Open Agenda

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

Wednesday 4 September 2013
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Membership

Councillor Rebecca Lury (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Denise Capstick
Councillor Neil Coyle
Councillor Rowenna Davis
Councillor Jonathan Mitchell
Councillor Michael Situ

Reserves

Councillor Patrick Diamond
Councillor Dan Garfield
Councillor Paul Kyriacou
Councillor Eliza Mann
Councillor Mark Williams

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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: 27 August 2013

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

Wednesday 4 September 2013
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.	
4.	**MINUTES** 4.1 To approve as a correct record the Minutes of the open section of the meeting held on 15 July 2013.	1 - 12
5.	**ACQUISITION OF PRINCESS ROYAL UNIVERSITY HOSPITAL BY KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST**	
6.	**ACCIDENT & EMERGENCY** This item is part of the new review into Access to Healthcare in Southwark. An Urgent & Emergency Care briefing is attached from Lambeth and Southwark Urgent Care Board.	13 - 15

Item No.	Title	Page No.

7. 111 SERVICE

This item is part of the review into Healthcare Service in Southwark. Papers will follow from Southwark Clinical Commissioning Committee and Healthwatch.

8. REVIEW: ACCESS TO HEALTHCARE IN SOUTHWARK 16 - 23

The Terms of Reference to the review of Access to Healthcare in Southwark are attached.

The summary of the recent House of Commons select Health Committee report om' 'Urgent and emergency services' is attached. The full report can be accessed here : http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/13-07-23-urgemrepcs/

9. PSYCHOTIC DISORDERS IN ETHNIC MINORITY POPULATIONS IN LAMBETH & SOUTHWARK 24 - 40

This item is part of the review into the 'Prevalence of Psychosis and access to mental health services for the BME Community in Southwark'.

A paper is attached from Lambeth & Southwark Public Health Team.

10. REVIEW: PREVALENCE OF PSYCHOSIS AND ACCESS TO MENTAL HEALTH SERVICES FOR THE BME COMMUNITY IN SOUTHWARK 41 - 42

The Terms of Reference for the review into the ' Prevalence of Psychosis and access to mental health services for the BME Community in Southwark' are attached.

11. WORK-PLAN

12. REPORTS FOR INFORMATION 43 - 58

The following reports are attached for information:

- CCG monthly update on performance data and QIPP
- Health Services in Dulwich - update

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

PART B - CLOSED BUSINESS

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

Date: 27 August 2013

Open Agenda

Agenda Item 4

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 Monday 15 July 2013 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Rebecca Lury (Chair) Councillor David Noakes (Vice-Chair) Councillor Neil Coyle Councillor Rowenna Davis Councillor Jonathan Mitchell Councillor Michael Situ
OTHER MEMBERS PRESENT:	Councillor Peter John
OFFICERS & PRESENTERS SUPPORT:	Dr. Ruth Wallis , Public Health Director
	David Sturgeon, Head of Primary care, South London, NHS Commissioning Board
	Andrew Bland; Chief Officer , Business Support Unit (BSU) Southwark Clinical Commissioning Group (CCG)
	Malcolm Hines, Chief Financial Officer, Southwark BSU/CCG
	Gwen Kennedy, Director of Client Group Commissioning BSU/CCG
	Tanya Barrow, Community Safety Manager
	Emily Finch, Clinical Director, Addictions, SLaM
	Rebecca Walker, DAAT and Interim Commissioning Manager
	Rebecca Scott Dulwich Programme Manager , Southwark CCG
	Alvin Kinch, Healthwatch Southwark Manager
	Fiona Subotsky, Healthwatch Interim Board member
	Julie Timbrell; Scrutiny Project manager

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Capstick and apologies for lateness from Councillor Mitchell.

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

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

4.1 The minutes of the last adminstratives year's committee meeting , held on 1 May 2013 , were cirulatated to note.

5. HEALTH & WELLBEING BOARD

5.1 The Leader, Cllr Peter John, ran through the presentation circulated: 'Building a healthier future together - Developing Southwark's Health and Wellbeing Board and Strategy'. This was followed by a presentation by the Public Health Director, Dr. Ruth Wallis, on the 'Joint Strategic Needs Assessment'. The chair then invited questions.

5.2 A member commented that he had not seen measurable targets and outcomes for the shadow board, and asked if these will come. The Leader responded that all the departments do have targets and measurable outcomes and it is anticipated that these will link this up with the strategy. The member asked when this would happen and if this would apply to the shadow strategy or the one being developed. The Leader replied it would most likely apply to the current strategy but it would take some time to align different parts of system - for example a tranche of targets and measures would be provided by the Children's Trust. The member went on to comment that the LSP always found it difficult to demonstrate its

achievements and the Leader assured the committee that he was very keen to get measurable outcomes.

5.3 A member commented that the committee asked a number of public health professionals and clinicians to say their top priority and Professor Moxham said his was smoking. He added that his top priority was Sexual Health and noted the highs levels of Gonorrhea, Syphilis and HIV in the Southwark. The Leader responded that smoking is there as a priority and recently money has been committed for Sexual Health.

5.4 The Public Health Director agreed that sexual health is a big issue in Southwark. She went on to observe that part of the reason that rates went up recently is that statistics are now based on where tested people are tested , rather than residence , and Southwark has invested in improved testing. She also noted the good work on early detection of HIV - the proportion of people presenting late in Southwark is about 30% , whereas other areas it is more like 80% .She reported that Southwark have brought in a scheme for people to get tested on registration with a doctor . She voiced disappointment on the recent decision on improving cigarette packaging. The member commented that he thought is would send a strong message if Sexual Health was a political priority - given the life changing consequences on fertility of Chlamydia infection and rates of HIV infection among the young gay community .

5.5 A member asked what work is being done with 2 year olds and also helping older people to be fit and healthy. He noted the effectiveness of simple things like inviting people for walls around Dulwich Park and reminiscence. The Public Health Director commented that there are a number of approaches and activities that focus on these age groups, and she commented that the Marmot report demonstrates the importance of early intervention.

5.6 A member referred to the work of the Peckham Experiment and suggested this could be an inspiration. She went on to ask if community engagement has been prioritised and resourced. The Leader assured the member that community engagement is a very important part of the approach there will be outreach.

5.7 The Public Health Director was asked about sources of data and she responded that some of the data used is national. One concern is that ONS have said that they can no longer afford to produce data on childhood mortality and teenage conceptions, and this poses challenges. The chair asked the Public Health Director to report back on this.

5.8 The Public Health Director was asked about the budget available and any decommissioning plans and she said that there is no direct budget and the Health and Wellbeing Boards role is more

about influence. The Leader commented that there are some commissioned budgets we are negotiating around HIV.

5.9 The Leader was asked about the role of the Police on the Health and Wellbeing Board and he explained that the board wanted their intelligence. He added that there are targets around children and presence on the board offers an opportunity to shift mindsets across lots of different organisations. The Public Health Director noted that many attendances at A and E are alcohol related so this is an opportunity to think collectively .The Leader recommended the report ' Re-wiring Public Services' , which writes about the need for local delegation of budgets.

RESOLVED

The following will be provided:

- A briefing on the recent announcement that the Office for National Statistics may no longer be able to afford to produce data on childhood mortality and teenage conceptions.

- An update on Health & Wellbeing strategy and Joint Strategic Needs Assessment in 6 months time.

6. HEALTHWATCH

6.1 Healthwatch representatives Alvin Kinch, Healthwatch Southwark Manager, and Fiona Subotsky, Healthwatch Interim Board member, went through the presentation circulated with the papers and the chair invited questions.

6.2 A member asked what significance does it have for Healthwatch to be a subgroup of Community Action Southwark (CAS) and the Healthwatch Manager commented that Lambeth Healthwatch is setting up as a charity and went down a the co-production route. She said it will not affect Healthwatch priorities which will be decided by CAS trustees and also by Healthwatch members. A member asked how the membership will be decided and asked if there will be an election process and if membership is open to the public. The Healthwatch manager commented that they do not know yet, however Healthwatch aim to decide that by October. She reported that Healthwatch is currently doing a membership drive. The member commented that he was keen to understand the democratic and engagement process.

6.3 A member asked if Healthwatch will function like a police neighbourhood watch. The Healthwatch manager asked for clarification and he suggested that people might have labels on their windows showing that they are advocates for health. The manager agreed that Healthwatch do want and encourage people to raise issues. She added that issues are put into a local and national database. A member asked if there was an option such as telephone line to raise concerns and the Manager responded that Healthwatch are developing a signposting system.

6.4 A member said he thought the emphasis on engagement was very good . He added that he would like to see diversity on the board and asked if Healthwatch will provide training. The manager responded that the staff team will be doing that across the borough .She explained that at the moment they are focused on good clear communication so people understand what Healthwatch are doing . She added that the organisation is also aiming to offer members appreciation and ensure expenses are covered.

6.5 Healthwatch were asked if they had the resources to support people with Learning Difficulties or refugees and the Manager responded that the organisation has £100,000 per year to spend , so they do need to work within these resources. She explained that Healthwatch intends to tap into what is out there already and emphasised that Healthwatch is a network of networks.

6.6 An audience member commented that she had done work for LINks, the predecessor organisation, but had not heard back from Healthwatch. She questioned whether the priorities were sufficiently local or if they were driven more by national priorities. The manager and board member responded that they were sorry the audience member felt like that and reported that LINks have done a legacy report, which is to be presented to the board. This will look at how to take the work of LINks forward. The audience member said she had felt disheartened and emphasised the importance of maternity and early years, and expressed the hope that this would be one of Healthwatch's priorities. The chair asked Healthwatch to report back on the priorities once they have been agreed and thanked the presenters.

RESOLVED

In six months time Healthwatch will provide information on:

- governance arrangements; including democratic engagement and details of any elections
- Healthwatch priorities

7. SOUTHWARK CLINICAL COMMISSIONING GROUP

7.1 Andrew Bland, Chief Officer, and Malcolm Hines, Chief Financial Officer, Southwark Clinical Commissioning Group (CCG) presented the CCG paper and the chair invited questions.

7.2 A member asked if the CCG thought that there will be a shift of resources to keeping people well rather treating ill people over time . Malcolm Hines responded that the CCG do look at this over time for redesign . He added that the CCG are also looking at a 10% growth of population and that there are also the new specialised treatments and drugs. Andrew Bland commented that the CCG would like to see more integration with social care and also primary care as the CCG do see more value there . He indicated that there is an anticipated shift of resources in this direction in 2016 and this will run to billions of pounds . He added that there is a tendency for acute services to suck up most resources, however the CCG would like to move to integrated care, but this is challenging to make real .

7.3 A member asked about data received from providers on performance and commissioning plans and Andrew Bland commented that the CCG had made a commitment to provide this monthly to the committee.

RESOLVED

The CCG will provide a monthly update on performance data and the QIPP programme.

8. NHS ENGLAND - LONDON SOUTH COMMISSIONING PRIMARY CARE

8.1 David Sturgeon, Head of Primary care, South London, gave his presentation on 'Commissioning Primary care' and the chair invited questions.

8.2 A member asked about potential conflicts around 'local enhanced services' and the Head of Primary care said that these have been delegated to the CCG and local authority. He explained that the provision will now need to go through the 'any qualified provider' commissioning process when they are 're-provided'. He gave smoking services as an example and suggested that the council or the CCG will probably want to re-provide, and in these circumstances then the council or the CCG might want to consider

if those service would be better delivered by 'any qualified provider' (the voluntary or private sector) rather than a doctor's surgery . A member commented this would mean the transfer of local resources to Any Qualified Provider.

8.3 An audience member commented that he tried to get some help for a 93 year old man and raised a complaint via email 7 weeks ago with the NHS Commissioning Board; however he only got an email saying this will be followed up and that is it so far. The Head of Primary care indicated that there is a backlog of 174 complaints and contacts - some of which go back to contractors and take time to resolve. He assured the committee that they are trying to clear the backlog and offered to take details and follow up individual issues.

8.4 A member of the audience asked if the service is accountable to the Secretary of State and remarked that the recent restructure of Health Services seems to have decimated adequate oversight by managers. The Head of Primary care explained that the NHS Commissioning Board is not accountable to the Secretary of State but does have a mandate from the Secretary of State and they are now consulting on the delivery of services.

9. MARINA HOUSE AND THE DRUG & ALCOHOL POLICY FRAMEWORK

9.1 The Marina House and the Drug & Alcohol Policy Framework presentation was introduced by Gwen Kennedy, Director of Client Group Commissioning , Tanya Barrow, Community Safety Manager, Emily Finch, Clinical Director, Addictions, SLaM and Rebecca Walker, DAAT and Interim Commissioning Manager . The chair then invited questions.

