation Trust. Making sure that governance works is important to maintaining the independence and accountability of an FT. Governors may have concerns that the sheer size of the merged organisation would make it more difficult for them to fulfil their duties. The Full Business Case must address an appropriate structure for the new Council of Governors that enables the Governors to represent their communities of interest and to hold the Board to account.

Would merger lead to reconfiguration of services?

7.11 Some of the benefits of a new merged organisation may only be realised by changing or reconfiguring services. However, no decision has yet been made about what changes might be appropriate. Although some changes are put forward as examples in this SOC, it is recognised that these proposals would require engagement and/or consultation with stakeholders, including commissioners, public and patients and consideration of the guidance and law.

How will the costs of restructuring the organisation be managed?

7.12 In the Full Business Case resources would be dedicated to detailing costs of restructuring the new organisation and ways to manage these, such as pay differential between the end organisations. Transformation of the organisation would have costs but we believe these would be outweighed by the clinical and

academic benefits, would be offset by the savings that are achieved and would not all be immediate. Moreover, the new organisation would have greater financial flexibility than the individual organisations currently do to invest for the long term.

Would creating a single organisation affect the investment plans of the partners?

7.13 Each of the four partners has significant investment plans. Organisational integration cannot and should not impede future investment. However, the Full Business Case process would need to ensure that these investments are fully aligned with the shared goals for King's Health Partners. It may turn out that joint investments in the new organisation would be a more efficient way of delivering some of these plans (for example, to procure new IT systems).

Would organisational integration reduce patient choice and competition?

7.14 In nearly every other part of the country outside London, it is the norm that only a single teaching hospital would serve the size of population that King's Health Partners does. Nonetheless, it may be the case that the proposed integration of the NHS Trusts is deemed to require consideration by the relevant competition authorities. However, a preliminary review of evidence indicates that for acute services in this sector of London, significant choice and competition would remain. Some of the key arguments to support this assessment are laid out below.

- *Access to services would not be reduced.* Core local services such as maternity and Accident and Emergency departments would remain on the existing two sites. Due to the size of the units there is not a risk that services will be closed or reconfigured at a later date.
- *Many alternative providers would remain for routine services.* There are numerous other providers in the local area. King's College Hospital and Guy's and St Thomas' are two of 25 acute trusts in London. For non elective services there are significant alternatives. Within 30 minutes drive time (~6miles) 44% of the population have a choice of 2-5 Accident and Emergency departments. For elective service such as a knee replacement there are a number of alternative providers, all of whom conduct significant numbers of procedures.
- *Specialist services must be considered on a regional or national base*. For example, 68% of patients receiving Coronary Artery Bypass Grafts (CABG) are regional or national referrals and in this market there are a large number of other providers.
- *Any reduction of choice and competition would be outweighed by improvements in the quality of care.* The benefits case is detailed in section 5 of this document. A single organisation would improve patient care and experience in a number of ways. Without merger, the realisation of these benefits may not occur or would be much slower.

Would merger impede King's Health Partners' ability to respond to the external environment?

7.15 Significant changes are underway in the healthcare system (for example, the developments around the future of South London Healthcare Trust), in the academic world and in the wider economy. Part of the justification for organisational integration is to better equip King's Health Partners to respond to this changing environment. However, if we proceed with integration we would ensure that we do not become too inward focussed in the short term. For example, we would continue

to jointly lead the development of an Academic Health Sciences Network for south London, to help spread innovations in healthcare across the whole sector. Organisational integration would also better prepare us to deal with the challenging economic environment that all NHS organisations will be facing. This would help protect the interests of local patients.

What would be the risks of not proceeding?

7.16 There are also risks if the partners do not proceed to form a single academic healthcare organisation including the creation of one NHS Foundation Trust more closely integrated with KCL. First, King's Health Partners may need to adjust its ambition and/or the expectations about the pace of delivery. Second, King's Health Partners would be in a poorer position to respond to future trends in healthcare, the economy and the academic world. Third, not proceeding may itself require organisational restructuring to CAGs. Finally, alternative processes might need to be found to deliver financial savings in years to come.

8. FORWARD PLAN

8.1 There are five core sets of activities on the forward path to approval:

- creating a Full Business Case and integrated business plan for the new organisation (including detailed set of financials);
- designing the organisational and operating model;
- gaining approval from the regulatory and competition authorities;
- working with commissioners, engaging formally with the public and our members, and broader communications with our staff and stakeholders;
- planning for the transition to and implementation of the new organisation, including the appointments process and integration plans.

