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

MINUTES of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Wednesday 1 May 2013 at 7.00 pm at Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Mark Williams (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Denise Capstick
Councillor Norma Gibbes
Councillor Rebecca Lury

OTHER MEMBERS PRESENT:

OFFICER AND HEALTH PARTNER SUPPORT:
Professor John Moxham; Director of Clinical Strategy, King's Health Partners
William McKee; Director of Transition and Transformation, King's Health Partners
Dr Michael Heneghan; Liver Consultant, King's College Hospital
Mr Chris Rolfe; Head of Communications, King's College Hospital
Zoe Reed; Executive Director Strategy and Business Development, South London and Maudsley NHS (SLaM)
Philippa Garety; Professor of Clinical Psychology , Clinical Director and Joint Leader Psychosis Clinical Academic Group (SLaM)
Andrew Bland; Managing Director of the Business Support Unit Southwark Clinical Commissioning Group (SCCG)
Tamsin Hooton; Director of Service Redesign SCCG
Ying Butt, deputy Chief Nurse, Community Guy's & St Thomas' NHS Foundation Trust
Cliff Bean; Director of Patient Safety, SlaM
Julie Timbrell; Scrutiny Project Manager

1. APOLOGIES

1.1 Apologies were received from Councillors The Right Reverend Oyewole and Mann with Councillors Chopra and Mitchell attending as substitutes.

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

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 Councillor Mitchell mentioned his long standing involvement in campaigning for Dulwich Hospital.

4. MINUTES

4.1 The minutes of meeting held on 25 March 2013 were agreed as an accurate record with the following amendments :

RESOLVED

It was agreed that Mr. Kenneth Hoole's comments recorded in the minutes under the Health Services in Dulwich item, would be amended to make clear that he said that the consultation plan looked *as if* it was produced by Saatchi and Saatchi; that more than one practice was linked to Dulwich Hospital, including Dr Shama's surgery; and that Mr. Hoole chose to amend his comments to *avoid* litigation.

4.2 Members of the public asked a number of questions about Health Services in Dulwich and the chair requested the following information :

RESOLVED

Southwark Clinical Commissioning Group agreed to provide the committee with briefing notes on:

- The overall spend on Health services in Dulwich so that

people can respond to the consultation with sufficient understanding of the finances.

- The ownership of NHS assets in Dulwich, including an explanation of what property is held leasehold/ freehold and what property will transfer to the NHS Property Services Ltd.

5. SOUTHWARK CLINICAL COMMISSIONING GROUP

5.1 Tamsin Hooton, Director of Service Redesign at Southwark Clinical Commissioning Group (SCCG), gave a verbal update on Southwark and Lambeth Integrated Care; Frail and Elderly Pathway. She reported there had been significant progress, but the initiative is slightly behind where they would like to be. This is community based multiple disciplinary team. Primary care are engaged to access the risk of all people over 70 years of age and the initiative is also focused on simplifying discharge from hospitals to the community. The chair requested board papers and encouraged members to look at these and consider follow up questions.

5.2 Andrew Bland; Managing Director of the Business Support Unit (BSU) SCCG referred to the Register of Interest circulated with the papers. He explained there are regular opportunities to update. The NHS commissioning board provided more guidelines on good practice.

5.3 A member commented that declarations appear variable and that sometimes members declare their political party membership, and that of their partners, while other members do not appear to be doing this. Andrew Bland responded that there are minimum requirements but people can declare more. The member queried how clear the policy was on political affiliations and Andrew Bland indicted he would circulate the updated policy to the committee.

5.4 Andrew Bland reported that the SCCG had received renewed guidance on contracts. He had received a note from the scrutiny project manager on the legal clause that the council uses to ensure providers are subject to scrutiny and he will consider this.

RESOLVED

<u>Frail and Elderly pathway</u>

SCCG will provide boards papers.

It was recommended that this is added to the work plan of the next administrative committee and Members will be encouraged to submit questions in advance.

SCCG Conflicts of Interest and providers 'subject to scrutiny'

SCCG guidance and policy on the Register of Interests and Declarations of Interest will be circulated to the committee.

The SCCG will report back on progress to include a clause in contracts that will ensure that all providers are subject to scrutiny.

6. PRESSURE ULCER FOLLOW UP REPORTS AND PRESENTATIONS

6.1 Ying Butt, Deputy Chief Nurse, Community, Guy's & St Thomas' NHS Foundation Trust (GST) ;Cliff Bean, Director of Patient Safety, SlaM ; Tamsin Hooton, Director of Service Redesign , SCCG and Professor John Moxham, Director of Clinical Strategy, King's College Hospital presented and contributed to this item .