9.2 Officers were asked if most drug treatment had moved out of Marina House and how it will be utilised more fully in the future. Officers confirmed that it was principally now being used to provide back office support. Officers explained that it is a SLaM building, which means it can be used for beyond Southwark residents. Officers said Marina House was not entirely full, and that development of the space will be tied in with the Drugs Needs Assessment. Voluntary groups have also been invited to propose services to be delivered from there. A member of the public asked for details on the proposed arrangements with voluntary providers, however, officers said this was not ready to be shared as officers are still developing relationships and scoping the proposals out.

9.3 A member quiered the amount of training GP have received to assist drug users. Members queried the data on the amount of

GPs who had completed levels one and two, and the expressed disappointment with the lack of detailed information and targets. The scrutiny project manager commented that more information had been given in a previous report and officers offered to provide a more detailed follow on report.

9.4 The member reminded the officers that one of the challenges that scrutiny put down when the original plans moved drug referral to GP practices was that there would be an investment in training. Rebecca Walker responded that there are specialised drug workers in the many of the surgeries. She explained the service are reluctant to push GPs to work with drug users who do not want to do this as that gives poor outcomes . There are also drug clinics that people can use if they can't access drug services adequately in surgeries, as primary care have some GP practices who don't want to provide a drug service, but patients who still want to stay registered for other health care. Rebecca Walker asked members why this was such a concern and the committee members reminded officers of the original commitment to train GPs when the service re-design emphasised the referral role of primary care and restricted self referral and reduced services at Marina House. Members pointed out those now only 10 GPs are trained at level 2 out of a total of 240.

9.5 A member commented that Marina House is a threadbare service and raised concerns that this used to be a place people went from the south of the borough for treatment for serious drug problems. He suggested that this left a big hole in the south for services. Rebecca Walker responded that there are two big services in Camberwell, and SEDAC do outreach. She offered to provide a map and description of the services. Offices emphasised that treatment access has gone up and success rates have also increased, furthermore that is an overall drop in opiate users.

9.6 Members asked how the Drug Needs Assessment will be done and officers said that this will be commissioned out and use a literature review, focus groups and national data. Members asked when this would be completed and officers explained that they might be able to come back in October, however it might be later.

9.7 A member asked if crystal meth use is increasing as she had heard local reports that suggested it was. Officers said that it was, however it is still very low, so cases are rising from 4 to 10.GBL is more concerning, however the service predicted a significant rise in crystal meth that did not happen. Officers explained that they do a promotion with gay men on GBL on risks. There is also concern on manufacturing as a fire risk.

9.8 An audience member commented that he was very concerned about the increasing levels of alcohol abuse and said he

understood this was a major problem. Tania Barrow commented that there are different service arrangements for drugs and alcohol, as dugs are illegal and alcohol legal; she offered to make available the Southwark's Alcohol Strategy. The chair invited audience members to consider the information officers have promised to provide and contact her in advance with any quires.

RESOLVED

Council and CCG commissioners will provide the committee with:

- A briefing on drug services in the south of the borough, including a map of all the treatment centres and a description of activities, including outreach.
- More details on GP drug training.
- A copy of Southwark's Alcohol Strategy
- Return with the Joint Strategic Needs Assessment on drugs, when it has been completed, in around 6 month's time.

SLaM and the commissioners will provide the committee with a scoping document setting out plans for Marina House**,** including how it will be used for the provision of drug services**.**

10. HEALTH SERVICES IN DULWICH

10.1 Andrew Bland, Chief Officer, Southwark CCG, and Rebecca Scott Dulwich Programme Manager , Southwark CCG presented on Health services in Dulwich .

10.2 A member queried the level of consultation responses given the big distribution of questionnaires and noted that there has been quite a low response rate, particularly in hard to reach areas. Rebecca Scott explained that there has been a huge amount of community work with lots of in-depth responses received. These include responses from community groups who are often not heard, for example there has been engagement with Travellers. A member said he was interested that 3% of the respondents had learning difficulties, which is more than most but a high level of services users. Rebecca Scot said that the CCG did go back twice to one provider so she was sure that a thorough job was done in getting the views of people with learning difficulties. Andrew Bland said that the consultation plan also invested in a high quality Equality Impact Assessment.

10.3 A member of the audience voiced concerns about free schools utilising the Dulwich Hospital site and lobbying done by developers and local politicians. She said that she believed that the consultation has been marred by the free school issue. The chair pointed out that the consultation process can not look at the wider land use question, but is restricted to the health services to be delivered in Dulwich. The audience member commented that this only became clear after lots of pushing and said that there should have been more clarity and transparency to start with. A committee member said he had always been aware that the Dulwich Hospital site would have a wide range of community uses. The audience member commented that while that might have been clear to the member and this committee is was not clear to her or the public.

10.4 A member commented that he would like to see other community uses on this land, rather than commercial uses and he raised concerns that available land on the site could be swallowed up by developers.

10.5 Councillor Coyle asked how many representations about Harris School Councillor Noakes had made and he responded that he had made none, but other local councillors had been active.

10.6 Andrew Bland commented that he would like to focus on health services in Dulwich as this is what the CCG can deliver on. He added that wider issues were raised about transport and access and there is an issue about location. He said that when the CCG consulted they found that people wanted to talk about the quality of health services delivered rather than buildings, ownership and land arrangements. The audience member responded that thousands of people had submitted a petition about Dulwich Hospital. She added that a key issue for her is that the ownership of the hospital and has moved to a prop co (NHS Property Services). She asked if the CCG made representations to NHS Property Service and if the CCG have to get NHS England to commission services. Rebecca Scot explained that the plans are in the remit of the CCG; however the CCG will need to make a business case. This will need to outline the tenant's requirements and NHS Property Service will set out how psychical infrastructure will be built and how this will be financed. She added that the CCG can not say at the moment who will be the head lease holder, as this will be done on 'best value'. Audience members queried if Dulwich Hospital buildings are presentably leased from NHS Property Services and the current terms. Andrew Bland advised this query was best addressed to NHS Property Services.

RESOLVED

The committee will write to NHS property services requesting clarification on parties and terms of the current lease on Dulwich Hospital.

11. REVIEW : PSYCHOSIS AND BME COMMUNITIES

11.1 The committee agreed to defer this item until the next committee meeting.

12. REVIEW : GP ACCESS (OUT OF HOURS, A&E, 111 SERVICE, URGENT CARE)

12.1 The report was noted and discussion deferred until the next meeting.

13. WORK-PLAN

13.1 The workplan was noted.

Update briefing on GP's drug training and services

Since 2006, 110 GPs have completed the RCGP Part 1 training we estimate that we have about 120 trained GPs in Southwark (Bearing in mind GP turn over).

20 practices have a specialist drugsworker (also RCGP part 1 trained) from Kappa attending weekly or fortnightly to co-manage a satellite clinic with a GP. Each of these 20 practices has at least one qualified GP but up to 5 in some practices - they all have named, lead substance misuse GP and second to cover in their absence.

There are about 10 GPs with RCGP Part 2 in Substance Misuse, a one year intensive course for those who want to be a GP with Special Interest.

The RCGP training is run and funded by us twice a year and is available to all Southwark GPs. Ad hoc training is provided on request if we have an influx of new GPs or requests. Dr Frances Diffley and Dr Emily Finch run a 6 weekly clinical supervision session and are available for individual consultation.

Frances also offers shadowing and has 2 GP trainees on placement per year - she is also a GP trainer.

Frances also manages 2 clinics with Kappa staff for those who haven't got a GP or whose GP won't prescribe - this has capacity for 45. There are 2 GP Practices in Camberwell Green who have a Kappa clinic, one has an RCGP Part 2 trained GP (GP with Special Interest).

We have a specialist Primary Care Alcohol Nurse and worker who manage hubs across Southwark GP surgeries. The nurse runs 8 hubs for clients with complex alcohol problems across surgeries and all surgeries can refer into them (with a phonecall) and the worker has 8 hubs (at different surgeries) for those with less complex needs.

I hope this is helpful. If you have any questions please do not hesitate to contact Julie Cuthbert Julie.cuthbert@southwark.gov.uk or Dr Frances Diffley Frances.Diffely@nhs.net

Yours

Becca Walker

Becca Walker

DAAT and Interim Commissioning Manager

Agenda Item 6

NHS
Southwark
Clinical Commissioning Group

Urgent & Emergency Care

Lambeth and Southwark Urgent Care Board Briefing

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

September 2013 Meeting

1. Introduction

During the 2012/13 winter period, national performance against the 4 hour target deteriorated significantly relative to previous years. In response to this, NHS England issued guidance in May, which set out a number of key actions for local urgent care systems to support improved A&E performance, which included the development of a local Recovery & Improvement Plan. This document summarises the plan developed through the Lambeth & Southwark Urgent Care Network which has representation from key stakeholders across the health economy.

2. Performance overview

Whilst both GSTT and Kings ED performance met the 4 hour standard for all type attenders on average over 2012/13, both Trusts were unable to meet the standard in quarter 4.

In order to gain an understanding of the reasons for this change in urgent care performance a Winter Demand Review was completed which considered a range of metrics across the wider system e.g. community services, London Ambulance Service, primary care including GP out of hours providers, in addition to a wide range of hospital indicators.

The key findings were:

- Overall A&E department attendances during Quarter 4 had not changed significantly in the past two years, either at Trust or CCG level. However there was an increase in activity amongst the older age groups at CCG level and GSTT
- Whilst the total numbers of emergency admissions have stayed relatively stable, there was in increase in activity amongst the over 65 age group across Lambeth & Southwark.
- Whilst providers had reported an increase in the acuity of patients presenting at A&E, analysis of measures to assess this presented a mixed picture.
- The number of mental health patients presenting at A&E departments requiring assessment and appropriate interventions has increased significantly, especially local people who are unknown to the service
- Both Trusts have experienced issues with capacity. At GSTT this has been related to clinical staffing, whilst at Kings it has been due to bed and critical care capacity.
- The review identified specific pressures related to stroke and paediatric capacity

In addition to this review, the Urgent Care Network also completed an assessment of current urgent care system, considering each stage of the patient pathway e.g. prior to A&E, hospital system, discharge from hospital.

3. 2013/14 Recovery & Improvement Plan

The Recovery & Improvement Plan has been informed by the findings of the Winter Demand Review and the system-wide assessment exercise. The key actions for this coming year are set out below.

a) Key priorities for 2013/14

The key actions over the coming year are outlined within the full recovery plan and include:

- Acuity: the review has highlighted increases in admissions amongst the frail elderly population. Lambeth & Southwark CCGS have commissioned a package of community based admission avoidance schemes, which form part of the broader Southwark and Lambeth Integrated Care Progamme's (SLIC) frail elderly pathway. We have worked with both the local authority and community services to keep people well and cared for in the home.
- Capacity: Both Trusts are implementing large scale ED redevelopments in over the next two years which will create additional physical capacity. Clinical capacity is being addressed through both staff recruitment strategies and review of working arrangements.
- Communications: research seeking to gain a greater understanding of patient behaviour will be completed during September and inform a communications campaign, part of which will be targeted at particular patient groups e.g. children, people with long-term conditions, frail and elderly population.
- Mental Health : an integrated care pathway for mental health patients has been introduced which will provide an improved experience for patient. A review of frequent attenders to A&E is in progress, with an intention to develop plans to work differently with this group of patients.
- Primary care: a review of demand and capacity within general practice was undertaken in March, as part of the development of the Primary and Community Care Strategy. This will provide a framework for improving the quality and scale of delivery of primary and community care services in the borough over the next three to five years. The South East London Community Based Care Strategy will underpin the work with primary care and ensure best use of resource including pharmacies.

b) 2013/14 Winter Plan

Each year, the Lambeth & Southwark Urgent Care Network develop a winter plan which sets out the arrangements each provider across the health economy will put in place over the winter period to respond to the increased pressures upon the system. In addition it describes the systems used to monitor performance and escalate and resolve operational issues in a timely way. One of the key recommendations from the review of last winter was the importance of initiating this process earlier and as a result of this, the Winter Plan will be finalised by 23rd September.

c) Demand & Capacity Audit

A system-wide demand and capacity exercise is currently in progress, which will feed into the Winter Plan. This piece of work is being undertaken jointly across South East London and will provide assurance that there is appropriate capacity and arrangements in place ahead of this coming winter.

d) Winter funding monies

NHS England recently announced that £500million would be available to support urgent care systems to manage winter demand - details of how this will be allocated and criteria have not yet been finalised. The Urgent Care Network will support the development and co-ordination of proposals as part of the winter planning process. This would include a focus upon enhanced seven day working arrangements.

Agenda Item 8

Access to Health Services in Southwark

Terms of Reference

Access to health services throughout the borough is varied, with differing issues presenting at each. Each of these are interlinked, and an under-performance in one sector will necessarily impact on other health services. With increased sustained pressure on health services it is important, now, more than ever, to have services which truly deliver for our residents. The Health and Adult Social Care Committee would therefore like to consider the range of health services provided in the borough, specifically Out of Hours care, GP surgeries and A&Es. The proposed KHP merger and the impact of the TSA will also have an impact on delivery of services.