8.2 These activities would be managed as a programme separate from the 'business as usual' of both the King's Health Partners Executive and the various partner organisations. It would be led and managed by a Programme Management Office (PMO) and accountable to the King's Health Partners Board for designing and managing the work and co-ordinating the interactions with the key stakeholder groups. The PMO would be led by members of the King's Health Partners Board supported by a full-time Programme Director and team. It would report regularly to the King's Health Partners Board and a subset of this board between board meetings as required.

Regulatory and competition process

8.3 The current estimated path to regulatory approval runs to April 2014. During this period, the core milestones on this path are engaging with commissioners and stakeholders, the start of formal public consultation and formal engagement with Monitor and the competition authorities (beginning with pre-notification discussions in April 2013). The latter requires the five-year integrated business plan to be complete.

8.4 There are two key external uncertainties around this timeline which could potentially impact the timing by a year or more:

- the detailed implications of the recent Health and Social Care Act, including the licensing regime;
- the impact of the appointment of a Trust Special Administrator in respect of South London Healthcare Trust (SLHT) – a process in which the FT partners are keen to play a constructive part.

8.5 An important step following approval of this Strategic Outline Case by Partner boards and the KCL Council would be to seek further guidance from various authorities around these uncertainties.

Communications and engagement

8.6 Ahead of a public consultation and in conjunction with the development of a Full Business Case, we would need to communicate the positive case for a new

organisation, demonstrating to staff, members, governors, patients and stakeholders the benefits and explaining how we would manage the risks.

8.7 To achieve this communication, we would continue to use face-to-face methods and to use the media and our own publications, but we would also significantly increase our use of digital media channels and look to foster debates in other environments.

8.8 We would hold a further series of broad staff engagement events as well as with specific staff groups, both clinical and non clinical. We would produce communications materials to clearly outline the benefits of a new organisation and explain the proposals to our staff and stakeholders. We would continue to meet with local health scrutiny teams, MPs, commissioners, clinicians, patients and patient groups to understand their views, and we would work closely with regulators (including HEFCE and Monitor) and the Department of Health on the proposal.

8.9 It is recognised that some of the proposals in this document will require engagement and/or consultation with stakeholders. At the appropriate time, engagement and consultation, following best practice, will be undertaken. It is important that, at this stage, no decision has yet been made about what changes (if any) might be appropriate.

8.10 Each of the partners in King's Health Partners understands their obligations under the Equality Act 2010 and, in working through the detailed issues arising from this SOC and the development of any case for organisational change, will properly analyse and take into account the impact of any equality issues in order to meet the three main aims of the general equality duty.

9. CONCLUSION

9.1 The analysis undertaken in this SOC helps answer the four questions that were posed.

What is the rationale for organisational integration?

9.2 There are a number of significant external drivers for King's Health Partners to consider changing its organisational form - healthcare, academic, economic and social.

9.3 The internal driver for change is the King's Health Partners mission. The proposition is that a more integrated King's Health Partners could deliver more and at greater pace. A single organisation would achieve this through closer alignment of priorities, greater financial flexibility, simplifying partnership working, and organisational scale.

9.4 An integrated academic healthcare organisation could thereby help King's Health Partners realise an enhanced vision, with a particular focus on physical and mental health integration and on the challenges of population health.

What is the preferred organisational model?

9.5 Merger of the three Foundation Trusts and closer integration with KCL has been identified as the preferred organisational model.

Do the benefits outweigh the costs and risks of integration?

9.6 A number of clear benefits have been identified from organisational integration, including improved care for patients, enhanced academic performance and increased economic value. The costs of integration will include transitional costs and short and longer-term restructuring costs. Neither the costs nor benefits of integration have been fully assessed at this stage. The risks of organisational integration are significant, but we believe these could be managed. The Full Business Case would undertake a more detailed (and quantitative) analysis of the full benefits and costs of integration.

What is the forward plan?

9.7 If the Boards of the partner organisations decide to proceed, the next step is to assess fully the costs and benefits in a Full Business Case. We believe this could be completed by early 2013.

9.8 Depending on the regulatory process, the organisation could legally come into form by late 2014.

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Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee 2012/13

Work Programme

The committee will conduct reviews on:

a) King's Health Partner merger

b) Public Health

c) Dementia

The committee will keep watching briefs and receive regular evidence on:

- Mental Health Older Adults;
- Psychological Therapy Services;
- Southwark Clinical Commissioning Group transition to full delegation and implementation of our recommendations;
- Future of Dulwich Hospital;
- Impact of welfare reforms on disabled people and people receiving social care;
- personalisation, safeguarding and the associated risks.

An interview will be conducted with the Cabinet Member for Health and Adult Social Care, Councillor Catherine McDonald, on 19 December.

Receive annual reports on:

- adult safeguarding
- hospital reports/accounts

Members of the committee will visit the three acute trusts

Agenda Annex

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2012-13**

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