6.2 Ying Butt, Deputy Chief Nurse (GST) presented Guy's & St Thomas report on Community Acquired pressure sores and noted that in the time period inquired about there were 19 pressure ulcers acquired prior to visiting hospital and three of the patients were Southwark residents. Ying Butt explained that when a pressure ulcer is identified as not acquired while receiving care from Guy's and St Thomas' services it is still reported to the commissioners and if there are any safeguarding concerns a referral to the local authority safeguarding team will be made in accordance with pan London safeguarding procedures.

6.3 A member asked about procedures and the Tamsin Hooton , SCCG , explained that there is a requirement for services to make a record of all pressure sores for people receiving health services, including funded nursing care. A member asked if there was guidance on this and he was told there was. Health professionals explained that there was a recent meeting on developing better protocols for sharing information about pressures sores between providers and commissioners . Cliff Bean, SlaM, commented that they are now monitoring this better as there is a focus on pressure sores through the Patient Safety Thermometer.

6.4 Members asked if there has been an increase in pressures sore and clinicians said that hospitals are seeing an increase of stage 2 and 3, and sometimes grade 4, pressure ulcers in patients not seen previously by clinicians. Professor Moxham commented that King's is seeing an increasing number of frail elderly people coming in to hospitals needing total care and also intensive care. The Deputy Chief Nurse, GST, explained many patients have co morbidity .Cliff Bean, SlaM, commented this often involves people with dementia or on an end of life path.

6.5 A member asked if pressures sore were caused by carers not turning mattress or not enough nurses. Professor Moxham said there had never been more care, and mattress, and more resources focused on this in hospitals. Members asked for the causes and clinicians explained that extra cases may be from private residents and from private care homes and they will be looking at this forensically. Cliff Bean, SLaM, explained that people can acquire a serious pressure sore very rapidly, for example in one case somebody collapsed and could not move; by the time they were found they had developed a pressure sore. There were concerns raised that care in the community is not working.

RESOLVED

The Trusts will provide:

Follow up information on how community acquired Pressure Sore cases are resolved, with particular focus on quarter 2 2012/13 and new protocols being developed.

An analysis of why Pressure Sores are increasing, including data on where these are acquired.

7. SAFEGUARDING UPDATE

7.1 The papers were noted.

8. REVIEW : KING'S HEALTH PARTNER MERGER

8.1 The chair invited Professor John Moxham, Director of Clinical Strategy, King's Health Partners (KHP) and William McKee, Director of Transition and Transformation, King's Health Partners to update the committee. Professor Moxham reported that KHP are developing options for closer working, however progress has been slowed because of the impact of the TSA and the proposed acquisition of Princess Royal University Hospital (PRUH). He commented that there are two judicial reviews in the pipeline concerning the TSA and Lewisham Hospital.

8.2 William McKee introduced himself and explained he is a career trust chief executive and oversaw the merge of six previous Trusts in Northern Ireland. These are now fully integrated .He will be leading on closer integration of KHP and developing the business care.

8.3 He reported that KHP felt the respective organisations could do better if they came together more tightly. There is intense activity going through to June and if the partners think that there will be benefits then they will go to a full business case this autumn, which will then go to stakeholders. Options that are being explored include full merger or formal cooperation. A contract with consultants Mckinsey & Company has been agreed. A full merger would be considered by the Office of Fair Trading and Monitor, which takes time and KHP would not expect to hear back until 2014

8.4 A member asked about risks and William McKee said he will be commissioning a piece of work from a range of sources looking at the potential risks

8.5 KHP representatives were asked how a closer working relationship between partners would benefit local people. Professor Moxham said that KHP will see global quality services in people's backyard and the partnership would also be offering better services for people with co-morbidity. He assured members that KHP do not have to do this and that if the partners find the benefits in terms of better care are not there, they will not pursue the merger option. A member commented there are problems related to the democratic deficit; people do tend to be concerned about their services in their patch and local people will be concerned about the vastness of KHP and people's ability to exert influence. Professor Moxham commented that if a local resident had a stroke they would go to King's, but an aneurysm would be treated at Guys and St Thomas, whereas a bone transplant would take place at King's too - working at scale allows this level of specialism. A member remarked that

he understands the rational for the acute services but is less convinced that this will improve services to the local communities.

8.6 A member commented that the KHP population now include the patients served by Princess Royal University Hospital (PRUH). Professor Moxham commented that the TSA process been challenging. King's is a medically successful organisation but it is rammed full. The upside of King's acquiring PRUH is that can it can drive positive change and efficiency in the PRUH. However, he cautioned, the acquisition of PRUH is still not a done deal and no final decision has been made yet .King's will not take PRUH on unless there is sufficient transitional funding to invest in PRUH. There would also need to be enough money to provide more maternity and emergency capacity, as King's is already full.