The inquiry will cover the following issues

1. Accessing out of hours care – specifically the 111 service and rollout in Southwark

2. Access to individual GP surgeries and walk in centres (both in terms of ability to take on more patients and then resulting waiting times for appointments)

3. The implications of the TSA and KHP merger on access to Emergency & Urgent care and resulting implications for GP surgeries

4) Understanding the reasons for increased use of A & Es over winter and how this could be reduced - where appropriate

Calls for evidence

Public Health Director

Health & Wellbeing Board

CCG - including wider GP membership

Primary Care

Community Services

London Ambulance Services

Local authority / social care

Lambeth and Southwark Urgent Care Board

Public Health England

Healthwatch

Hospitals

Patient Liaison Groups

Cabinet member (perhaps in December interview by committee)

Local experiences of patients

Select committee report/s

Healthwatch information (for example their current call for feedback on the 111 service)

Methodology

Verbal and written submissions

Tracking patient journeys - taking a systems approach. This could take the form of a survey or short interview at an A & E / urgent care department to see what services patients accessed prior to their visit (for example a call to 111 , their doctor or social services).

A survey via social media and snail mail of patients asking about their patient journey (this could try and pick up problems as well as what is working well)

Doctors/ practitioners / social service / the CCG and Hospital asked about patient pathways

Potential stakeholder roundtable with patients regarding their experiences

Summary

Growing demand

The failure of emergency departments to meet national waiting time targets in the early months of 2013 reflected the ever greater demands that are being placed on the emergency care system. Whilst growth in attendances at emergency departments has been limited, admissions have grown substantially placing more pressure on hospitals and restricting the ability of emergency departments to manage the flow of patients. Beyond this, however, analysing the growth in demand is more problematic. Evidence regarding the profile of patients presenting at A&E is contradictory and there is a pressing need for clearer information which can detail where cases present across the system and the case mix of such presentations.

The problems that have manifested themselves within emergency care cannot be attributed to any one factor or failure within the system. The Committee notes that reduced bed capacity is an important factor in limiting the flexibility of hospitals, but neither this, nor problems with out–of–hours care, or the failures associated with NHS 111 can sufficiently explain why emergency care is operating under such sustained stress.

What we can identify is a broader failure resulting from fragmented provision of emergency and urgent care and a structure that is confusing to patients. A&E departments remain the default option for many patients and hospitals must ensure that they have the flexibility to meet demand by providing sufficient bed numbers.

The Government response

Urgent Care Boards

The Government's response to the pressure in emergency and urgent care revolves around improving local system management in the short term and restructuring care for the medium term. Urgent Care Boards (UCBs) have been created to implement emergency care improvement plans in local areas. Additionally, local oversight appears necessary to restore a degree of system management removed as a result of the reforms implemented in April 2013. However, the evidence we heard in relation to the Government's proposals did not persuade the Committee that UCBs will be able to implement reforms and influence commissioning. From the evidence presented by NHS England it was unclear whether UCBs are voluntary or compulsory, temporary or permanent, established structures or informal meeting groups. We believe UCBs have potential to provide local system management but they have no executive power and no clear direction.

The improvement plans which UCBs determine are intended to be funded through the 70% of the emergency care tariff for work over 2009 levels which is not paid to hospitals and, instead, retained by the commissioner. Commonly known as the marginal tariff, this money is already at work and as a result the Committee believes that UCBs will have to identify opportunities for disinvestment elsewhere to fund the appropriate plans. UCBs will be challenged by the fact that they have no statutory role but must exert authority over

Clinical Commissioning Groups in order to deploy resources to support the improved delivery of emergency and urgent care.

We do not believe that the local re-organisation of care can be successfully managed in such a fashion. As they stand, the Government's plans to improve emergency care and support local changes to the delivery of care require further refinement. Ministers should seek much greater clarity from NHS England regarding their plans for UCBs and either UCBs or Health and Wellbeing Boards should be held to account for plans to improve local emergency and urgent care. We recommend that local Urgent Care Plans should be in place by 30 September this year.

Commissioning

An overall lack of authority in local commissioning is concerning. Lines of responsibility and accountability for funding and managing the system have become blurred by the presence of UCBs. They feed in to a system which is already built around multiple commissioners and budget holders commissioning providers at regional and sub-regional levels. Allowing providers to work with a single commissioning team can simplify the process, establish key relationships and, importantly, bring providers together to work collaboratively.

Restructuring

The bulk of the evidence we received made a strong case for centralisation of treatment for patients with certain conditions such as stroke care, cardiac care and major trauma. When implemented successfully, the creation of specialist centres enhances clinical skills and concentrates resources, with demonstrably improved outcomes for patients. Centralisation, however, is by no means a universal remedy for the ills of emergency care. Service redesign must account for local considerations and be evidence based. Some rural areas would not realise the benefits from centralising services that London has, therefore the process must only proceed on the basis of firm evidence. The goal is to improve patient outcomes – centralisation should not become the end in itself.

Improving A&E performance

The four hour standard

Performance failure against the four hour waiting time standard has prompted public concern and the eventual publication of proposals to improve emergency care. In this sense the four hour target maintains a degree of intrinsic value as it can highlight when pressure is growing and performance is suffering. Nevertheless, the Committee is clear that the target is not a useful indicator of the quality of care received by a patient.

Patient flow

The smooth flow of patients through hospital from their initial attendance at the emergency department to eventual discharge is fundamental to the operation of an

emergency department.

Smooth patient flow can be aided by early senior review of cases. Evidence suggests that the constant assessment and reassessment of patients by junior staff in emergency departments and medical assessment units only breeds duplication and delays authoritative decisions regarding treatment, transfer or discharge. It is imperative that Hospitals learn from best practice in the NHS in order to implement practical reforms that can improve the operation of emergency departments. Increasing the availability of consultants and developing systems of early senior review of patients is at the heart of this.

Delayed discharge

It is evident that one of the major contributory factors to the breakdown in patient flow is the inability to discharge patients from hospital. The Committee heard that this is often because places are not available in social care to accommodate patients who have no medical need to stay on a ward. Anecdotal evidence from clinicians and hospital mangers identifies this as a fundamental problem which inhibits patient flow, but the official data says fewer bed days are being lost to lack of social care rather than more. The discrepancy between the evidence of people working with patients and the formal data is striking and we find the data incredible. Methods of data collection must be reviewed to ensure that such data provides an accurate picture of the relationship between hospital discharge and social care. Most importantly, data collection must provide system managers with accurate and useable information so they can shape services appropriately.

Staffing

Staffing levels in emergency departments are an area of considerable concern to the Committee. They are not sufficient to meet demand, with only 17% of emergency departments managing to provide 16 hour consultant coverage during the working week. The situation is even worse at weekends and consultant staffing levels are nowhere near meeting recommended best practice.

Emergency staffing at all levels is under strain and a 50% fill rate of trainees is now resulting in a shortfall of senior trainees and future consultants. Emergency medicine is not seen as an attractive specialty by young doctors considering their long-term futures. The working environment is uncertain, the conditions are stressful, there is an unsatisfactory balance between work and personal life. Health Education England and local education and training boards must take steps to ensure that emergency medicine is both professionally and personally rewarding.

Tariffs

The way in which hospitals which operate emergency departments are remunerated for the services they provide only adds to the challenges that they face. The marginal tariff has failed to encourage the delivery of care outside of emergency departments and penalises them for being open and available to all patients 24 hours a day, 7 days a week. Existing tariffs can provide perverse incentives and do not reflect the need for providers of different services to work together to make sure patients get the best treatment. It is imperative that

tariffs are designed to reward all NHS providers for putting patients on the correct pathway at the first time of asking; however they come in to contact with the health service.

Alternatives to A&E

Primary care

It is apparent that a significant proportion of emergency department work could more appropriately be classified as primary care and undertaken by GPs. However, we found no evidence that primary care has the capacity to absorb additional work. Walk-in-Centres certainly cater for demand outside of A&E and traditional GP surgeries but the evidence suggests this demand was induced by the provision of additional services.

In principle urgent care can be delivered in primary care but not without substantial restructuring of existing services. No blueprint drafted in Whitehall can deliver a solution for each local health system, and Ministers should look to clinicians to understand what works well and can be replicated elsewhere. The Committee is particularly keen that a new model of integrated primary care should account for the needs of elderly patients. In particular, this would address clinical responsibility for out of hours care, relationships with social care and other providers, and high-quality end of life care. The elderly are too often failed by existing services and many older people end up in emergency departments without any genuine clinical need for this type of treatment.

Urgent Care Centres

One way of beginning to instil efficiency and clarity in the provision of emergency and urgent care services is to co-locate Urgent Care Centres with emergency departments on hospital sites. This can offer considerable organisational and patient benefits by concentrating resources and providing a system for quickly directing patients to the correct level of care. We recognise that this model is not appropriate for all locations but UCBs should consider the benefits of this when putting together their improvement plans. The plethora of titles for similar units offering similar services is highly confusing and the purpose of UCCs must, therefore, be clear to patients.

NHS 111

It is clear from the evidence presented to the Committee that Ministers rolled out NHS 111 without attempting to interpret the evidence from pilots, which themselves were limited in scale and scope. NHS 111 was launched prematurely without any real understanding of the impact it would have on other parts of the NHS including emergency and urgent care.

NHS 111 is based around triage by a call-handler who is not clinically trained. Call-handlers use the NHS Pathways IT system to assess patient symptoms, but this was regarded by witnesses as excessively risk-averse. In the view of the Committee, NHS 111 does not embody the principle of early assessment by a clinician qualified to a level where they can appropriately quantify and balance risk. We understand the principle of creating a highly recognisable non-emergency telephone service, but believe the process of triage may be so off-putting to patients that they prefer the option of going directly to A&E. In its

current configuration we do not believe that NHS 111 will help to keep people from inappropriately attending A&E. In light of this, NHS England should review the balance between triage and clinical assessment.

Ambulance services

Like the emergency departments they often work with, ambulance services are meeting ever increasing demand. In order to enhance the overall system of emergency care in England, ambulance services should be regarded as a care provider and not a service that simply readies patients for journeys to hospital. Increasing the number of fully qualified paramedics can help achieve this. Skilled paramedics can treat more patients at scene, reduce conveyance rates to emergency departments and make difficult judgements about when to by-pass the nearest A&E in favour of specialist units.

Treating at scene and reducing conveyance rates would contribute to alleviating some of the pressures in emergency departments and offer a better service to patients. Particularly in those rural areas where journey times are long and a major consideration, highly skilled paramedics can play a significant role in providing emergency and urgent care. The precise relationship between the development of more highly skilled ambulance crews and conveyance rates and should be investigated thoroughly by NHS England to help ambulance trusts further develop their workforces.

There is more that can be done to support ambulance services in improving the provision of care to patients. UCBs should ensure that ambulance services in their areas have access to key patient data – such information can be crucial in putting together a swift and accurate assessment of a seriously unwell patient. The local implementation of newly developed tariffs designed to reward treating patients over the phone or at scene is similarly important. NHS England should monitor the use of such tariffs in order to understand whether they do provide genuine encouragement to Ambulance Trusts to invest in more high skilled paramedics and treat and discharge patients rather than transporting them on to emergency departments.

Ultimately, the ambulance service has the potential to coordinate other elements of the emergency and urgent care system and lead integration of services. Changing the staff mix, reforming tariffs and ensuring access to patient information are important elements of a process of developing ambulance services in-to care providers in their own right.

Agenda Item 9

Psychotic disorders in ethnic minority populations in Lambeth & Southwark
An introduction
Lambeth & Southwark Public Health Team
July 2013

1. Introduction

This is an introductory briefing on psychotic disorders and the impact on ethnic minority populations with particular reference to populations in Lambeth and Southwark.

Psychotic disorders (sometimes called severe mental illness - SMI) include schizophrenia and extreme disorders of mood (mainly bipolar disorder). The disorders are characterised by severe disturbances in thinking and perception such that perception of reality is distorted. This may result in different types of delusions about the self, others and the environment including hearing voices.

There is substantial research that shows that in the UK rates of mental illness including psychosis in some ethnic minority populations are higher than rates in white British populations although the levels are not consistent and are different for men and women.

The main source of information about the numbers of people in the population with mental ill health nationally is taken from a large household survey conducted in England in 2007, and its predecessors which covered England, Scotland and Wales in 1993 (16-64 year olds) and 2000 (16-74 year olds) by the Office for National Statistics (ONS).

The Adult Psychiatric Morbidity Survey (2007) for England (a household survey)
The proportion of the population assessed as having a psychotic disorder in the past year prior to interview was 0.4% (0.3%of men, 0.5% of women). There was no change in the overall prevalence of probable psychosis between the 2000 and 2007 surveys

In both surveys the highest prevalence was observed among those aged 35 to 44 years (1.0% in 2000, 0.8% in 2007). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7%and 1.1%respectively).

The age standardised prevalence of psychotic disorder (schizophrenia and bipolar disorder) was significantly higher among black men (3.1%) than men from other ethnic groups (0.2%of white men, with no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women.

The prevalence of psychotic disorder varied by equivalised household income, increasing from 0.1%of adults in the highest income quintile to 0.9%of adults in the lowest income quintile. This trend was more prominent among men than women.

In addition to these estimates 0.5% of the population were thought to have 'probable psychosis' where symptoms did not reach threshold levels or the interview suggested a history of a psychotic episode but not during the year previously.

There is also an increasing body of research in the UK and internationally. Much of the UK research is of the population in south east London. A rise in the number of people nationally with psychotic disorders would be expected at least until 2026 mainly in older age groups, due to demographic change in the population.

Newton[1] summarises the international picture from the literature

- Rates of new cases of psychotic illness vary from between 8 – 43 per 100,000
- Rates in men are usually significantly higher than in women
- It is common to find higher rates in migrants including second generation migrants, people born in cities and people born in the winter-spring
- There are differences in recovery between developed and developing countries with substantially better recovery in developing countries than in developed nations (although this is contested in more detail where there are negative connotations to mental illness and restrictive practices (such as incarceration and restraint)
- Outcomes are worse where the onset is insidious rather than acute & outcomes at 2 years were the best predictor of outcome at 15 years

2. What does this mean for Lambeth & Southwark?

A very rough estimate of expected numbers in Lambeth and Southwark can be made using the ONS prevalence rate and applying it to the adult population. This is a 'point prevalence' so the estimate is more likely to be a range around this figure but the figure is also likely to *underestimate* actual numbers because the national survey did not include people in hospital, supported accommodation, prison or secure mental health institutions.

Table 1 Expected number of adults with psychosis or probable psychosis by borough

	Population Aged 16+ years	Estimated prevalence	Estimated expected number with psychotic disorder in the past year
Lambeth	255,000	0.4%	1,020
		0.5% (probable psychosis)	1,275
Southwark	242,000	0.4%	968
		0.5% (probable psychosis)	1,120

Source: Greater London Authority Interim Round Population Projections (2012) and Psychiatric Morbidity Survey (2007)

3. Detection of psychotic disorders in Lambeth and Southwark

Apart from applying national or research data to local populations an important method of estimating prevalence is to look at local rates of detection; how many people do we know about with psychotic disorders? This can be done by looking at the numbers of people with a documented severe mental illness (SMI) in GP records.

Although it is not possible to know about severity from this figure it is fairly reliable because it is a requirement that all people known to have SMI are offered a physical health check annually and GPs have to report on this. Against this is the fact that there can be a delay in maintaining up to date records when people move or die or get better so again this should be seen as an estimate. Furthermore, when calculating a rate from this information, the GP registered population is used not the resident population. In both Lambeth and Southwark there are more people registered with GPs in the boroughs than there are in the census estimates. Despite this the detection of SMI in both boroughs is substantially higher than the estimates from the national survey and compared with London and England.

Table 2: Detection of Severe Mental Illness in Primary Care 2013

Area	Period	Number of registered patients aged 16 or over	Number with Severe Mental Illness	Detection rate (%)
Lambeth	2012/13	304,464	4,548	1.5%
Southwark	2011/12	270,004	3,504	1.3%
London	2011/12	7,178,822	89,289	1.2%
England	2011/12	45,284,513	452,608	1.0%

Source: DataNet 2012/13; QOF 2011/12
NB: Lambeth data omits 2 practices

Reasons for the higher rates may include

- The high levels of deprivation and inequality in Lambeth and Southwark
- The age distribution of the population which is relatively young compared to the national population (SMI is more common in people of early middle age)
- Higher than average prevalence in ethnic minority populations
- The proportion of people with SMI in hospital, supported accommodation, prison etc who remain on the GP list but would not have been identified in the national survey
- GPs in Lambeth and Southwark are good at detecting and recording SMI
- Delays in updating or maintaining records in primary care
- Migration of severely mentally ill to inner city conurbations

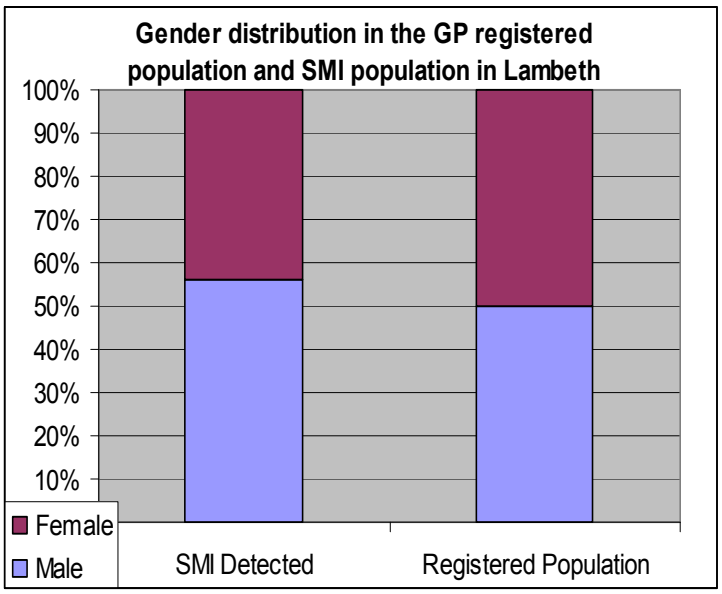
4. Who has SMI in Lambeth and Southwark?

For nearly 10 years Lambeth GPs in partnership with Public Health and London South Bank University (and now King's College London - KCL) have been developing use of their data for public health purposes particularly to understand some of the health inequalities between different populations and take appropriate action. To do this, in addition to clinical data GPs have also collected demographic information that can be extracted and analysed (anonymously) at borough level using a platform called DataNet. This means that it is relatively straightforward to assess inequalities at population level in the borough. The information provided in the next section is therefore taken from Lambeth data (note: all the data excludes information from two practices with a combined population of approximately 17,000 patients) but as a borough with many similarities to Southwark it can be used to illustrate some of the issues for Southwark patients.

There is a proposal to develop this facility in Southwark in partnership with KCL and the Lambeth & Southwark Public Health Team.

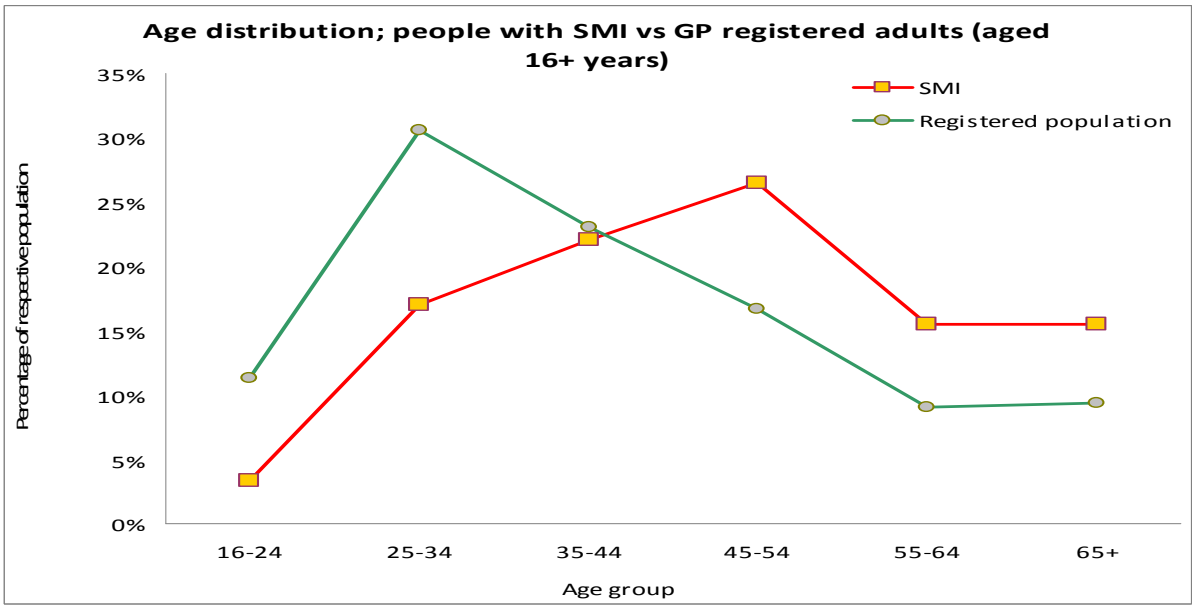
Figure 1 shows that slightly more men than women are diagnosed with SMI than would be expected from the population make up.

Figure 1: Registered and SMI Population by Gender in Lambeth



Source Lambeth DataNet 2013

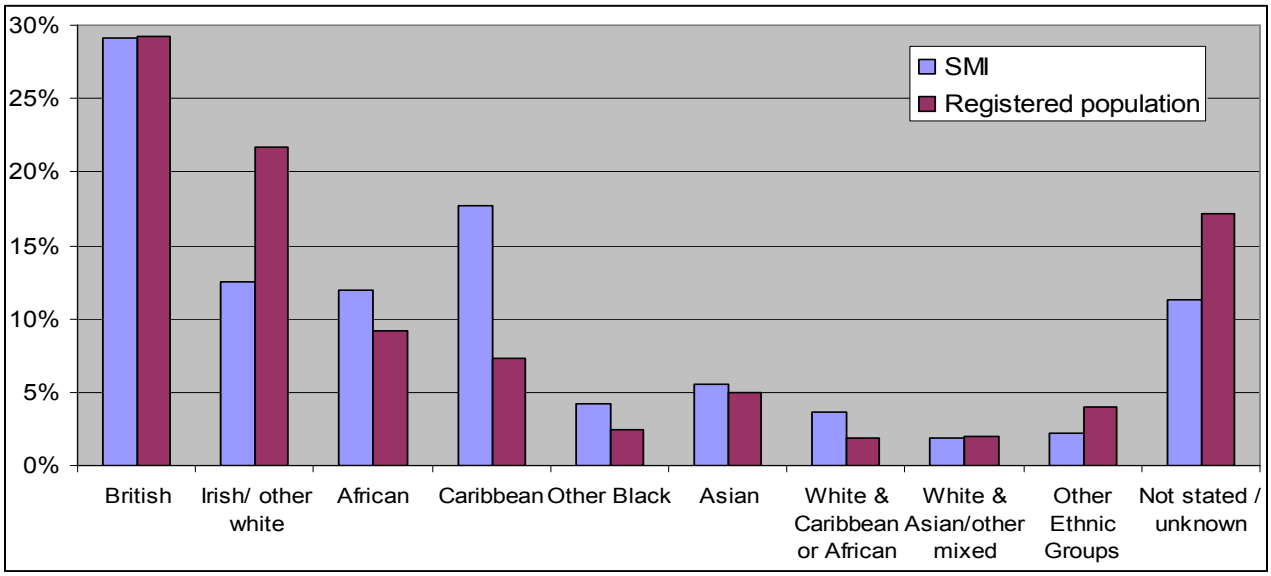
Figure 2: age distribution of the registered and SMI populations of Lambeth



Source: Lambeth DataNet 2013

Figure 2 shows that people with SMI tend to be older than would be expected from the population distribution. This is in keeping with the nature of psychotic disorders which tend to last for many years.

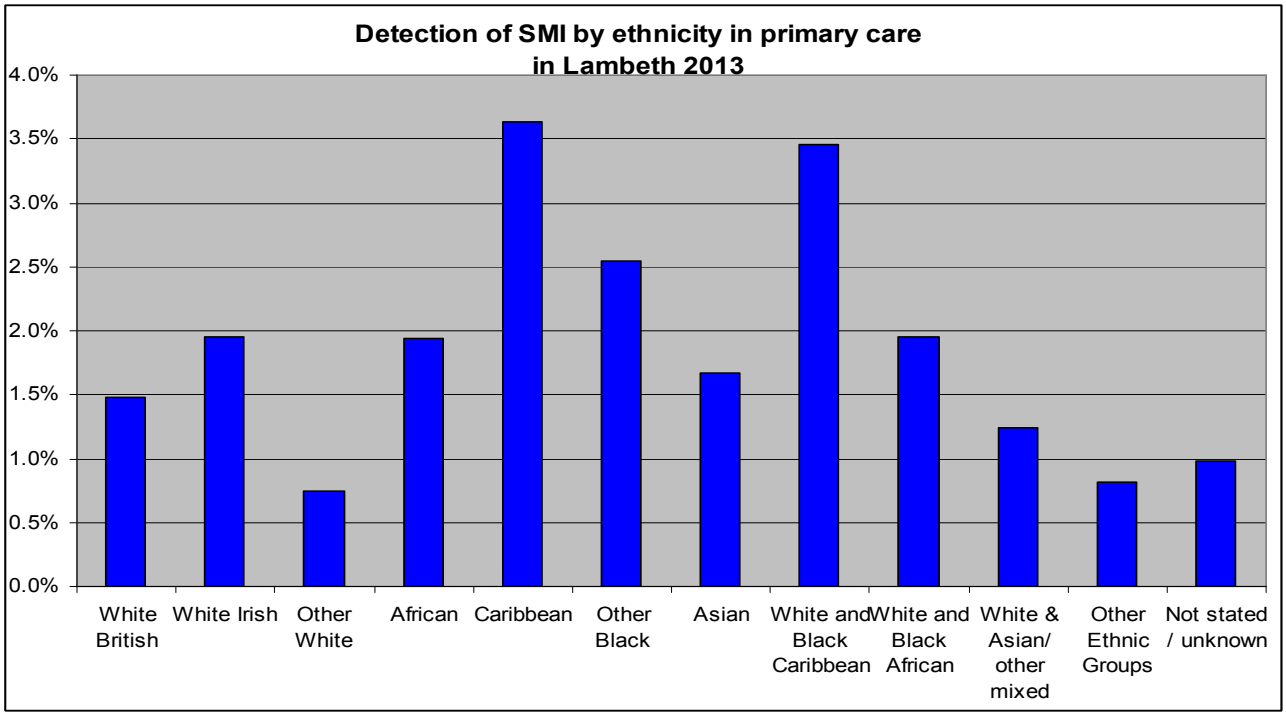
Figure 3: People detected with SMI & GP registered population by ethnicity



Source: Lambeth DataNet 2013.