8.7 Members asked about the relationship with SCCG and Professor Moxham said they are extremely cordial and that KHP will have to demonstrate a convincing case to our commissioners and patients. Andrew Bland, SCCG Managing Director commented that the SCCG have produced a statement on what would be good for KHP. He continued that the TSA have said that the solution to King's being too full is to bring to life Community Care. Professor Moxham commented that integrated care is the future is we all want to make best use of money

8.8 A member commented that adding PRUH to KHP means the addition of the Bromley population. Whereas before there was more of a focus on the local population of Southwark and Lambeth, with existing close community and geographical ties, this additional population is an additional layer of complexity, and there is the additional a risk that the acquisition of PRUH will not be completed. William McKee said that when KHP write the higher order business case KHP will write in an assumption that PRUH is acquired.

8.9 A member voiced concerns that the merger could be perceived as a done deal and asked to what extent people will be able to see the evidence of each option. KHP representatives responded that the board is arranging an away weekend for a deep dive to identify risks. The chair asked if this information will be published and KHP representatives responded that this would be encouraged but they are unable to say for sure. There was a discussion on if a merger of KHP would amount to a substantial variation. KHP representatives said that they thought that the Secretary of State would be neutral and that a merger would not need his or her approval.

RESOLVED

The committee asked to be kept up to date about progress with negotiations between King's and the Department of Health and to have first sight of early documents produced in June in connection with the business case for PRUH and the options for KHP.

9. KING'S COLLEGE HOSPITAL LIVER TRANSPLANT PRACTICE

9.1 The chair invited Dr Michael Heneghan, Liver Consultant, King's College Hospital, and Mr Chris Rolfe, Head of Communications, King's College Hospital to present the paper. The chair then remarked that on first sight of press reports he was concerned, however said he now feels reassured by the verbal and written reports received. He asked Dr Michael Heneghan to give an explanation of a patient's journeys and an explanation of how organs are offered and the processes involved.

9.2 Dr Michael Heneghan explained that King's transplant about 200 livers a year and are the largest centre in the UK. They have been pioneering processes to make more livers usable .There are two categories of priority: Group One is for NHS patients and European Union patients - NHS are the majority. If no recipients are available for NHS patients in the UK then a liver will be offered to Ireland and then further afield. Group Two is comprised of private patients; King's only perform between 2 and 8 operations a year. These recipients may get offered a liver because of rare blood groups such AB. Private patients only receive livers that would be discarded if they were not used for private patients.

9.3 A member asked how long livers are viable for and the Liver Consultant explained that they are viable for 12 -14 hours , however King's are trying to use organ resuscitation machines to keep them usable for longer. The Head of Communications explained that Kings also retrieve EU livers. He reassured the committee that whatever their views are on private operations, livers are always offered to NHS patients first.

9.4 The Liver Consultant explained King's is a site of excellence. King's turn down 5% of livers, whereas Newcastle does not use up to 65 % of its donated livers. Kings was one of the first centres to

split livers and take risks. Kings have a big list and the centre does what is can. Newcastle have smaller list and so wait for better organs, however King's outcomes are some of the best in the world. King's would like a national waiting list. It is worth bearing in mind that 50% of people on the waiting list do not want a marginal organ.

9.5 A member said he understands that under EU law the NHS is required to perform operations on EU patients. The King's representatives explained that King's tend to perform operation on patients from Malta and Cypress where there are reciprocal arrangements in place as these countries do not have the clinical capacity to do these operations in their local hospitals. There are also special arrangements with Dublin, particularly for children. In the last 5 years 28 patient have received organs from EU countries, half of whom are children. King's have received 20 organs from Cypress and Malta. The Republic of Ireland is a net exporter of around 300 organs.

9.6 Professor Moxham explained that the 3 month death rate for King's transplant recipients is incomparably better and much of this is down to experience and critical mass. The closer you live to a transplant centre the more likely you are to have a transplant .Good transport networks are related to successful organ donation too and Kings have been making links with Plymouth to improve access and clinical skill. Kings want to raise other providers to their level.

RESOLVED

The chair asked King's to send press releases, and other relevant information, to the scrutiny project manager when contentious issues arise.

10. REVIEW: PREVALENCE AND ACCESS TO PSYCHOSIS SERVICES; BME COMMUNITIES

10.1 The chair invited Philippa Garety, Professor of Clinical Psychology , Clinical Director and Joint Leader of the Psychosis Clinical Academic Group and Zoe Reed, Executive Director Strategy and Business Development, South London and Maudsley NHS to present and then invited questions

10.2 Members queried the evidence that ethnic minority members are more at risk generally but this reverses when a BME community reaches a certain level of density at a very local level. The Professor of Clinical Psychology explained that this is true of many immigrant communities and the second generation is more at risk than the first generation, unless they come from a war torn country. Members commented that Southwark and Lambeth have high levels BME communities in some wards; however Southwark still has high rates of psychosis. Philippa Garety responded that these communities would be more resilient, but only if there was a high density at a very local level. A member commented about half of Brunswick Ward is composed of BME communities and the Professor of Clinical Psychology said this is a good example; while members of BME communities might do better in Brunswick , they might do less well in College Ward. A member noted that Richmond has a low density of ethnic minorities but also low levels of psychosis. The Professor of Clinical Psychology explained that there are many interrelated factors such as levels of social exclusion, including employment levels.