Figure 3 compares the ethnic make up of the GP registered population and the group who are known to have SMI. It shows that whilst for some groups the proportion of people with SMI is roughly equivalent to the background GP registered population, for people of black and mixed white and black ethnic background there are higher than expected proportions known to have SMI especially for the black Caribbean group. The slightly higher rate in Asian groups is based on relatively small numbers.

Figure 4: Detection of people with SMI in primary care in Lambeth by ethnic group



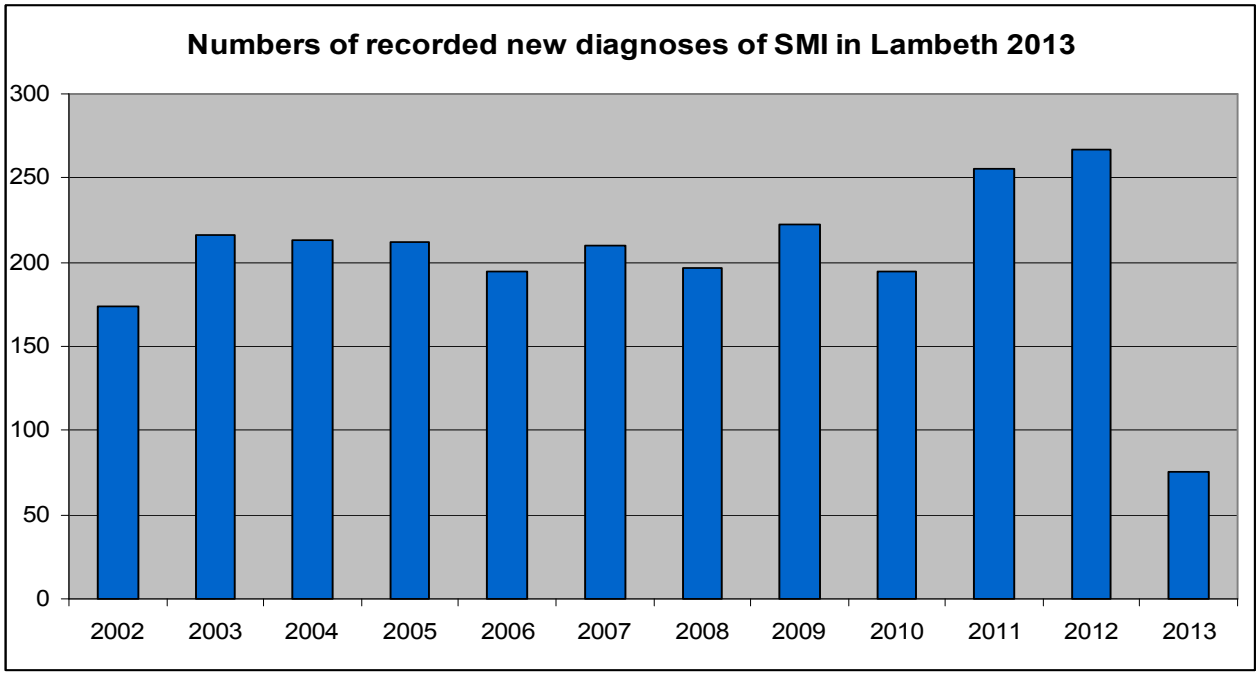
Source: Lambeth DataNet 2013

Figure 4 shows detection rate by ethnic group. The average detection rate in Lambeth is 1.5% so it can be seen that several groups including white Irish, black African, black Caribbean and other black have higher than average detection rates. The groups of white and black mixed ethnic background have similar rates to that of their counterparts who identify as black ie people of mixed white and black Caribbean origin have the same rate as people who identify as black Caribbean.

5. Incidence: new diagnoses

People are concerned that the numbers of new diagnoses of psychosis are increasing. Figure 5 shows the picture in Lambeth over the last ten years. The graph shows numbers not a rate but given that the GP registered population over this period has increased substantially the levels of new diagnoses per year is remarkably stable.

Figure 5: Numbers of newly recorded diagnoses of SMI in Lambeth 2002-2013

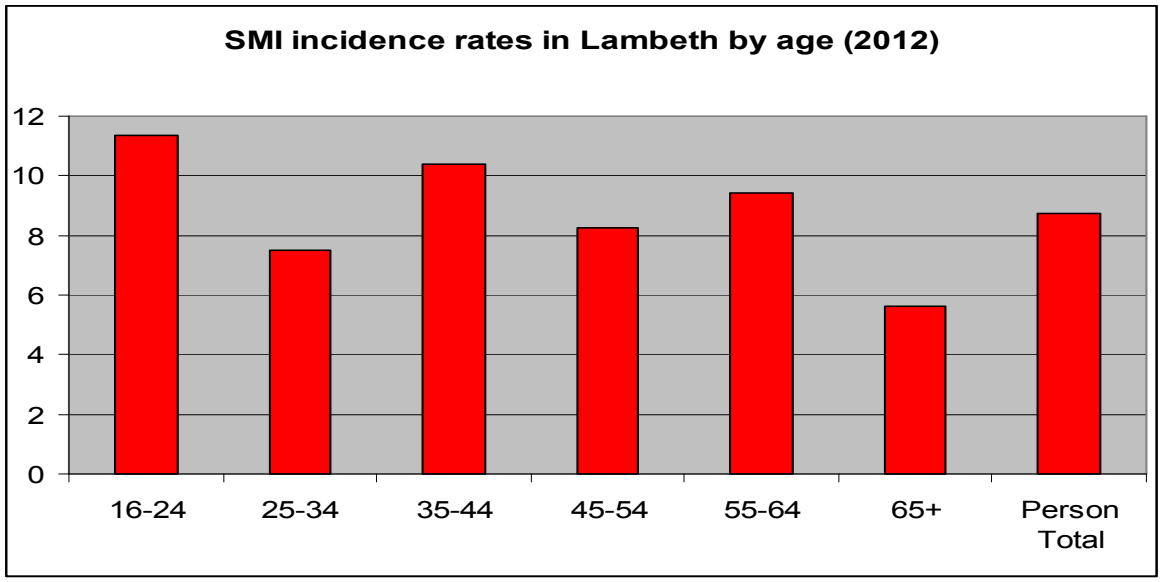


Sources: Lambeth DataNet, 2013

The years 2011 and 2012 may indicate a change but it is not easy to tell at this stage. Note that 2013 is an incomplete year.

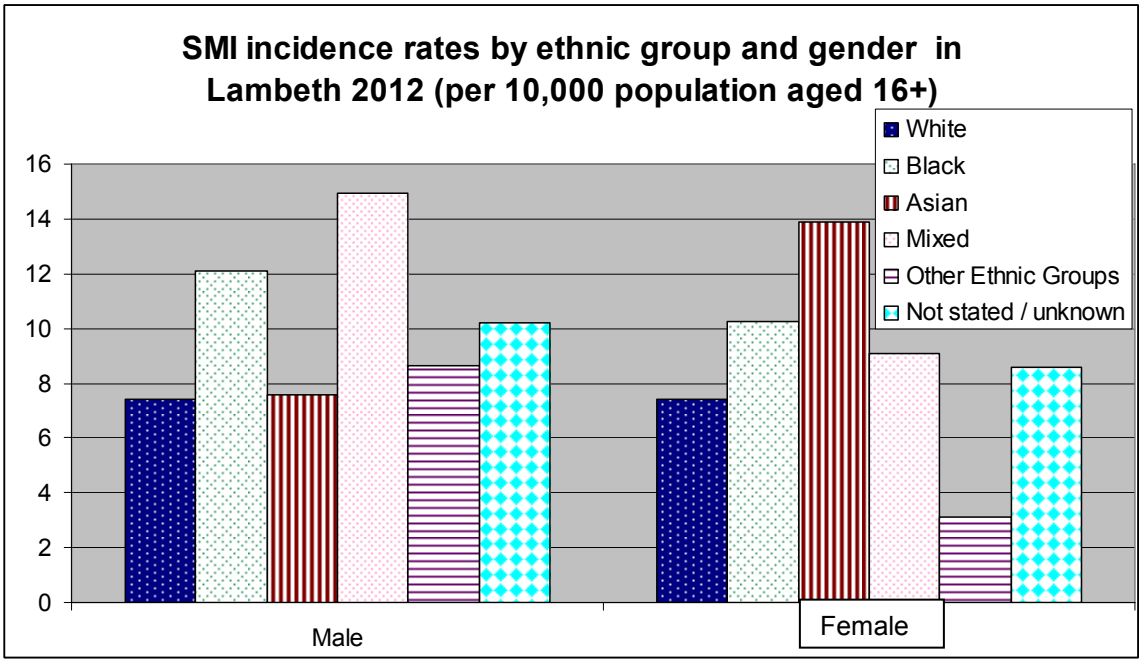
Small numbers make it difficult to assess trends in Figure 6 but suggest that, although as expected the highest rate of new cases is in the 16-24 year group and lowest in older people, new cases arise across the age range.

Figure 6: Rates of new diagnoses of SMI per 10,000 population per year in Lambeth by age group



Source: Lambeth DataNet 2013

Figure 7: rates of new detections by gender and ethnic group in Lambeth



Source Lambeth DataNet 2013

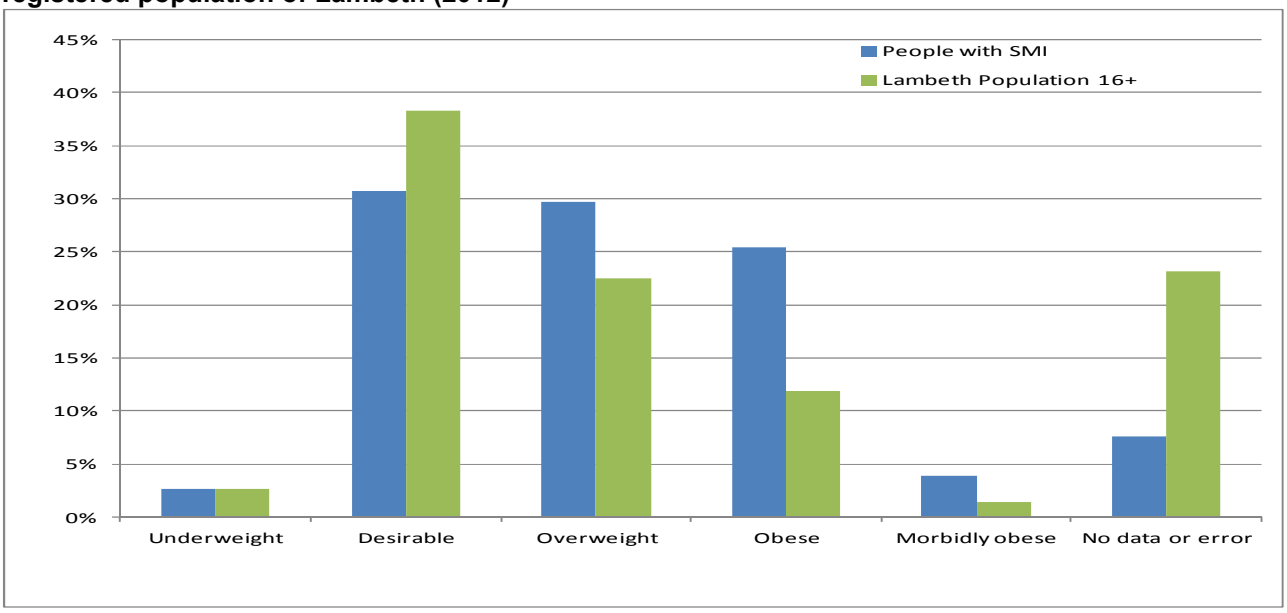
Figure 7 also uses small numbers so rates should be viewed with caution but the findings are in line with other information to suggest that the incidence is higher in Black populations and people of mixed heritage especially in men. In women the incidence appears higher in Asian groups.

6. Health of people with SMI

It is widely known that people with psychotic illness experience poorer health than average and are at increased risk of premature death (death before the age of 75 years).

The differences in health can be shown from GP records.

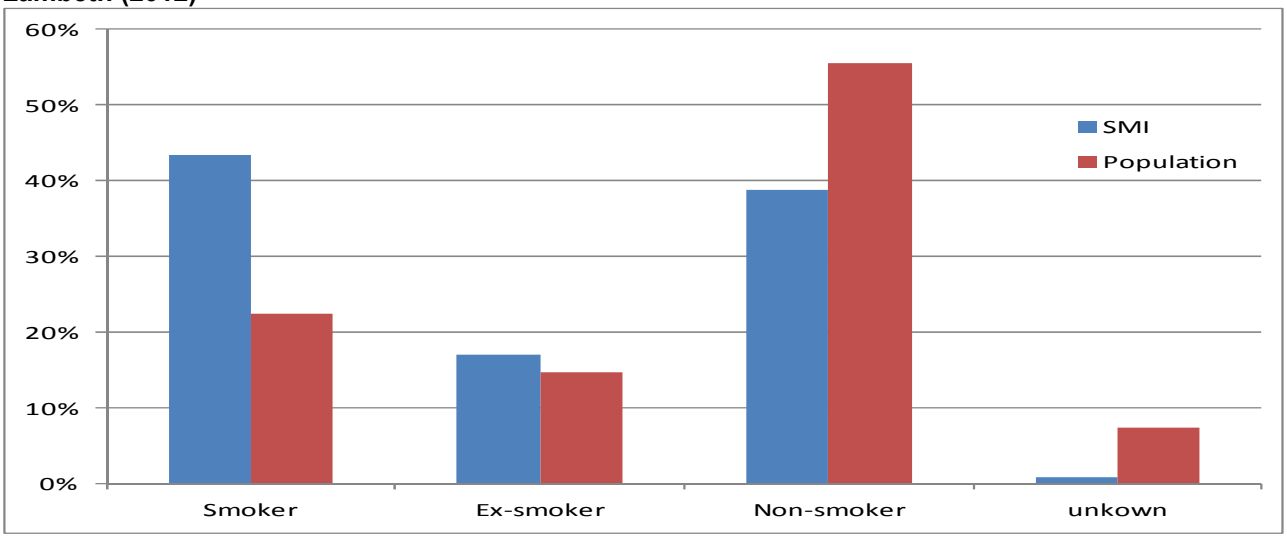
Figure 8: the distribution of overweight and obesity in people with SMI and the Adult GP registered population of Lambeth (2012)



Source: Lambeth DataNet 2012

Figure 8 shows that over 30% of GP registered adults are overweight or obese (although there is no record in over 20%) but for people with SMI this figure is nearly 60%.

Figure 9: the distribution of smoking in the adult GP registered and SMI populations in Lambeth (2012)



Source: Lambeth DataNet 2012

Figure 9 shows that whilst about 22% of the adult GP registered population smokes, over 40% of people with SMI smoke.

7. Access to services

People with psychotic illness are severely ill and need treatment. Nationally the APMS survey (ONS, 2007) found that about 65% of people with psychosis and 85% of people with probable psychosis living in private households were on treatment. The difference may be because some of the people with probable psychosis have a history of psychotic symptoms but had not experienced them in the previous year whereas some of the people with psychosis were new and had not yet accessed services.

One third of people with psychoses had contact with their GP in the past 2 weeks, and two thirds had had contact in the past year.

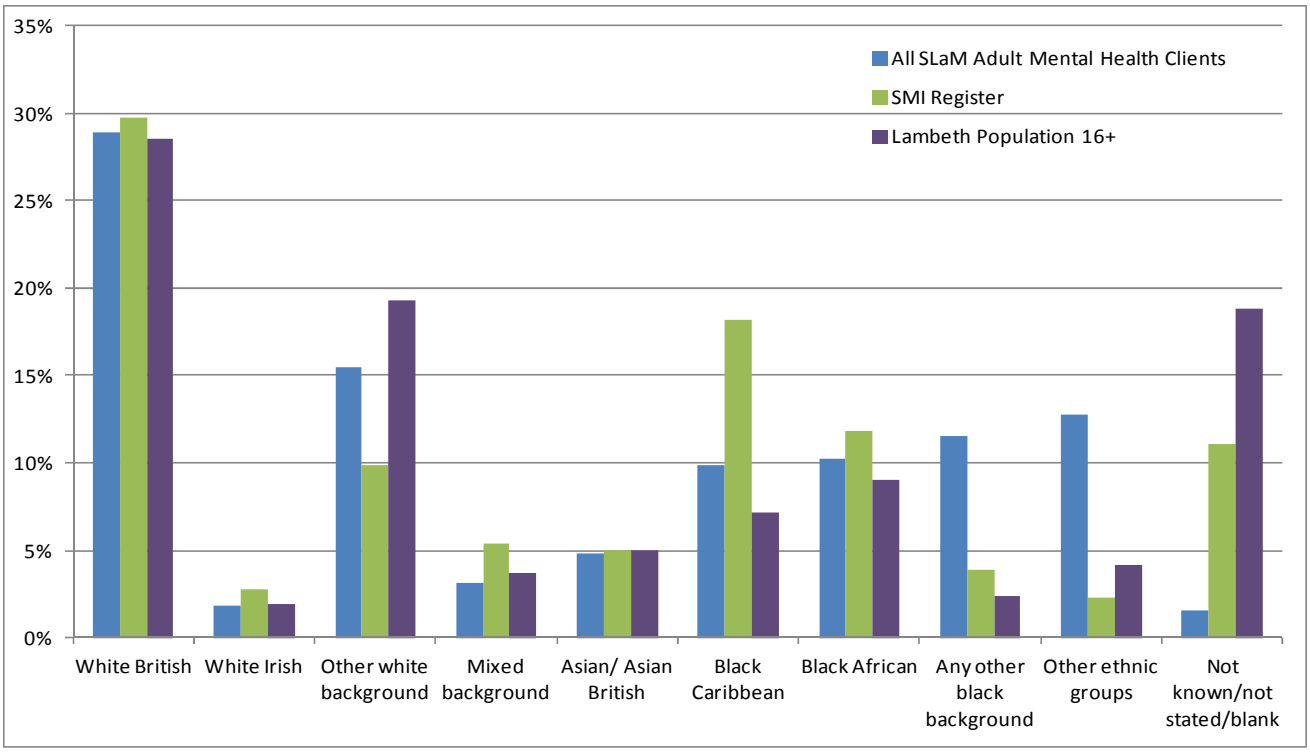
Table 3: Estimated numbers of *resident* population with SMI (Adults 16-74 years) who have used health services

	Expected number with psychotic disorder in the past year	Not receiving treatment (35%)	In patient sty in last 3 months (6%)	Out patient visit in last 3 months (30%)	Spoken with GP in last 2 weeks (25%)	Ever admitted to a hospital specialising in mental health (65%)
Lambeth	1,020	357	61	306	255	663
Southwark	968	339	58	290	242	629

Source: PMS 2007 and LGA (2012)

The national survey does not look at access to services by ethnicity but Figure 9 shows there are some differences in the ethnic make-up of the 3 populations; patients of mental health services, people with SMI known to the GP and the GP registered population. The differences in proportion between the GP registered population and the people known to have SMI have already been discussed in relation to Figure 3. This suggests that ethnic minorities have relatively good access to primary care for their SMI although this information does not tell us anything about quality or experience. There are some marked differences between the proportion of the population with SMI and the ethnicity of SLaM patients. This could represent a difference in access but without further investigation it is not possible to draw firm conclusions.

Figure 9: Ethnicity of SLaM (Lambeth) Adult Mental Health Clients, the GP SMI Register, & the Lambeth GP Registered Population (16+years)



Source: SLaM monitoring data, Lambeth DataNet (2012)

Nationally there is evidence of differential access to services for ethnic minority populations although some of this information is relatively historic eg;

- Admission rates to psychiatric hospitals for African-Caribbean populations are higher than for the general population (Coker 1994, Cochrane & Bal 1989) – *local data suggests this could be related to need*
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 to 6 times higher among African-Caribbean groups than among the white population (Coker 1994, Cochrane & Bal 1989) – *again this could be in line with what is expected in the population*
- Diagnoses of depression and anxiety are less likely among African-Caribbean groups than among the general population (Lloyd 1993) – *this could be related to differences in how diagnoses are made and the help seeking behaviour of different groups*
- African-Caribbean groups are more likely to be subjected to harsh and invasive types of treatment including intramuscular injections and electro-convulsive therapy, more likely to be placed in secure units, to be described as aggressive and to be hospitalised compulsorily under the Mental Health Act (Dunn and Fahy 1990, Davies 1996, Bhat 1996). *This appears to still be the case*
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 times higher among Asian males than among the white population (Coker 1994, Bhat 1996). *This requires work to look at locally*
- Suicide rates among women from the Indian sub-continent and men and women from East Africa are higher than those for the general population. Suicide rates among Asian women 15-24 years are more than twice the national rate and 60%

higher in Asian women aged 25-34 years (Soni Raleigh 1992, 1990) – *this is very difficult to look at locally as suicide numbers are low and suicides in women are very low. Ethnicity is not recorded on the death certificate*
- Psychiatric patients from BME groups make less use of psychiatric services (Donovan 1992, Kareem 1989). *These papers are old and local information suggests this is may not be the case overall although service use may differ eg less use is made of talking therapies and more of psychiatric inpatients*
- The ethnicity of a patient influences the clinical predictions and attitudes of practising psychiatrists (Lewis 1990).

Source: Lee, B., Syed, Q., Bellis, M. (2001). Improving the Health of Black and Ethnic Minority Communities: A North West England Perspective. North West Public Health Observatory.

8. The causes of mental ill health and why is incidence different in different ethnic groups?

Biological, psychological, and environmental (social, family, economic etc) factors all contribute to the development and progression of mental wellbeing and mental disorders. Opinions have swung to and fro between the relative contribution of biomedical (such as genes and brain chemistry) and environmental factors (such as parenting, school, work and life events) and between different interpretations and understanding of the brain and the mind. More recently there has been increasing recognition of the impact of nurturing on brain development in infancy and early childhood and specifically on the impact of negative infant and childhood experiences on future mental illness[2]. Studies now suggest that early childhood neglect and certainly more overt emotional or physical abuse can affect brain development adversely and increase risk of various issues including mental illness especially if other circumstances occur[3,4]. There is also recognition that some forms of mental illness seem to run in families especially bipolar disorder although in nearly two thirds of people with schizophrenia there is no other family member with the disorder[1].

Psychological factors that may contribute to mental illness include:
- Severe psychological trauma suffered as a child, such as emotional, physical, or sexual abuse
- An important early loss, such as the loss of a parent
- Neglect (emotional and, or physical)
- Poor ability to relate to others

Environmental factors or stressors that may trigger mental illness (although not specifically psychosis) in a person who is susceptible (especially having been exposed to some of the factors above) include:
- A dysfunctional family life including domestic violence
- Death or divorce
- Unemployment
- Bullying or harassment (in the workplace, school etc)
- Substance misuse by the person or the person's parents

These situations can be compounded where a person has pre-existing feelings of inadequacy, low self-esteem, anxiety, anger, or loneliness and, or where there are

specific social or cultural expectations of someone (eg a society that associates beauty with thinness can be a factor in the development of eating disorders.)

A systematic review of the evidence[5] suggests that the following groups of people are at risk of poor mental health. This is mainly because of their exposure to traumatic life events, neglect and or the stress of social exclusion and social isolation.

Table 4.

Adults	Children
Unemployed Severe life events (eg; separation, bereavement) Long terms carers of highly dependent people Women with a history of depression in pregnancy	Living in poverty In a family experiencing parental separation or divorce, or bereavement With behavioural difficulties

A more comprehensive summary of potential risk factors is in the Appendix.

There is also a relationship between mental health problems and substance and, or alcohol misuse. This includes common mental illness, severe mental illness, problems with self harm and suicidal behaviour. Misuse of drugs and, or alcohol is also associated with increased risk of suicide. The Department of Health reports that about 30% of people seeking help for a mental health problem are likely to be misusing drugs[6]. What maybe less well explored is some of the motivations underlying substance and alcohol misuse for instance how people may use alcohol and drugs to offset or self medicate their mental and psychic pain. Both alcohol and drugs may also potentiate mental illness for instance alcohol is a depressant. The evidence around the influence of cannabis is controversial but may have a role in psychosis in genetically susceptible people (less than 20% of those developing a psychotic illness) when used in early teenage years. Cannabis can also exacerbate symptoms and sign in established psychotic illness eg paranoia and hallucinations[1].