10.3 A member commented that the causes seem to be related to societies problems and that people need support to maintain health, which could come though schools or through their neighbourhood communities; people need kindness and caring, particularly if they get unwell. The chair commented that the discussion suggested that focussing on social factors and reducing social adversity might yield the most useful recommendations.

RESOLVED

Public Health and Adult Social Care will be asked to provide a briefing paper.

Members will be asked to comment on the scoping document.

11. MARINA HOUSE UPDATE

11.1 Tanya Barrow, Community Safety Partnership Service Business Unit Manager, referred to the briefing tabled at the meeting and explained that the commissioning structure for Drug and Alcohol services is a complicated picture. There is a partnerships board with a pooled budget, which is top sliced. The council leads this and holds the SCCG budget through which services from SLaM

are commissioned and managed. Treatment is provision is declining because there is a national trend of declining opiate users.

11.2 There were despite protracted negotiations to deliver the Integrated Offender Management (IOM) service programme at Marina House; however it was not considered the right location. The substance misuse service user group have fed back positively on the current arrangements.

11.3 Local resident Tom White commented that the Older People Partnership Board frequently talk about alcohol misuse. He asked if there was good news on reductions in illegal drug use but increases in problematic alcohol consumption. Tania Borrow agreed that this is a national trend; however Marina House did not treat alcohol abuse. She explained that the service tends to offer different treatment services as alcohol is legal and drugs are illegal. She explained that there is a drugs needs assessment being conducted that will look at prevalence and the effectiveness of treatment options.

11.4 A member commented that the level one course for GPs to refer to drug service is not very demanding and more about awareness rising. She explained that the healthcare assistants at her place of work do this level of qualification, and that she was concerned that it was not an adequate level of training to equip General Practitioners to undertake referral work with patients with complex needs. Tania Barrow commented that the partnership do not want to want to force GP's to do higher level courses; furthermore some surgeries also have drug workers. She added that there are specialised services at Blackfriars complex and in hostels.

11.5 A member asked how treatment performance is measured and Tania Barrow commented that they look at levels of recovery and if someone re-presents within 6 months.

11.6 A member commented that there were a number of promises for Marina House, and the reconfiguration of drugs services, which he is concerned have not come to pass. He added that the explanation about IMO is useful, but he was concerned about the rest of the services. The committee were given certain assurance about Blackfriars, however the footfall looks different. He commented that this engenders certain scepticism about the information given during the consultation.

11.7 Members queried if levels of drug use level are going down; one member said he thought this was the national picture and that Richmond are seeing a reduction in cases, however another member commented that she is seeing an increased proportion of drug users at Belmarsh Prison where she works.

11.8 Chair invited Tom White to make further comment. He said that he thought it was a dire situation to recommend that drug users go to Blackfriars for treatment as this is often not easy. He raised concerns about the loss of lives because of a lack of self referral options and added that local MPs think it was retrograde step to end the self referral, but SLaM refuse to re-consider this. He said that comparisons are made with other illness - but drug use is completely different.

11.9 He complained about the quality of the consultation document circulated with the agenda and said that he thought that information was missing. He went on to say that although the letter says that the £95 000 was not applied for in the end he has documents saying that this was accepted. Tom White said he knew Mike Farrell, a drug treatment expert, who used to treat GPs and dentists at Marina House. Tom White said he was concerned where health professionals would now be able to access treatment. He ended by saying that he thinks that Marina House is virtually empty, while there are record numbers of drug users arriving at King's College Hospital. He thought Marina House was effectively being closed down as a drug treatment centre, without consultation.

11.10 The chair thanked Tanya Barrow for her presentation and requested further information on the points raised by Tom White and the committee.

RESOLVED

SLaM and Southwark Clinical Commissioning Group will be asked to present.

The following information will be requested:

- The number of patients presenting at King's over the last 5 years with drug and alcohol problems, including a breakdown on the number of Southwark residents.
- Information on where GPs and dentists with drug misuse problem are being provided with treatment.
- Mental health emergency crisis room at Kings and to what extent people in crisis do use this facility to access mental health treatment, including prescriptions.
- Statistics from the police on the number of arrests for drug and alcohol offences, including trends for the last 5 years