Exposure to risk factors is variable across the population including within and between different ethnic groups and it is important not to make assumptions in this regard. However it is possible to summarise that not only do many people live in deprivation in Lambeth and Southwark, in itself a reason for high prevalence of mental health problems, but also for many ethnic minority groups, a higher proportion than (the national) average are poor and live in highly stressful circumstances (eg. more likely to be unemployed and unemployed for longer periods, living in poor housing in deprived areas, exposed to crime and violence both in the neighbourhood and personally, and subject to discrimination, bullying and victimisation at school, in the street and at work). This situation also impacts negatively on family life and can make it much more difficult for parents to provide for and nurture their children especially if they were also neglected as children.

This perspective should be seen as a general rather than a specific point. Clearly many people are extremely resilient in the most adverse circumstances and maintain strong and supportive family ties successfully bringing up similarly resilient children and young people. But the situation in Lambeth and Southwark is very unequal and for the most

part ethnic minority populations are more likely to be disadvantaged and therefore at more risk.

In addition we know that in Lambeth substance and alcohol misuse is a substantial problem across most population groups.

All these factors contribute to the high prevalence of mental health problems in Lambeth and Southwark. The evidence also suggests that for some ethnic minority groups, poor socio-economic circumstances, low education, unemployment, and the chronic strain of stigma and discrimination and social exclusion is highly relevant.

9. Possibilities for action

To be most effective and useful intervention should focus on the risk factors that can be altered. Whatever the contribution of genetics little can be done to influence this. In contrast there is a great deal that the public sector and communities can do to prevent detrimental family settings and mitigate the impact of some of the traumatic trigger life events.

Newton (2013)[1] suggests that because of its contribution to mental illness including psychosis, childhood neglect/ abuse is the area that is maybe most amenable to intervention and would give the biggest impact. This could be achieved by eg

- Continued action to prevent teenage pregnancy that offers alternatives and promotes aspiration and educational success ie a holistic and integrated approach to adolescent development of boys and girls
- Continued and broadened parenting support especially to teenage parents, mothers with mental illness and others who are in particular difficulty including socio economic deprivation
- Offering therapeutic foster care in specific circumstances especially where foster care has broken down
- Offering expert support and supervision to parents with children under 8 years with special needs

Table 5 shows a generic list of 'best buys' in mental health. They are a mix of preventive and early intervention actions. In Lambeth and Southwark there are good examples of where these are being implemented but sometimes provision may be short term and not comprehensive so many people at most risk do not have access to what is on offer.

Table 5. Best buys to for mental health

Intervention	Saving (per £1 invested)
Social and emotional learning programmes in schools	£84
Suicide prevention through GP training	£44
Early intervention for psychosis	£18
Pre-school educational programmes for 3-4 year olds in low income families	£17
School based interventions to reduce bullying	£14
Screening and brief interventions in primary care for alcohol misuse	£12
Work based mental health promotion	£10

(after 1 year)	
Early interventions for parents of children with conduct disorder	£8
Early diagnosis and treatment of depression at work	£5
Debt advice services	£4
Cognitive behavioural therapy for people with medically unexplained symptoms	£1.75

In discussing the types of intervention that might be effective Newton notes that because much of the trauma experienced is that of deep humiliation and shame the type and method of intervention has to avoid compounding these feelings and doing more harm (eg by offering support that stigmatises and shows what a failure you have been in your parenting etc). This is a highly relevant point when planning how best to offer support to ethnic minority groups who may already feel stigmatised and excluded at societal level.

One way of achieving this is to ensure universal approaches ie where the provision is for all and within this setting there is access to additional support to avoid the benefits being 'captured' by those with more motivation and ability to make use of provision but who may have less need. As Lambeth and Southwark are highly diverse extra attention needs to be paid to the differing understandings and experiences of different groups. This requires excellent staff training and development beyond what is usually seen as adequate from a clinical or technical perspective.

The concept of a 'fresh start' has also been shown to be less stigmatising and relatively effective; offering input at community level that is not related specifically to failings or illness but that seeks to enable people to achieve their goals in life. The Cares of Life Project in Southwark was one such cost effective intervention.

Where psychotic illness has been diagnosed along with appropriate treatment, it is essential to have societal and staff attitudes that instil hope of recovery and the potential for a rewarding life. Anti stigma and mental health awareness programmes amongst communities and staff are helpful in achieving this.

Beyond the medical concepts of recovery (a reduction in signs and symptoms) a conceptual model for recovery that is not illness focused is suggested by Leamy et al (2011)[7]; that of

- Connections
- Hope
- Identity
- Meaning & purpose
- Empowerment

Or 'CHIME'. They found that in studies amongst ethnic minorities spirituality and stigma played a more important role and also identified two additional themes: culturally specific facilitating factors and collectivist notions of recovery; ie factors that were specific to the community in question and the extent to which the community sees a person as recovered.

10. Conclusion

This paper has outlined some preliminary information to show the disproportionate impact that psychosis has on some ethnic minority groups in Lambeth and Southwark. Although the data are mainly from Lambeth it is likely that they reflect the picture in Southwark and it will be helpful to undertake a similar exercise when technology allows as well as in relation to people's access to services including in primary care to inform priorities and practice.

The data show that black groups, people of mixed white and black heritage, white Irish and Asian groups have a higher prevalence of severe mental illness than other groups. It suggests that despite the rising population new diagnoses of SMI are remaining relatively stable but the incidence rate in men of black or mixed heritage is higher than the average. The incidence rate in Asian women may also be higher than the average although this is based on small numbers

Analysis of quantitative data only takes knowledge so far. Qualitative information drawn from a good cross section of people with direct experience of psychosis and services is also essential to inform commissioning and service provision.

This paper has not covered the interesting findings in research relating to the distribution of schizophrenia and what is called 'ethnic density' (where ethnic minority groups are less likely to develop psychosis where they are living in close proximity with a community from their own ethnic background), much of which was undertaken locally. However given the known importance of social relationships in promoting and protecting mental health and wellbeing this is an area for further exploration as researchers ask whether 'ethnic density' is an indicator of some form of buffering that mitigates other risk factors mentioned.

Public health is working with both the Lambeth and Southwark Councils and CCGs to improve access to information and build the case for appropriate interventions to prevent mental illness and promote mental wellbeing. Interventions that are effective and appropriate for a highly diverse population is an integral aspect of this work.

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July 2013

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Appendix 1

Risk factors potentially influencing the development of mental problems and mental disorders in individuals, particularly children[8]

Individual factors	**Family/social factors**	**School context**	**Life events and situations**	**Community and cultural factors**
Prenatal brain damage	Having a teenage mother	Bullying	Physical, sexual and emotional abuse	Socioeconomic disadvantage
Prematurity	Having a single parent	Peer rejection	School transitions	Social or cultural discrimination
Birth injury	Absence of father in childhood	Poor school attachment	Divorce and family breakup	Isolation
Low birthweight	Large family size	Inadequate behaviour management	Death of family member	Neighbourhood violence and crime
Birth complications	Antisocial role models (in childhood)	Deviant peer group	Physical illness/ impairment	Population density and housing conditions
Physical and intellectual disability	Family violence and disharmony	School failure	Unemployment, homelessness	Lack of support service including transport, recreational facilities etc.
Poor health in infancy	Marital discord in parents		Incarceration	
Insecure attachment in infant/child	Poor supervision and monitoring of child		Poverty/ economic insecurity	
Low intelligence	Low parental involvement in child's activities		Job insecurity	
Difficult temperament	Neglect in childhood		Unsatisfactory workplace relationships	
Chronic illness	Long-term parental unemployment		Workplace accident/injury	
Poor social skills	Criminality in parent		Caring for someone with an illness/ disability	
Low self esteem	Parental substance misuse		Living in nursing home or aged care hostel	
Alienation	Parental mental disorder		War or natural disasters	
Impulsivity	Harsh or inconsistent discipline style			
	Social isolation			
	Experiencing rejection			
	Lack of warmth and affection			

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Prevalence of Psychosis and access to mental health services for the BME Community in Southwark

Terms of Reference

There is substantial research that shows that in the UK rates of mental illness including psychosis in some ethnic minority populations are higher than rates in white British populations although the levels are not consistent and are different for men and women.

Nationally the APMS survey (ONS, 2007) found that about 65% of people with psychosis and 85% of people with probable psychosis living in private households were on treatment. One third of people with psychoses had contact with their GP in the past 2 weeks, and two thirds had had contact in the past year.

It is suggested that ethnic minorities have relatively good access to primary care for their SMI although this information does not tell us anything about quality or experience. There are some marked differences between the proportion of the population with SMI and the ethnicity of SLaM patients.

Biological, psychological, and environmental (social, family, economic etc) factors all contribute to the development and progression of mental wellbeing and mental disorders. Data shows that black groups, people of mixed white and black heritage, white Irish and Asian groups have a higher prevalence of severe mental illness than other groups. It suggests that despite the rising population new diagnoses of SMI are remaining relatively stable but the incidence rate in men of black or mixed heritage is higher than the average. The incidence rate in Asian women may also be higher than the average although this is based on small numbers

The Health and Adult Social Care Committee wishes to examine the reasons behind a difference in mental health prevalence in the BME community, as well as looking at current routes to accessing support services and the ways in which these need to be improved to benefit those affected. The inquiry will cover the following issues:

1. The prevalence of Psychosis in the BME community in Southwark

2. The reasons behind the prevalence of Psychosis amongst the BME community

3. The current ways in which mental health services are accessed by the BME community, and associated problems and/ or best practice

4. The ways in which mental health services currently interact with each other throughout Southwark.

The aim will be for the committee to understand the reasons behind the prevalence of mental health disorders amongst the BME community, suggesting some reasons and possible steps to help mitigate prevalence. It will also consider the current provision of mental health services and make recommendation as to how these can be improved.

Calls for Evidence

SlaM

Cooltan Arts , Dragon Cafe and other voluntary/community mental health groups

BME community groups

Black majority churches / faith groups

Academic papers

Service users (can we work through SLAM and Cooltan Arts and other groups to survey their patients/the people delivering the services)

Public Health Department

CCG

Healthwatch

Health & Wellbeing Board

Methodology

Verbal and written evidence

Outreach visits to get the input of people using mental health services.

Possible stakeholder event using Appreciative Inquiry approach (this emphasises what is working well and aims to build on this, encourages stakeholders to create a shared vision, and uses stories to gather information).

NHS
Southwark
Clinical Commissioning Group

CCG Performance & QIPP Highlight Report

Q1 2013/14

Southwark Council

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

August 2013

Background and Contents

NHS Southwark Clinical Commissioning Group

- This document is a highlight report, which is written to give OSC members an overview of current CCG and provider performance across a range of priority national standards. The highlight report covers Q1 of the year from April 2013; the period for which we have the most recent validated data.

- The CCG produces a full Integrated Performance Report each month. This full report looks at all CCG and provide KPIs across domains of quality & safety, performance, finance and QIPP delivery. It provides further details of the actions being taken to resolve identified KPI variance.

- The CCG presents the Integrated Performance Report to our Integrated Governance & Performance Committee every month, and to the CCG Governing Body on a bi-monthly basis. The latest version of the report is published on the CCG website: http://www.southwarkccg.nhs.uk/about/ourboard/Pages/CCGMeetingPapers.aspx

CCG Performance & QIPP Highlight Report Contents

1. Urgent Care
2. Referral-to-Treatment (waiting times)
3. Diagnostic waiting times
4. Healthcare acquired infections (MRSA and *clostridium difficile*)
5. Mixed-sex accommodation
6. Cancer waiting times
7. CCG QIPP delivery
8. Summary of CCG's financial position

Urgent Care (1 of 2)

NHS Southwark Clinical Commissioning Group

A&E waits (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

Month	April	May	June	Q1
KCH (all type)	96.3%	96.4%	96.3%	96.3%
GSTT (all type)	94.6%	96.4%	96.7%	95.9%

Reported Performance Position

- Both Trusts have consistently met the performance standard since April and have achieved the requisite 4 hour target for Q1 2013/14

NHS England A&E Improvement Plan

- Following last winter's extreme pressure and in response to national guidance, Lambeth & Southwark have developed a Recovery & Improvement Plan setting out key actions which will support sustainability in performance over the coming winter period.

- The plan has been developed through the Lambeth & Southwark Urgent Care Board, which has representation from key stakeholders across the health economy, and was informed by the Winter Demand Review and a system-wide assessment.

Urgent Care (2 of 2)

NHS Southwark Clinical Commissioning Group

The Winter Demand Review, which looked at emergency care demand in 2012/13 and the system-wide assessment completed as part of the national Recovery Improvement Plan have highlighted a number of key issues which form an integral part of the strategy for sustaining performance during the winter of 2013/14:

1. Acuity

- Southwark and Lambeth Integrated Care Progamme's (SLIC) frail elderly pathway: interventions include Home ward, Enhanced Rapid Response team, establishment of geriatrician-led hot clinics, Community Multi-Disciplinary Teams and the re-ablement programme.
- Simplified discharge process workstream
- Task and Finish group to develop proposals for enhanced 7 day working arrangements in acute trusts

2. Capacity

- Both Trusts are implementing large scale emergency department redevelopments over the next 2 years
- Clinical capacity addressed through staff recruitment strategies & review of working arrangements

3. Mental Health

- Review of frequent attenders to A&E in progress
- Plans to extend mental health community assessment services to align with GP opening hours

4. Stroke

- Plan to work with other lead agencies to ensure that the London-wide Stroke repatriation policy is being fully implemented locally

5. Paediatrics

- Review current paediatric pathway and scope opportunities for service redesign.

Referral to Treatment: 18 weeks

NHS Southwark Clinical Commissioning Group

RTT admitted (target 90%) - The percentage of admitted pathways completed within 18 weeks

RTT Admitted	April	May	June
Southwark CCG	90.6%	88.0%	90.7%
KCH	88.8%	88.2%	89.7%
GSTT	92.1%	92.0%	92.7%

Performance Position

- Admitted performance for Southwark CCG patients has been above the 90% standard except in May.
- KCH were below the performance threshold. This is consistent with the plan and trajectory agreed with the trust so that it has sufficient capacity to reduce the backlog of patients currently waiting over 18 weeks.
- The KCH trust-wide backlog has not grown over Q1 but has not been reduced at the levels originally anticipated due to pressures from emergency care.
- Admitted RTT Performance at KCH will continue to be below the threshold while the trust address their backlog of admitted patients. This has been agreed by the CCG and NHS England.

Actions Agreed to Meet Performance Standard

- KCH have a combination of increased internal capacity and outsourcing to private providers in place to address their backlog position.
- During 2013/14 the trust will continue to ensure RTT/backlog balance until additional capacity is in place
- King's have transferred orthopaedic patients waiting 18 weeks or more to GSTT

Referral to Treatment: 52 + week waits

NHS Southwark Clinical Commissioning Group

52 weeks long waiters (target 0) - The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period

52 + Week Waits (Incomplete Pathway)	April	May	June
Southwark CCG	3	5	7
KCH	49	44	31
GSTT	9	5	1

Current Performance Position

- All of the Southwark long waiters are at KCH.
- The specialities with long waits at King's are orthopaedic and gastroenterology.

Actions Agreed to Meet Performance Standard

- KCH has used a combination of additional in house capacity and outsourcing to reduce long waiters .
- The remaining long waiters at KCH (trust – wide) are in orthopaedics and gastroenterology, the trust plans to clear long waiters in these specialities by the end of Q2 2013/14.
- The trust keeps these patients under regular clinical review to ensure there is not clinical risk for long-waiting patients.
- The CCG applies a contractual financial penalty each month to the trust for long-waiting patients. This has been implemented since April 2013 in line with national arrangements.

Diagnostic Waits

NHS Southwark Clinical Commissioning Group

Diagnostic wait less than 6 weeks (target <1%) - The % of patients waiting 6 weeks or more for a diagnostic test

Month	April	May	June
Southwark CCG	1.86%	1.95%	1.85%
KCH	3.00%	4.20%	2.77%
GSTT	2.00%	2.10%	3.08%

Cause of Reported Performance Position

- Trusts should ensure that less than 1% of diagnostic waits exceed 6 weeks
- Southwark diagnostic breaches occurred at KCH and GST
- The service areas of concern for Southwark is echocardiography at KCH.

Actions Agreed to Meet Performance Standard

- KCH successfully delivered on their action plans for diagnostic recovery for all areas apart from echocardiography.
- For this diagnostic the trust had a deficit in physical and staffing capacity.
- Both have now been addressed however there is a lead time for the additional staff to be fully operational.
- The CCG is also exploring the feasibility of outsourcing options for echocardiography patients.

Healthcare Acquired Infections

NHS Southwark Clinical Commissioning Group

Number of cases of MRSA (target 0) and ***clostridium diffcile (CCG annual target 48)***

MRSA & *c.difficile*

- 2 reported MRSA cases at KCH in April, May & June 2013
- 1 reported MRSA cases at GSTT in April, May & June 2013
- 2 Southwark CCG MRSA case in April, May & June 2013 (Lambeth had 1 MRSA case in Q1)
- 8 *c.difficile* cases at KCH in April, May & June 2013 – under trajectory for Q1
- 3 *c.difficile* case at GSTT in April, May & June 2013 – under trajectory for Q1

Actions Agreed with Providers to Meet Performance Standard

- All MRSA and *c.difficile* cases are discussed at the monthly Clinical Quality Review meetings at King's and GSTT. These meetings are chaired by CCG Clinical Leads in Southwark and Lambeth
- King's and GSTT undertake a Root Cause Analysis (RCA) on all MRSA and *c.difficile* cases
- Public Health currently review all GSTT RCA's for GSTT. It has been agreed that the Public Health team will now implement this RCA review process for King's to identify the key learning and themes for action
- Picture across London shows a spike in cases. Locally we are closely monitoring acute performance to establish whether this is a temporary spike or a sustained increase in cases
- Clinical assurance that patient safety is not compromised.

Mixed Sex Accommodation

NHS Southwark Clinical Commissioning Group

Mixed-sex accommodation breaches (target 0) –
All providers of NHS funded care are expected to eliminate mixed-sex accommodation

Month	April	May	June
Southwark CCG	12	6	7
KCH	49	19	29

Cause of Reported Performance Position

- Southwark breaches occurred at KCH
- Majority of breaches at KCH due to lack of timely single sex bed capacity in step down from critical care.
- Breaches likely to continue until KCH new capacity from Infill 4 development comes on stream in 2013/14

Actions Agreed to Meet Performance Standard

- Contractual penalties being applied to breaches
- CCG undertook a clinically-led assurance visit to KCH in November 2012
- CCG receives on-going assurance that patient safety is not compromised

Cancer Waits (latest validated data is for April & May 2013)

NHS Southwark Clinical Commissioning Group

2 week GP referral - % of patients seen within two weeks of an urgent GP referral for suspected cancer

Target = 93%		
Month	April	May
SCCG	96.7	98.2
KCH	96.9	98.6
GSTT	94.4	96.7

31 days treatment - % patients receiving first definitive treatment within 31-days of a cancer diagnosis

Target = 96%		
Month	April	May
SCCG	97.1	98.7
KCH	100.0	99.0
GSTT	98.3	97.9

62 days treatment(85%) - % patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Target = 85%		
Month	April	May
SCCG	83.3	90.2
KCH	93.3	87.9
GSTT	68.6	80.5

Cancer Waits: 62 day pathway at Guy's & St. Thomas'

NHS Southwark Clinical Commissioning Group

Reported Performance Position

- GSTT failed to meet the 62 day target Q1-3 12/13. This is attributable to late referrals from other trusts, in particular from South London Healthcare Trust.
- In the first two months of Q1 2013/14 the trust has continued to miss the 62 day standard for GP-initiated referrals.

Actions Agreed to Meet Performance Standard

- A cross-trust group was established to review the pathway issues between GSTT and SLHT and to improve the timeliness of referrals and ultimately treatment.
- GSTT invited the Department of Health Intensive Support Team (IST) to review the pathways for 62 days, with particular focus on urology and lower GI.
- The formal report is still awaited but initial feedback from the IST suggested changes to the early part of the pathway, including diagnostics.
- GSTT intends to implement the recommendations arising from the review

CCG QIPP Programme

NHS Southwark Clinical Commissioning Group

Acute

Acute Productivity Programme = £2.29m

Shift of outpatient care = £1.47m

A&E avoidance to lower cost setting = £0.40m

Mental Health & Client Group

SLaM Productivity Programme = £ 1.09m

Redesign of mental health of older adults inpatient capacity = £0.29m

Male PICU inpatient redesign = £0.35m

CCG QIPP 2013/14
£7.37m (net)

Primary & Community Care

Primary care prescribing = £1.00m

Community Services Productivity = £0.20m

Other Programmes

CCG corporate = £0.28m

CCG-Led QIPP: Transformation Programmes (1 of 2)

NHS Southwark Clinical Commissioning Group

Acute

Shift of Outpatient Care QIPP

- Single points of referral (SPR) and community clinics are part of the CCG's commitment to further expand community provision in order to shifting care out of hospital.
- SPRs are currently operating for MSK (MCATS), diabetes, respiratory disease, ENT, dermatology and heart failure.
- Services have 'virtual clinics' to support primary care in reviewing practices' caseloads and providing advice on management.
- 'Virtual Clinics' are currently available for diabetes, respiratory, dermatology and ENT community services.
- In Q1, the community diabetes service delivered 38 virtual clinics. The integrated respiratory care team delivered 11.
- Community CVD clinic has been expanded to encompass direct GP referrals to the community for patients with atrial fibrillation, lipid management and hypertension.

A&E Avoidance QIPP

- Phased implementation of London Urgent Care Standard being led by south east London-wide Urgent Care Group.
- Expansion of the Southwark Homeward and Emergency Rapid Response teams.
- Development and testing of 7 day working discharge proposals from local hospital trusts .
- Collaborative approach across the urgent care system to respond to issues highlighted in the 12/13 winter demand review.
- CCG improving access in primary care: work to progress support to 5 practices with highest A&E attendances.
- Re-commissioning of Guy's Urgent Care Centre with primary care 'front end'.
- Southwark & Lambeth Integrated Care programme delivering community multi-disciplinary teams & risk stratification.
- Implementation of programme to enhance primary care services to Southwark care homes.
- Development of number of self-care strategies including minor ailments scheme.

CCG-Led QIPP: Transformation Programmes (2 of 2)

NHS Southwark Clinical Commissioning Group

Mental Health & Client Group

Redesign of MHOA Inpatient Capacity QIPP

- Programme focuses on time limited assessment, treatment and successful placement of people with complex dementia.
- Enhanced assessment and liaison project to improve the 'front-end' assessment and triage function to support 'rapid referral' from GPs.
- Redesigned services acts to stabilise patients before discharging into care homes appropriate to meet their needs.
- Investment in a Dementia Care Home Support Team for the local care homes and develop an educational hub.
- This programme seeks to reduce admissions to SLaM beds and thereby reduce commissioned beds from 30 to 16.
- This programme is being coordinated in partnership with SLaM and Lambeth CCG.

Male Psychiatric Intensive Care Unit (PICU) Inpatient Redesign QIPP

- The number of Male PICU beds will be reduced from 8 beds to 6 beds from April 2013.
- CCG lead a programme of service redesign to support patients to access services in primary care and in community settings.
- The CCG contract with SLaM is now based on occupied bed days.
- The CCG will fund a minimum of 6 beds equivalent occupied bed days.
- Above this level there will be a 50:50 risk share up to a capped level equivalent to 8 beds.
- Above 8 beds 100% of costs will be borne by the CCG.

Summary of CCG Financial Position (M4)

NHS Southwark Clinical Commissioning Group

Programme Budget	Annual Budget (£k)	Variance to Month 4 (£k)	Predicted End of Year (£k)		Best Case (£k)	Worst Case (£k)
Acute	194,442	-1,291	-8,337		-2,921	-12,705
Client Groups	70,720	43	200		150	-2,800
Community Contract	29,138	0	0		0	-300
Prescribing	31,617	100	300		300	-200
Corporate Costs	4,078	90	80		100	0
Earmarked Budgets and reserves	14,747	1,058	7,757		8,500	7,757
Planned Surplus	3,972	1,324	3,972		3,972	3,972
Total	**348,714**	**1324**	**3,972**		**10,101**	**-4,276**
Month 3 (for comparison)	*354,203*	*993*	*3,972*		*4,332*	*-3,472*

NHS
Southwark
Clinical Commissioning Group

Health, Adult Social Care, Communities and Citizenship Overview and Scrutiny Sub-committee

4 September 2013

Update on consultation: Improving health services in Dulwich and the surrounding areas.

1. At the last meeting of the Health, Adult Social Care, Communities and Citizenship Overview and Scrutiny Sub-committee NHS Southwark CCG fed back on the Consultation Report and the Equalities Impact Assessment.

2. Since then work has been under way to develop the recommendations from those reports. They will be considered by the Governing Body at their meeting in public on the 12 September 2013.

3. The recommendations have been developed through an iterative process of discussion.

4. They will draw directly on:

    - the four conclusions from the Consultation Report,
    - other significant points raised in the report,
    - the Equalities Impact Assessment, and in particular the reasonable adjustments proposed in direct relation to the Dulwich Programme.
    - issues that build on the consultation

5. This work has strong links with a number of other parallel pieces of work: the Community-based care Strategy, the Primary and Community Strategy, and the Southwark and Lambeth Integrated Care Programme.

6. The full version of the report, its appendices and the Equalities Impact Assessment can be found at:

    http://www.southwarkccg.nhs.uk/GetInvolved/ImprovingServicesConsultation/Pages/default.aspx

Rebecca Scott
Programme Director - Dulwich

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2013-14**

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